IN THE CORONERS' COURT OF THE NORTHERN TERRITORY

CORONERS' FINDINGS

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

I, Elisabeth Armitage, Coroner, having investigated the death of a 20 year old Aboriginal female (the deceased) and without holding an inquest, find that she was born on **29 July 2000** and that her **death occurred on 1 December 2020, at Freshwater Road, Jingili in the Northern Territory.**

Introduction

1. The deceased was killed by WD on 1 December 2020, and he was charged with her murder. WD entered a plea of not guilty to murder but guilty to manslaughter on the basis that he was entitled to the partial defence of diminished responsibility. The Crown did not accept the plea of guilty and the matter proceeded to trial. Following a trial by jury, on 18 March 2024 WD was found guilty of murder.
2. On 2 April 2024 WD was sentenced to life imprisonment with a non-parole period of 20 years. He was also found guilty of an aggravated assault against the deceased's sister and sentenced to 2 years and 6 months. The sentences were backdated to 1 December 2020.

Cause of death:

1(a	Disease or condition leading directly to death:	Stab wound to the left mid-anterior of the chest in the context of multiple other sharp force injuries

Following an autopsy on 1 December 2020, Forensic Pathologist, Dr Marianne Tiemensma commented:

Post- mortem examination report dated 3 December 2020 and Supplementary post- mortem examination report dated 18 January 2021

Circumstances surrounding death

The decedent was reportedly found with multiple sharp force injuries in Freshwater Road, Jingili, on the morning of 01/12/2020. Resuscitation was attempted to no avail. A history of domestic violence was reported by the police.

Summary of main pathological findings

- Autopsy showed:
  - Four stab wounds to the torso, including one to the left mid-anterior aspect of the chest, one to the right anterior aspect of the abdomen, one to the posterior aspect of the left shoulder, and one to the left thoracic area of the back.
- The track of the stab wound to the left mid-anterior aspect of the chest perforated the left 6th costal cartilage, the anterior aspect of the pericardium, and the anterior wall of the right ventricle of the heart. Approximately 350 ml of blood was measured in the pericardial sac.
- The track of the stab wound to the right anterior aspect of the abdomen perforated the right hemi-diaphragm, the mesentery, and the right psoas muscle.
- The tracks of the stab wounds to the posterior aspect of the left shoulder and the left thoracic area of the back perforated adipose tissue and muscle, without entering the left thoracic cavity, and without causing any significant injury.
  - Defensive sharp force injuries including:
- Four stab wounds on the dorsal aspect of the left forearm, with underlying injury to the left forearm muscles.
- Superficial incised wounds across the dorsal aspects of the left 3rd, 4th, and 5th fingers.
  - An abrasion on the dorsal aspect of the left elbow.

Essential history

- Female, 20-years old.
- The decedent was reportedly found with multiple sharp force injuries in Freshwater Road, Jingili, on the morning of 01/12/2020. Resuscitation was attempted to no avail.
- An autopsy was conducted on 01/12/2020 at 2:15pm, of which the findings are contained in an autopsy report (dated 03/12/2020). The cause of death was ascertained to be a stab wound to the left mid-anterior of the chest in the context of multiple other sharp force injuries.

Histology review and results of toxicological and biochemical analyses

- Toxicology report (Results received on 08/01/2021)
  - 0.052% alcohol was detected in the preserved iliac vein blood.
  - No other drugs listed in the Scope of Analysis attached to the formal toxicology report were detected in the preserved iliac vein blood.

Note:
A blood alcohol concentration of 0.052 % generally correlates with a "light" degree of clinical intoxication, depending on many factors, such as individual tolerance and metabolism. The autopsy was conducted within a few hours after death, with no signs of decomposition present at autopsy, and I do not believe that the measured alcohol concentration was a result of post-mortem alcohol synthesis.

