CITATION: *Inquest into the deaths of Fionica Yarranganlagi James, Keturah Cheralyn Mamarika and Layla Leering* [2020] NTLC 022

TITLE OF COURT:	Coroners Court
JURISDICTION:	Darwin
FILE NO(s):	D239/2017, D186/2016, D225/2017
DELIVERED ON:	15 December 2020
DELIVERED AT:	Darwin
HEARING DATE(s):	16 – 18 September 2020
FINDING OF:	Judge Greg Cavanagh
CATCHWORDS:	**Deaths of teenage girls in remote Aboriginal communities, high levels of trauma and stress, perfunctory police investigations, little to no assistance from government agencies**

REPRESENTATION:

Counsel Assisting:	Kelvin Currie
Counsel for Police Commissioner:	Trevor Moses
Counsel for Territory Families:	Michael McCarthy
Counsel for Education:	Helena Blundell
Counsel for Top End Health Service:	Stephanie Williams
Counsel for family of Ms James and aunt of Ms Leering:	Mark Thomas

Judgment category classification:	B
Judgement ID number:	[2020] NTLC 022
Number of paragraphs:	311
Number of pages:	82

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

No. D239/2017, D186/2016, D225/2017

In the matter of an Inquest into the death of

FIONICA YARRANGANLAGI JAMES
ON 28 DECEMBER 2017
AT WARRUWI COMMUNITY

In the matter of an Inquest into the death of

KETURAH CHERALYN MAMARIKA
ON 22 NOVEMBER 2016
AT UMBAKUMBA, GROOTE EYLANDT

In the matter of an Inquest into the death of

LAYLA LEERING
ON 10 DECEMBER 2017
AT BULLA COMMUNITY

FINDINGS

Judge Greg Cavanagh

Introduction

1. This inquest was the first of two inquests that dealt with the deaths of Aboriginal children known to government agencies to be at significant risk within their community and yet who received no real assistance. These children lived and died in conditions of violence, sexual molestation and despair. That these conditions continue to exist in an affluent country such as Australia is a disgrace. These are similar conditions to that witnessed by

me and recorded in my findings into youth suicide deaths in 1999[1] and in relation to volatile substance abuse deaths in 2005[2].

2. The known circumstances of the deaths of these girls are confronting. Much about their lives is similarly confronting. The trauma they experienced was significant. The stress to at least two of them considerable. The failure of government agencies to recognise their plight is disturbing. My responsibility as Coroner is to reveal the truth of all circumstances in connection with these deaths. In my view, only a full description of the sad reality of their lives will provide the basis for government, policy makers, bureaucrats, and community elders to find answers and solutions to the evident problems.

3. These three deaths were listed together to be investigated in the same inquest because they raise similar issues. Three Aboriginal teenage girls aged 17, 16 and 15 years respectively, died by hanging in remote Aboriginal communities. They were all slight in stature. They were all known to government agencies due to their various traumas and difficulties. They were known to be sexually active (in two of the cases from the age of 12 and 13 years) and to have been provided Implanon contraceptive implants by the local health services at the behest of their families. Two of the girls were sent to boarding school with very poor outcomes. All had disengaged from education and there had been no attempt to re-engage them.

4. Police were unable to confidently determine the circumstances of their deaths. Two had fresh genital injuries, indicating the likelihood of sexual assault and the other a fresh laceration above her right eyebrow along with evidence that she and her family were threatened with "war" in the early hours of that morning by her boyfriend while wielding weapons.

---

[1] Inquest into the deaths at Nguiu, Bathurst Island of Tipungwuti, Kerinaiua, Puantulura and Orsto, 25 November 1999

[2] Inquest into the deaths of Kumanjay Presley, Kunmanara Coulthard and Kunmanara Brumby [2005] NTMC 086

5. The families of the three deceased indicated that they had no objection to the girls being referred to by their first names. The Aunt of Ms Leering (who had a major role in raising her) preferred that she be referred to as "Gulum", but her mother wanted her to be referred to by, "Layla, the name I gave her". Accordingly, I will refer to the three girls by their first names.

In the matter of an Inquest into the death of

FIONICA YARRANGANLAGI JAMES
ON: 28 DECEMBER 2017
AT: WARRUWI COMMUNITY

Short Story

6. Fionica grew up in a strong family in Maningrida and on Goulburn Island. She attended School and was a good achiever. At 14 years of age she attended school less and became involved with an older man. Her mother and aunt took her out bush to get her away from the man and disciplined her in the cultural way (drawing blood). But she couldn't get away from the older man. He assaulted her and told her that if she did not become his girlfriend he would hurt her family.

7. She was traumatised and found refuge with a woman who was not family. Her family were unhappy and insisted she go to family at Warruwi. One DCF staff member knew that to be a bad idea and asked that the agency not support her move to Warruwi. She said Fionica was too traumatised and would self-harm. However she was sent and soon after tried to kill herself. From there, with the help of the Department of Education, she was sent to boarding school in Queensland without family, friends or other support. She returned two months later and stayed home for another 5 months. She returned to boarding school for the last term but was so depressed she remained in bed all day and refused to attend classes. She was sent home three weeks later.

8. The next year she met another older man. He was the wrong skin and treated her badly. Her family didn't like him. He went to prison for nine months for breaching his parole (violence to sister and intoxication) and she went back to school. She saw the school counsellor five times but when her boyfriend got out of prison she stopped attending. He treated her badly again and two months later she was sent to hospital with crushed and broken fingers. A family member escorted her to Darwin but left her the same day to go drinking. Another family member was sent to Darwin to look after her but again left as soon as she arrived. While in Darwin, Fionica had a number of panic attacks. She returned to Warruwi three weeks later.

9. She found her boyfriend had started another relationship while she was away. One night she went home with her family. At 2.30 in the morning he arrived at the house with a spear and axe. He said if she did not return home with him there would be war between the families the next day. She was so frightened she called the police on two occasions. She was told there were no police on duty.

10. When the sun came up she went back to her boyfriend before her family woke. He said they had sex and he went to sleep. It seems that while he slept she contemplated her options. She woke him and asked that he buy her a coke. The moment he left she slipped out and headed to the bush where she took her life.

Longer Story

11. Fionica was born on 18 February 2000 in Royal Darwin Hospital. Her parents were Bridgette Gurrunama and Jerome James. She had two younger siblings.

12. She was mainly raised on Goulburn Island, Croker Island and in the Maningrida Community. By the time Fionica was 10 years of age (2010) her parents were struggling with alcohol and drugs. She went to Maningrida to

live with her uncle, Robert and maternal auntie, Sarita. She was known to be a quiet and shy girl.

13. On 5 December 2013 while still 13 years of age, she was taken to the health clinic by her aunt. She had a sore right knee and was walking with a limp. Overnight it had become swollen, hot and tender and she was unable to weight bear. Her right elbow was also very sore. She said she had been bitten a couple of days ago by a centipede. It was initially thought she might have been suffering acute rheumatic fever, acute renal failure or septic arthritis.

14. She was evacuated to Royal Darwin Hospital where she was diagnosed with rheumatic fever and gonorrhoea. She underwent a SARC examination. She was found to have resolving genital tenderness and abrasions to the vaginal area. She denied any sexual activity. She was provided counselling from an Aboriginal SARC counsellor.

15. On 12 December 2013 a notification (**first notification**) was made to the Department of Children and Families (DCF) due to her testing positive for gonorrhoea. However she was discharged from hospital and returned to Maningrida on 20 December 2013 without being seen by any DCF staff. Indeed, nothing was done by the Department until 3 February 2014. By that time she had gone to the Maningrida Community Health Clinic to have a contraceptive implant (Implanon) on 13 January 2014.

16. When DCF staff travelled to Maningrida on 4 February 2014, Fionica told them she had not had sex and did not have a boyfriend. She maintained that story despite being told that she must have done so because of the sexually transmitted disease. Her mother was asked whether she thought the sex was consensual or forced. She replied “Don’t know, probably forced”. The staff were also told that on the weekend her father had punched her mother while Fionica was present. Fionica’s aunt told her father to leave. Fionica was assessed as ‘safe’.

17. On 28 February 2014 the child protection investigation was substantiated. However it was only in relation to being exposed to domestic violence. There was no more meaningful activity in relation to assessing the risk to Fionica due to her evident sexual activity or ensuring her protection over the ensuing months.

18. On Wednesday, 24 September 2014, it was noted that Fionica had not been at school for a week. That was unusual. There was talk that she was seeing "a lot older" boyfriend and that she had been disciplined by her family. Fionica was found by police and taken to the Maningrida Community Health Centre. It was said her mother was angry with her being with an older man and had grabbed her hair and dragged her down the road. Her mother was also said to have struck her several times with a brick.