Comments

- A total of four stab wounds present to the torso, with additional defensive sharp force injuries to the left forearm and fingers of the left hand.
- Ancillary investigations did not reveal any significant factors that could have contributed to death, and I am of the opinion that the cause of death is a stab wound to the left mid-anterior of the chest in the context of multiple other sharp force injuries.
- Although the tracks of the stab wounds to the abdomen, posterior aspect of the left shoulder and left thoracic area of the back were quite deep, none of these resulted in any immediate life- threatening injuries, and the fatal stab wound is the one to the left mid-anterior aspect of the chest, with perforation of the anterior wall of the right ventricle of the heart, and resultant haemopericardium (blood in the pericardial sac) and cardiac tamponade.
- Cardiac tamponade causes death by increasing the intra-pericardial pressure and producing progressive external compression of the heart, with subsequent inadequate filling of the heart chambers, and it can also cause mechanical interference with ventricular myocontractility.
- The additional sharp force injuries may have incapacitated the decedent and rendered her incapable to defend herself against the fatal stab wound.

Circumstances

3. The deceased was born in Darwin and grew up in Wadeye with her four siblings. At the age of 5 she went to live with her grandparents. In around 2014 her grandmother passed away and she took on the responsibility of caring for her grandfather, including escorting him to various medical appointments in Darwin. In 2015 she spent a brief time in foster care in Darwin, before returning to live with family in Wadeye.

4. WD was born in Darwin on 6 June 1984. He lived in Wadeye most of his life but attended Kormilda College in Darwin and finished year 12. His English was very good.

5. By 2016 he was in a relationship with NB and they had a child together. The relationship was troubled.

   - In October 2017 there was an incident of jealousing, WD slapped his partner and they agreed to separate.

- In September 2018, he pulled her from a taxi in Nightcliff and dragged her along the ground. Both were intoxicated. A witness called police who attended and charged WD with assault (for which he was later convicted) and the police also issued a non-intoxication/non-harm DVO.
- In January 2019 there was a drunken argument between the couple that was brought to the attention of police, but no further action was taken.
- In October of 2019 he stabbed himself to the chest following an argument with his ex-partner. The injury was minor, he received medical attention and there was no further police involvement.

6. In around 2019, the deceased met WD, and they commenced a relationship. They lived initially in Wadeye and in about October 2020 they travelled to Darwin where they resided at various locations, staying mainly with his family.
7. The relationship was troubled and each reported matters to police and there were concerning medical records.

- On **11 October 2019** the deceased entered the Darwin Police Station and told police she had thoughts of self-harm, she did not feel safe returning to her place in Darwin and wanted to go to Wadeye. She had a stab wound to her left big toe which was cleaned and dressed. She was intoxicated.
- On **14 June 2020** WD reported to police that he did not know where the deceased was and requested a welfare check. Viewing the matter now, with a DV lens, this notification may well have been an act of coercive control.
- On **23 June 2020** WD reported to police that the deceased was "playing around on him" and had told him not to return to Wadeye and he should stay away from her or she would stab him. Police advised him not to return to Wadeye but no further follow up or action was taken. Viewing the matter now, with a DV lens, this report may have been an act of coercive control by him at a time when the deceased was seemingly taking steps to actively separate from him. Although she was reported as the 'aggressor', applying a DV lens, police could have taken steps to speak to her about a DVO or offered to refer her to other supports.

- On **12 August 2020** the deceased called police to her location in Wadeye. She said she had been in an on-and-off relationship with a Mr C who was jealousing her over WD. Mr C had punched her in the face and started to swear at her. When police attended the deceased was present with WD.
- On **17 August 2020** the deceased called the police. She was highly intoxicated and talked of being stabbed or stabbing someone. When police attended, she was found distressed in the street because her partner, WD, had moved on and had met another girl and she felt like hurting someone.
- On **18 August 2020** the deceased attended the Wadeye Clinic holding her right side in pain. She said that WD had punched her in the ribs and scratched her face. The clinic records state that there was a phone call to police and she was given Panadol for the pain.
- On **20 August 2020** police called the Wadeye Clinic requesting that a nurse attend the police station to assess the deceased for custody. She was intoxicated, vomiting and complaining of a painful left shoulder from being pushed over by her partner.