19. Fionica had a three centimetre laceration to her head and tested positive to Trichomonas vaginalis, chlamydia and gonorrhoea. When asked about her sexual partner she said that a 24 year old male had been forcing her to have sexual intercourse.[3] She told the nurse she wanted to get out of Maningrida and would like to go to boarding school in Darwin.[4]

20. On 26 September 2014 another notification (**second notification**) was made to DCF about Fionica being assaulted by her mother and aunty while disciplining her for being with the older boyfriend. It was said her mother assisted the aunty, dragging her towards her grandfather's house.

21. On 5 October 2014 DCF received a further notification (**third notification**). They were told that Fionica was in a relationship with a 24 year old male and that on 3 October 2014 while at the Maningrida football oval he had punched her to the face and when she fell to the ground, had hit her twice to the back. He then forced her to follow him around and return to his residence. The following day the male was arrested for aggravated assault

[3] Clinic notes 9 October 2014
[4] TF CCIS notes for 28 October 2014

and deprivation of liberty. A full non-contact domestic violence order was put in place and he was refused bail.

22. That same day DCF received a notification (**fourth notification**) relating to the sexually transmitted diseases from the testing undertaken on 24 September 2014. However, that information was added to an already open case. Fionica was spoken to on 31 October 2014 by DCF staff. She recalled her mother hitting her on the head with a buffalo bone. She denied having sex with anyone including the older male.

23. Fionica's family wanted to send her out of Maningrida before the older male was released from prison, either to Goulburn Island or to boarding school. The primary reason was that the older male had threatened that if Fionica did not return to him he would suicide. They worried that if that happened there would be payback and black magic from his family. The school counsellor said that Fionica was "appearing thin, unkempt and reporting she had no safe place to sleep at night".[5]

24. A referral was made to MOS Plus (Mobile Outreach Service Plus Projects[6]) by DCF and the plan from the family was that Fionica be sent to Warruwi. Until she went to Warruwi she stayed with the woman outside Maningrida. She said she felt safe there. However, family were insistent that she return to them.

25. A local DCF worker wrote of, "serious concerns for Fionica's mental health if she was forced to go to Warruwi". She went on to say that Fionica was "at risk of suicide if she goes based on my knowledge of her past trauma and my contact with her". However, that was seemingly ignored by the urban based DCF staff.

[5] Statement of R Dunne dated 24 April 2020 p2
[6] A government service

26. After being forced to return to her family, Fionica attempted to kill herself. That information was conveyed to DCF by a member of Fionica's family who sought that she be provided counselling. The information was referred to MOS Plus who made contact with her family, however never spoke to Fionica.

27. By January 2015 it was arranged by Maningrida College that she go to Saint Saviour Boarding School in Toowoomba. She commenced at St Saviours on 11 March 2015. While there she was awarded certificates as the most consistent AFL junior and was an Australian Rules Football, Darling Downs representative. She also received a bronze certificate for "excellence in learning" during the first semester.

28. She then returned home for a funeral on 7 May 2015. She did not return to the school for the balance of term 2 or for term 3. It appears that the school understood that throughout the 3rd term she had health concerns preventing her return, although that is not corroborated by her health records. She did however return for term 4. The term commenced on 6 October 2015.

29. She left Saint Saviours Boarding school for the last time three weeks later, on 27 October 2015. The letter from the Principal read in part:

> "I write to sadly confirm that Fionica was unable to settle on her return to the College. Endless support from a wide range of staff from the College and Boarding to encourage her and to make modifications to assist in her transition.
>
> Fionica did not accept any assistance offered and refused to attend school. This behaviour was ongoing and a means of distress to all staff involved.
>
> Her personal well-being holds high significance in terms of residential care. It became obvious that irrespective of all efforts Fionica was so homesick she could not focus on her learning. In order to care for her it was necessary that additional staff be on duty during the day time to ensure her safety."

30. One of the teachers believed that Fionica was suffering culture shock. Toward the end she was refusing to get out of bed, spending her days in her room with the curtains drawn and her head covered.

31. There is no record of her attending Maningrida College at all in 2015. However, she re-enrolled in 2016. Her attendance rate however fell and was just 58.3 per cent until 15 August 2016. On that date she transferred to Warruwi. Thereafter, she barely attended for the rest of the year (attendance 1.2%).

32. At Warruwi she met and formed a relationship with Alvester. He was four years older. It was not a good relationship. Alvester said that he was "wrong skin" and because of that her family did not approve of him.

33. On 2 November 2016 Alvester had been drinking and they had an argument. He said that Fionica was two months pregnant and lost the baby after her family had beaten her.[7] He took a hose tied it about 8 metres up a tree, tied the other end around his neck and jumped. The hose stretched and he was found shortly after standing on the ground with the hose tightened around his neck. The hose was cut and he was taken to the Clinic and then flown to Royal Darwin Hospital for assessment. The relationship with Alvester was interrupted shortly after when he went to jail for breaching his parole by drinking alcohol and assaulting his sister on 8 January 2017.

34. On 16 January 2017 Fionica was taken to the Maningrida Community Health Centre by her aunty and grandmother at 9.30pm. She said she had been struck to the back with an iron bar. She managed to walk from the scene but was found by family to be "fitting" shortly thereafter. The medical notes describe her presentation as:

[7] There are no medical records to corroborate the pregnancy, nor the allegation of her being beaten, nor the miscarriage. Her family say she was never pregnant. It is most unlikely she was pregnant as she had an Implanon contraceptive implant from 13 January 2014 and renewed early the next year on 17 January 2017.

> "Young woman, slight for height, clear eyes, hair and skin. Appears to look after herself. When she wakes she complains of pain in back and arm. Bruising and small amount of swelling to left elbow. Areas of soft tissue damage all over back. All tender."

35. She said to the clinic staff she was hit on her back and arms by an aunty. It was thought she might have an injured kidney and was sent to Royal Darwin Hospital. Careflight staff recorded:

> "Victim of assault last night by partner, struck with an iron bar to the back. Apparently was able to walk away from scene but pseudo seizures in clinic. Very distressed at the time requiring midazolam and morphine for pain."

36. Her kidney had not been damaged and she was returned to Maningrida. On 3 February 2017 she was again tested for sexually transmitted diseases. The tests were positive for Trichomonas vaginalis.

37. On 16 April 2017 Fionica was taken by family to the Maningrida Community Health Clinic. The family said she had a fight with a family member and another girl and had run off into the bush with an extension cord. Family members found her sitting beside the road. When they approached she appeared to have a seizure. She was found to have a painful right elbow and injury to her upper left back.

38. During the first half of 2017 (while Alvester was in prison), Fionica was enrolled in Maningrida College. Her attendance for the first term was 100 percent. In the second term it dropped to 73 percent and in the third, 21.3%. During that year she saw the Maningrida College counsellor on 5 occasions for mental health and depression issues. However, there are no records of those consultations to determine the issues discussed or if anything was done to support Fionica.[8] She ceased attending school altogether when Alvester returned.

---

[8] Statement Susan Bowden para 138

39. Alvester was released on 28 September 2017. Fionica met him at the airport. He took her to live at his uncle's house. However, things turned to unhappiness very quickly. Alvester said she admitted to "cheating" while he was in prison. He said Fionica was unhappy because they argued and because her family put pressure on her because they didn't like her being with him.

40. On 4 October 2017 Fionica attended the Warruwi Community Health Centre. She was treated for pelvic inflammatory disorder and samples sent for testing. She was positive for gonorrhoea and syphilis.

41. The next day she attended Warruwi Community Health Centre again. She said she had a sore back and mentioned the assault by her aunty in January. She said the pain had been there for about two weeks. The notes state:

> "Asked about sexual association/coercion, domestic violence and physical assault. Appeared reluctant to answer."

42. On 30 October 2017, she attended the Warruwi Community Health Centre at midday. She had a 3 - 4 centimetre laceration over her left eye. She said she had been in the shower that morning and when getting out had slipped. She said she was unconscious for some time. The following comment was made by the public health coordinator at the clinic, "poor historian – was unsure whether she fell back or forward – maybe hit a broom!" At no time did the clinic staff report their suspicions to Territory Families or the police. Of that injury, Alvester said he was throwing a can of food at a dog in the doorway of the residence. He said the can hit the door and bounced, hitting Fionica.[9]

43. On 24 November 2017, she attended the Warruwi Community Health Centre at about midday. She said she had pain to her right hand. She said she had fallen 2 - 3 days before. She was given analgesia.

---

[9] Audio statement 30 December 2017, Transcript p 47

44. She returned five days later on 29 November 2017 at 6.47pm. She had a crush injury, laceration and deformity to her right hand at the fourth and fifth digits. Alvester was with her when she attended the clinic. She said she was moving a table when she accidently fell and her hand was crushed by the table.