A domestic violence history

8. All in all, the deceased had 47 involvements with police recorded on the police PROMIS system and 4 criminal offences. WD was 36 years old when he killed the deceased, aged 20. He had 28 involvements recorded on PROMIS and 4 criminal offences.
9. The police records included the following domestic violence incidences between the couple which are summarized below. Following her death the NT Police conducted a review of their engagements with the deceased and the outcomes of this review are also summarised.
10. On **20 August 2020**, the deceased, who was very intoxicated, called 000 and said that WD was intoxicated and had hit in the face. The call taker could hear yelling and swearing in the background and a male saying “hurry up”. The deceased then stopped responding. Police attended and spoke to WD, who they described as mildly intoxicated but calm and rational. He denied any fighting. The deceased was described as highly intoxicated and irrational, and she was yelling she had hidden a knife and would kill someone. She denied being

assaulted. She was arrested, taken to the watchhouse and issued a summary infringement notice.

11. The Body Worn Video (BWV) of one officer was reviewed. The other officer failed to activate his BWV. A supervisor audit and the NT Police review found the police actions to be reasonable in the circumstances.

12. However, applying a DV lens, and in light of the menacing background noises to the 000 call, it is possible attending police misidentified the person most in need of protection and may have been manipulated by and/or colluded with the primary perpetrator.

13. On **12 October 2020**, the deceased contacted police from Palmerston flats in Gray reporting that her partner was drunk and trying to kill her. A police unit was dispatched and located the pair outside the Gray Shopping Centre. Both police activated their BWV. The deceased was visibly distressed. She told police that WD had smashed her phone (and showed them a broken phone) and choked her (and demonstrated by putting her hands around her neck). The officer was very polite and tried to get further information, but the deceased did not respond further or make a statement. The officer looked at her neck with a torch and did not see any injury and there were no independent witnesses. WD was questioned by the second officer. When asked if he damaged the phone or if there was arguing he said "nothing". Enquiries were made in relation to whether there were any relatives the deceased could stay with for the night, but none were established. She was taken into protective custody. This appeared to anger WD who said, "she not drunk". She stayed at the Palmerston watch house overnight.

14. A supervisor audit was conducted by a Sergeant and both that audit and the NT Police review found that separating the parties was a reasonable course of action to prevent further domestic violence. As the sobering up shelter refused to accept her, the Watchhouse was acceptable. However, the review identified that it would have been preferable for police to find out whether a women's shelter could have taken her before resorting to the Watchhouse. The NT Police review was not critical of the failure by police to take out a DVO on the available evidence.

15. On further reflection, in my view it is likely that police misidentified the person most in need of protection and there was more that could and should have been done to protect and assist the deceased.

16. It is likely that neither the attending nor reviewing police properly understood the seriousness of the choking allegation. The AIJA Domestic and Family Violence Bench Book refers to US research that women who have experienced non-fatal strangulation by a perpetrator within the previous 12 months are twice as likely to be killed and six times more likely to be a victim of attempted murder, compared to women who had not been strangled. The Bench Book also makes it clear that strangulation is a form of coercive control.[1] It is now well understood that allegations of choking are serious red flags that should not be minimized or overlooked. Choking can occur without leaving an injury and/or injuries can be subtle.

17. I am not persuaded that there was insufficient evidence for the issuing of a DVO. There was objective evidence to support the allegation that WD had broken her phone. She showed police the damaged phone.[2] His purported denial, "nothing", was hardly compelling. Damaging property is another recognized form of coercive control. Restricting access to and /or breaking a phone prevents victims from contacting people they may wish to contact (isolation), and it makes it harder for them to seek help. There is another example of this type of behaviour on 16 October 2020 (discussed below).

18. Finally, there is no evidence that police attempted to build rapport with the deceased or obtain a statement from her after she had been held in custody and sobered up, and this should have been done.

19. In response to this incident, at a minimum, consideration should have been given to obtaining a medical assessment of the deceased in response to the choking allegation, referrals to support services should have been offered, a risk assessment should have been conducted, and in my view a DVO should have been initiated.