45. She was transferred to Royal Darwin Hospital and admitted. On 30 November 2017 she had a closed reduction of the fractured proximal phalanx with internal fixation. It appears she was discharged the following day with a review to be conducted in outpatients on 8 December 2017.

46. She was staying at the Darwin Aboriginal and Islander Women's Shelter from 1 December 2017. On 3 December 2017 Territory Families received a notification (**fifth notification**). They were told that Fionica had arrived at the accommodation two days before with a carer but the carer had left the same day and had not returned. The notifier was given advice on other accommodation options.

47. On 6 December 2017 at 9.30pm she said she had chest pain that had suddenly worsened. St John Ambulance were called. They found her seated in her bedroom. She appeared very anxious and was hyperventilating. They transported her to Royal Darwin Hospital. On admission it was thought that she may be suffering gastritis with a differential diagnosis of a panic attack or costochondritis. She said her last sexual contact was three weeks ago.

48. The social worker saw her the next morning. The note in relation to that attendance is, in part, in the following terms:

> "patient was in RDH (3a) last week and was referred to Darwin Aboriginal and Islander Women's Shelter (DAIWS) regarding possible issues with boyfriend/absconding … patient is also booked on a flight tomorrow 8/12/17 – to return home. DAIWS will continue to support patient with any additional issues – as patient is well known to them."

49. The pain was thought to be anxiety driven. At 2.30pm on 7 December 2017 she said the pain had gone and she wanted to leave. She returned to the Hospital on 9 December 2017 at 8.00pm. She said she had generalised abdominal pain since that afternoon. The impression was gastritis or appendicitis. She was admitted the next morning at 12.15am and discharged that same day. Fionica eventually returned to Warruwi Community on 22 December 2017.

50. The main family member who raised Fionica from 2009 was her aunty, Sarita in Maningrida. She and her husband, Robert went to Warruwi for the Christmas and the New Year. They arrived on Saturday, 23 December 2017.

51. From 7.00am on Sunday, 24 December 2017 there were a number of contacts made between Alvester with another young female by phone. There were two unanswered calls and 9 messages saying "call me" in the space of less than three minutes. From 8.00pm that evening there were another four unanswered calls

52. Also on that evening Fionica told Sarita that Alvester had demanded that she fight with Sarita. She said if she didn't he said he would stab her with a knife.[10] Robert went and spoke to Alvester and told him they didn't want trouble and if he didn't look after Fionica he would "belt the shit out of him".

53. At 12.30am on 25 December 2017 the other young female sent a text to Alvester saying "Oi answer the phone plz babe" followed by a love heart exclamation emoji. Alvester replied 30 minutes later, "Sorry babe im at card". The young female responded, "Ok are u coming here tonight owat". Alvester replied. "Yes I'll text u course im card right now". She responded, "Yeah love you". There were 4 calls from the young female that went

[10] Statement of Robert James para 15

unanswered from 3.00am to about 4.45am. At 6.15am Alvester texted, "What you doing". She responded, "Laying down bored".

54. At 4.00am on 26 December 2017 Fionica read the messages on the phone while Alvester was sleeping. She sent a text to the young girl saying, "Excuse me why you call my husband 'babe'". Alvester said that finding out that he was cheating made Fionica unhappy and they argued.

55. According to Alvester, on the evening of Wednesday, 27 December 2017, he and Fionica were "arguing about smokes". She approached Robert who was playing cards at House 13 (known as the card house). She asked if she could have a cigarette. Robert said he didn't have one and she left. She later returned. She is said to have looked "scared and frightened". Robert asked her what was wrong. She said Alvester had sent her to ask two questions and he had instructed her to record the answers with her cell phone. The questions were said to be:

    a. Whether Robert and Sarita were her real parents; and
    b. Whether Robert had killed a person, because Alvester said he had.

56. Alvester denied sending her to ask the specific questions. He said her family was talking about him and he asked her to record those conversations.[11] Robert said it was all rubbish. Fionica was worried for Robert. He told her not to worry about him, but rather herself. Fionica went home with Sarita and Robert that night. By the time they arrived home it was the early hours of the following day (28th). Robert went to bed and Fionica was told to relax, but she couldn't and kept looking out the window.[12] The other women including Sarita sat on the veranda talking.

[11] Transcript p 50
[12] Statement of Sarita Ngalwiyayar para 23

57. Just prior to 2.30am Alvester approached the house. He was said to be carrying an axe and spear.[13] Her aunty, Sarita called out, “he’s coming” and they all quickly went inside and locked the door. He repeatedly called out to Fionica demanding that she go home with him.

58. Fionica rang “000”. She told the call taker that she was having a “lot of problems” with her “boyfriend”. She said he had “kinda threatened” her. She said he was “yelling stuff” and she was “really scared”. She said he was yelling and threatening to hurt her. The call taker asked whether she was safe where she was. Fionica answered, “I’m actually not, just wanna go to the Police Station”. She was told that there was no one at the Police Station. She asked when the Police were “coming here”. She was told that they were not on duty that night.

59. Alvester eventually yelled, “Alright, you don’t want to come with me, there’ll be war tomorrow”. He walked away. He returned later, he said, with his aunt.[14]

60. At 3.30am Fionica rang the Police call centre again. She said she was scared because Alvester had said, “If you won’t come out, I’ll come back tomorrow”. She then hung up. At some stage that morning Alvester contacted a 16 year old male in the house where Fionica was staying and asked to speak to Fionica. Before the adults woke Fionica left the house and went back to Alvester.[15] Shortly after she arrived the Police attended. The time was 9.55am.[16] They had looked through the activity overnight and saw her calls and went to check on her. She told them she hadn’t rung them and she didn’t need their assistance.

[13] Alvester said it was a big stick. Transcript p 50
[14] Transcript p 50
[15] For Fionica it must have been little different from when the 24 year old male had, in 2014, used threats against her family to obtain her compliance.
[16] Statement of Tyrone Smithers

61. The Police said they spoke to Fionica and Alvester separately. Alvester said that he and Fionica were together and were not spoken to separately. He said Fionica told the police her family had called the Police, not her. The Police said they checked and found no history of reported domestic violence between Fionica and Alvester. She told them, “nothing happened, we were sleeping”. Police saw no injuries on Fionica and left.

62. According to Alvester, on her return that morning, Fionica was unhappy. He said it was because he had threatened her family earlier that morning with war. He said they had sex and then he went to sleep. He said he was woken by Fionica who wanted him to go and buy her a drink. He left to go and get a can of coke. That was at 3.30pm. He returned a short time later to find her gone. His family said she had last been seen heading down toward the bush near the dump road.

63. During his evidence Alvester agreed that there was no reason for Fionica to head that direction unless she was thinking of self-harming. Initially he told police investigators that he had gone directly to the police to tell them he was worried and ask for them to assist. In fact, he went to the oval with other young men to kick the football. He did not call the police until 5.40pm.

64. He said did not want to go looking for Fionica as if she self-harmed and he found her he would definitely be blamed. Accordingly, when she had not returned, he asked an aunt, who was in her vehicle at the time, to look for Fionica down at the dump road. His aunt drove down to the dump road and found Fionica hanging from the same tree and with the same hose that Alvester had used in attempting to hang himself a year earlier. She was deceased.

Police Investigation

65. The police arrived at the scene at 6.05pm. The detectives arrived the following day at 9.00am (29 December 2017). An autopsy was undertaken

that day at 1.00pm. Dr Marianne Tiemensma, the Forensic Pathologist described the fresh injuries. They included the ligature marks on Fionica's neck and:

> "A fresh laceration (14mm x 5mm) was present above the lateral aspect of the right eyebrow. The scalp underlying this laceration showed fresh contusion."

Various exhibits including clothing, fingernail scrapings and vaginal swabs were taken by the Forensic Pathologist.

66. The police left Warrawi the next day (30 December 2017) at 4.30pm. The characterisation by the forensic pathologist of the laceration above Fionica's right eyebrow as a "fresh injury" was decided by the investigators to be incorrect. They preferred the explanations by:

    a. Alvester: That she had the injury for a couple of months since the time he threw a full can of braised meat.[17]
    b. The first police person on the scene who observed what appeared to be an "old wound" above her left eye. It was stated that there were no medical records in relation to that injury.

67. It appears police overlooked:

    a. The forensic pathologist's expertise;
    b. The fresh wound being above her right, not her left eye; and
    c. The medical records relating to the wound above her left eye from when Fionica visited the Warruwi Community Health Centre on 30 October 2017.