20. On **16 October 2020 at 4.22pm**, a female friend of the deceased contacted police to report that the deceased was being threatened by her ex-partner, he had taken her phone and left the location. When police attended the deceased reported that WD had punched her and had taken her phone. She had a visibly swollen left eye. She was very intoxicated. A male who was present told police that WD had hit her while he (the male witness) was downstairs paying for a taxi. The female friend said she would look after the deceased for the night.

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[1] Article | AIJA; DVFbenchbook.aija.org.au/article/1080149 accessed on 17/12/24; 4.2 Factors Affecting Risk
[2] That she had another undamaged phone is not to the point

Police said they would return the following day to obtain more details when she was sober. Entries on the police system indicate that the officers re-attended the location on 17 and 18 October 2020, however, could not locate the deceased. There is no evidence that police attempted obtain WD's version of events.

21. A supervisor audit was conducted by a Sergeant who reported: *"Minor DV incident where alcohol is a contributing factor. No offences alleged or detected. Boyfriend has girlfriend's phone"*. At that time, the relevant General Order[3] did not mandate what evidence must be reviewed in order for a supervisor to discharge his or her auditing obligation and there was no requirement for the supervisor to specify what evidence had been reviewed. The account provided by the attending police in the PROMIS case summary was deficient in that it omitted relevant information. However, it is clear that the supervisor did not review the BWV because if that had been reviewed, the supervisor would have discovered that the account provided by the attending member in the PROMIS case summary did not match the interactions captured on the BWV. It is unfortunate that the Sergeant missed this opportunity to provide guidance, supervision, and mentoring or to rectify the police response.

22. The NT Police review found that further questioning of the witnesses and of the deceased should have been undertaken during the initial attendance and statements taken. Police should have obtained a BWV recording of the deceased, to record not only what she said but also her demeanor and injury. The reviewer considered that if those steps had been taken there may well have been sufficient evidence to warrant the initiation of a DVO, if not charges.

23. The performance of the attending officers was considered to sufficiently depart from the expected standard to warrant referral to the Professional Standards Command (PSC). Both attending officers received written cautions which included the following:

> *Despite prima facie evidence that [the deceased] had been assaulted, allegedly by her partner [WD], you failed to take action required by the [Police Administration Act 1978] and Northern Territory Police Policy that is in place to attempt to prevent further violence being*

[3] General Order-Domestic and Family Violence promulgated 28 February 2014

inflicted on[the deceased].

…

I take this opportunity to remind you of the importance of a thorough and transparent investigation into all allegations of domestic and family violence. Due diligence is essential to ensure all domestic and family violence matters are investigated appropriately, preventative measures are taken to mitigate the risk of future violence, and a criminal prosecution is initiated when sufficient evidence exists.

[The deceased] was murdered on 1 December 2020 and her partner WD stands charged with causing her death. Whilst you could not have predicted that the victim you spoke to on 16 December 2020 would soon die at the same person she had accused of assaulting her when you attended, you failed to provide her with the assistance required of you as a Northern Territory Police Officer on the day of your attendance. I recommend that you reflect on this, and moving forward, work toward improving your attendance and response to domestic and family violence related incidents.

24. Later that same day, on **16 October 2020 at 6.52pm**, police received a call from a female who was at Palmerston flats stating that her partner had hit her, and she wanted to kill herself. The call taker heard what sounded like the female screaming and a male yelling and then screaming and crying, before the call was disconnected. The call taker tried calling back several times before the call was answered. While the person who picked up the phone did not answer any further questions, the call taker overheard someone say, “my wife is hurt”.

25. Police were dispatched and attended the Palmerston flats. They did not initially locate a disturbance but, after conducting a door knock of the unit complex, located the deceased. She was noted to be “extremely intoxicated” with a visible lump and laceration to her forehead and a ripped shirt. She told police that WD had come to the Palmerston flats and demanded that she go with him to another location. When she refused, he dragged her down the stairwell. Her female friend said she had witnessed the incident. Police took photographs of the deceased’s injuries and of her ripped shirt. Attending police reported that she was too intoxicated to provide a statement and “assault charges were pending a statement”. Police then located WD at

another address and arrested him for the purpose of a police initiated non-intoxication/non-violence DVO which was served on him, and subsequently confirmed.[4] A further witness who was identified at this time said that he was present during the incident and had tried to stop WD from getting to the deceased.

26. A supervisor audit was conducted by a Sergeant who noted: *"41 applied for and obtained. Before Court – DVO application. AAIO (all appears in order)."*

27. To their credit both constables had their BWV activated, however, the NT Police review identified other serious deficiencies. Most importantly their failure to take statements from the witnesses. The reviewer considered that if those statements had been taken there would likely have been sufficient evidence to charge WD with an assault.

28. The two police members were referred to the PSC and were counselled and cautioned for their negligent and inefficient discharge of duties in the same terms as the earlier officers.

29. However, the NT Police Review did not identify the deficiencies in the supervising audit. Unfortunately, the supervising Sergeant had also failed to detect that there was likely prima facie evidence of a criminal offence, assault, given the allegation made, the potential eyewitnesses and the evidentiary relevance of the injury and torn clothing. Accordingly, the Sergeant missed the opportunity to correct the constables and to intervene to rectify the response. I am advised that remedial advice will now be provided to this Sergeant.

The month in the lead up to her death

30. Despite the existence of the confirmed DVO, the violence continued. The deceased planned to end her relationship with WD and discussed this with family and friends. It seems that at some point WD learned of her intention to leave him. Several witnesses recalled that WD was looking for her and she was avoiding him.

31. On **6 November 2020** hospital records reveal that WD stabbed himself in the neck with a fork while intoxicated. He received medical treatment, but the matter was not reported to police and further circumstances are not known.

[4] The DVO was confirmed by the Local Court on 23 October 2020 for a period of 12 months and it was served on Mr Dhamarrandji on 5 November 2020.

Given the limited information it is not possible to conclude anything from this event, but it is well understood that self-harm and the threat of self-harm can be acts of coercive control.

32. A photo dated **9 November 2020** of an injury to the deceased's head was found on her phone by police (when they interrogated the phone after she had passed away).

33. On **29 November 2020**, JG drove the deceased to a residence in Wanguri to retrieve her belongings, as she was planning to return to Wadeye. She told JG that WD had been assaulting her, that he had punched her in the face and stabbed her in the back with a knife. After collecting her belongings, JG dropped her at the Jingili Watergardens with another female.

34. At **3.42pm on Sunday 29 November 2020**, the deceased called 000 from the Jingili Watergardens reporting that WD wanted to kill her, he had hit her, and she wanted him locked up. Police were dispatched but as both her and WD's names were incorrectly recorded by 000 the police attempt to locate their histories on PROMIS failed. The two attending police spoke with the deceased who provided a different name to that given to 000. The police challenged her about her name and accused her of lying. There was a veiled threat that they could find out her real name at the Watchhouse. A man who was sitting nearby told police who she was. The police recorded that "when she was challenged about several false details" she kept playing on her phone. She then showed police a photo of WD and said that he was her partner and he was no good. Police noted that his name was different to the name recorded in the 000 call. Police considered that the deceased might have a brain injury and concluded "appears to be some type of false malicious report, unable to establish any DV incident or involvement, this case to be closed".

35. The incident type in PROMIS was changed from Disturbance-Domestic to Disturbance-General in which case no supervisor audit was conducted, and the case was closed by a Senior Sergeant.

36. The NT Police review identified serious deficiencies with this police attendance. It was noted that the police accused the deceased of lying, they spoke to her in a condescending tone, showed no empathy and did little to enquire into what had really happened. Although there were four Aboriginal people sitting nearby, one of whom provided her name, no effort was made to ascertain whether they had witnessed an incident. Towards the end of the

interaction, it seems police became aware of the DV history but concluded their attendance with these words, “Well I can’t even confirm that he was he, she’s told us that many lies, haven’t you”. They then said, “Just leave the area if you are worried about him coming back. Last thing all these nice little families down here having a wonderful Sunday afternoon want to deal with is people fighting” and “so start walking, off you go”. Finally, police challenged her about the phone. She told them it was her uncle’s phone and one officer said, “Don’t be rude or you’ll be going to watchhouse”.

37. The NT Police review identified that there was a current DVO and had the matter been properly investigated a breach might have been established justifying the arrest of WD. The reviewer noted that the police failed to offer DFV referrals.

38. Both constables were referred to the PSC and they were formally counselled and cautioned in similar terms to the other junior officers. However, there is no evidence that the Senior Sergeant, who failed to conduct an audit of this incident, was disciplined.

39. The deceased stayed at a local hotel with family on Sunday 29 November and Monday 30 November. There was no further contact with police.

The day of her death

40. On the morning of **Tuesday 1 December 2020,** the deceased and her sister were dropped off at a carpark on Freshwater Road, at the Jingili Watergardens. They started walking towards a cousin’s place.

41. That same morning WD, who had been staying with family in Malak, went looking for the deceased. He stole a pushbike and rode to Jingili Watergardens. He had a backpack containing a large knife.

42. At the Jingili Watergardens he found the deceased and her sister walking together in the park. He rode up behind them and got off his bike. He asked the deceased, “Why are you going back to Port Keats?” and she responded, “I’m leaving you because you keep giving me a hiding”.

43. WD pulled the knife from his backpack and stabbed the deceased twice in her back. She fell on the ground. Her sister came to her assistance and hit WD with a small water bottle on his neck. He momentarily turned his attention to her and attempted to stab the sister in the neck. The sister helped the deceased up from the ground and they began to run away.

44. WD chased them onto a road and the deceased fell over, landing on her back. He then stabbed her seven more times to her arms and her chest while yelling out “you motherfucker”.

45. WD went back to his stolen bike and rode away. He disposed of the knife and changed his shirt.

46. St John Ambulance was contacted at 10.33am and arrived at 10.46am. She was unable to be revived and was declared deceased at 11.08am.

47. The fatal injury was inflicted while she was lying on her back on the roadway. One chest wound inflicted at that time perforated her heart, causing blood in the pericardial sac and cardiac tamponade. She had defensive wounds to her forearm and fingers.

48. Shortly before midday WD was located and arrested by police near the Jingili shops on the stolen pushbike. He was about 1200 metres from the scene of the killing.

Comments

49. As these findings contain comments which are critical of some police responses, NT Police were provided with an opportunity to consider these adverse comments and to respond. They did so, and the NT Police response is reflected in these findings.

50. I am satisfied that the deceased is one of the 82 Aboriginal women killed in the Northern Territory since the year 2000 as identified in the *Inquests into the deaths of Miss Yunipingu, Ngeyogo Ragurrk, Kumarn Rabuntja and Kumanjayi Haywood* [2024] NTLC 14. In those Inquests 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, including jealousing, property damage and acts of self-harm, 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 when women chose to leave, this is a period of heightened risk.
- 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.

51. Concerning her encounters with police, on occasions those interactions provided further examples of specific and systemic police failings, including:
    - In most instances there is nothing to indicate that attending police were aware of or accessed the history of domestic violence.
    - 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.
    - 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.
    - 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 appear to have been largely overlooked.

- DVOs were not taken out when they perhaps should have been.
- On one occasion police were rude and dismissive.

52. That NT Police had conducted a review and identified many of these operational failings was encouraging. That NT Police engaged with and corrected attending police who fell short of expected standards was also encouraging. But it was discouraging to discover that the NT Police review did not extend to the supervising police members. In response to this identified deficiency, I am advised that a direction will be provided to the Professional Standards Command to ensure all future investigations in similar circumstances will include an examination of the supervisor's conduct.

53. NT Police have advised that, with the introduction of SerPro (which has replaced the PROMIS system) the standard questions in the supervisor's domestic violence audit have been substantially expanded, and supervisors are required to complete a 'decision log', to ensure that audits are thorough. Although NT Police concede that reviewing BWV during a shift is not always achievable, attending members are required to answer additional questions in the occurrence log which are intended to assist supervisors to identify if there are deficiencies with the response. NT Police advise that the Domestic Violence audit process is much more comprehensive than formerly required.

54. In addition, NT Police have located five Domestic Family Violence Senior Sergeants in JESCC to: provide supervision and leadership to frontline members, facilitate dispatch on an immediate risk basis, conduct audits, provide advice, and identify and respond to persons most in need.

Conclusion

55. It is very clear from recent coronial domestic violence death investigations, including this one, that it is unfortunately not uncommon for police responses to fall short of the standards set by NT Police general orders, training and policies. This is a systemic failing that NT Police have acknowledged and are actively seeking to address through, for example, increased auditing of responses, refreshed training packages, the piloting of a co-responder model in Alice Springs, and the establishment of a DFSV command. I endorse all these endeavours and will repeat relevant recommendations from the *Inquests into the deaths of Miss Yunupingu, Ngeygo Ragurrk, Kumarn Rabuntja and Kumanjayi Haywood* [2024] NTLC 14 below. However, I propose to make one

additional recommendation in these findings to reinforce the need for a DV training refresh for all existing police officers who are found to fall short of expected standards.

56. 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 WD accessed programs or supports to assist him to recognize and change his abusive behaviours. Not enough is known of their childhood experiences or how this might have contributed to their behaviours. It is not known whether either of them accessed alcohol rehabilitation.

57. 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.

58. However, because this death, like all domestic violence deaths, 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 have decided to publish these anonymized findings.

59. As noted earlier, 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. While not formally repeating these as recommendations in this investigation, I note that on the particular facts in

these findings these recommendations from those Inquests 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 7: *Co-responder model*

As a matter of urgency, the NT government should provide further and sufficient funding to the current Alice Springs co-responder pilot (NT Police and the Department of Childrens and Families (DCF) DFSV Co-responder Model) to guarantee its full implementation and independent evaluation. The model must involve victim survivors (including children) as well as perpetrators. Adequate funding (inclusive of independent evaluation) should be provided so that this model can be evaluated, replicated and implemented in other regions. This expands on action 3.6 of Action Plan 2.

I addition, the NT government should consider the development and implementation of further co-responder models, including:

i. Consideration of models based on the success of the Queensland models; and

ii. Consideration of NT Police partnering with Aboriginal Community Controlled Organisations to develop a community-led co-responder model to incidents of domestic and family violence in remote NT communities.

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.

Recommendation 12: *A permanent NT Police DFSV Command*

The NT Police should:

i. Commit to a significantly expanded and appropriately resourced DFSV Command in Alice Springs and Darwin headed by an Assistant Commissioner, with permanent DFSV positions.

ii. Commit to ensuring that priority will be given to continuity of DFSV staff, with guidelines, policies and procedures amended (in consultation with the Current Command and NGO sector) to recognize the necessity of maintaining staff continuity.

iii. Commit to a training unit within the DFSV Command, with staff whose role would include a) liaising with the PARt coordinator to make sure that delivery is occurring as planned; b) recording and incorporating into training the lessons from the Family Harm Coordination Project; and c) ensuring that NT Police are aware of best practice in response to DFSV.

Recommendation 13: *Family Harm Coordination daily auditing program to be expanded*

The Family Harm Coordination project daily auditing program should receive continued funding and be expanded across the Territory.

Formal Findings

60. The formal findings that I make are:

a. The identity of the deceased is known and she was born on 29 July 2000 at Darwin in the Northern Territory.

b. The time of death was 11.08 on 1 December 2020, at Freshwater Road, Jingili in the Northern Territory.

c. The cause of death was: Stab wound to the left mid-anterior of the chest in the context of multiple other sharp 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.

Additional Recommendation

61. To NT Police, I recommend that all serving police officers who are identified

as falling substantially short of expected standards, when responding to or supervising responses to domestic and family violence incidents, be fast tracked for and rostered to complete appropriate PARt training, if they have not already completed that training.