68. Police also overlooked the likely violence leading to Fionica's visits to the Health Centre from October 2017 and the likely impact upon her of the threats to herself and her family in the early hours of the morning of the day she died.

---

[17] Memos to Coroner dated 4 April 2018, p 6 and 18 March 2019, page 11

69. The various exhibits taken by the forensic pathologist were not tested. The reasoning for that was that there were no anal or genital injuries detected and Alvester had said they had sex that day. The hose was tested but DNA was not able to be recovered.

70. The file was returned by my office to police on two occasions. Police undertook further enquiries and in 2020 had the exhibits taken by the forensic pathologist tested. Unfortunately, those items had not been kept in refrigeration and were of little forensic value.

71. Police tasked Detective Superintendent Lauren Hill to analyse the investigation. That review was of a high standard and was critical of the initial police investigation. Some of the more significant aspects included there being no overall investigative plan to address lines of enquiry, some family, relatives and friends being reluctant to engage with police and there being no domestic violence 'lens' considered by investigators.

Her known trauma

72. Her trauma was known because from at least the age of 13 years Fionica attended the Health Centres due to sexually transmitted disease or violence. When 14 years of age she was forced by a male to stay with him and was assaulted by him. She thereafter had difficulty finding a place to stay where she felt safe.

73. Her time in Warruwi was punctuated with an attempted suicide after which she was taken to the health clinic and her boarding school experience was not good. She was known to the school to be suffering depression and "mental health issues" and then disengaged from school altogether.

74. She was unhappy and attended the Health Centre for injuries likely the result of violence and was eventually sent to Royal Darwin Hospital. While there being treated she suffered panic attacks.

75. Those aspects were known to the various government agencies, although some of the information was not shared between them. That was despite there being a Maningrida Safety Coordination Group for the very purpose of sharing information and providing a better coordinated response. Fionica made it onto the review list of that group after the assaults by the male and discipline by her family in 2014. However when she left for boarding school a few months later she was removed from the review list. [18]

Family

76. Fionica's early life was said to be very good. Her grandfather, Mr Andrew Dowadi, recalled that she had a lot of friends and loved to go fishing and to the Blue Light disco's run by the local Maningrida police in the town hall. She liked to read and play on the computer and attended school. She was sporting and represented Maningrida playing football.

77. However, by the time she was 10 years of age her parents couldn't care for her because of alcohol addiction and she went to live with relatives. Older men began to prey on her. Her grandfather said:

> "We tried to fight for these boyfriends and men to leave Fionica alone … we did not want Fionica to get married in an Aboriginal way at such a young age … we wish we had more help from government departments and service providers … we were trying as hard as we could to help Fionica, but it was not enough because we are just grandparents …".[19]

78. Mr Dowadi is an elder of the Maningrida community and a senior member of the Burnawarra Justice Group in Maningrida. He set up the Justice Group with some of his cousins in 2012. The Group works with different organisations and people to resolve disputes and help the community look after the children.[20]

---

[18] Statement of Susan Bowden para 107
[19] Statement of Andrew Dowadi para 16 - 18
[20] Ibid para 53

79. One of the problems in looking after the children has been that the rules of Balanda (white people) prevent families using the forms of discipline they believed appropriate. However, alternatives have not been provided. Ms Broadfoot of Territory Families agreed there was a gap:

> "Certainly, when we … talk with a family, those conversations will often be had, but educating a community more broadly about expectations, what's acceptable, what's not acceptable, I think … there is a gap there and it's something that needs to be dealt with." [21]

80. For Mr Dowadi, the problem came about when it was sought to dissuade Fionica from being with older men. Initially the family sought to deal with it by taking her out bush and 'drawing blood'. The government agencies intervened when there was a notification of dragging her down the street and hitting her with a 'buffalo bone' (24 September 2014). So to try and bridge the gap, Mr Dowadi organised a 'big meeting' with the police and Night Patrol to ask for help. He said:

> "I wanted their help to protect Fionica by encouraging kids to go home at night and by breaking up any inappropriate relationship with older men."[22]

81. He was told that it was family business and it was suggested that the family send Fionica to Warruwi. He was frustrated. She was 14 years of age and involved with a man that was 24 years of age. He said:

> "The police make the rules, so they should stick to the rules. It's their responsibility and they get paid to look after people and keep them safe."

82. When Fionica was sent to Darwin for surgery, after her fingers were broken, her mother was sent as an escort but left to go drinking the day she arrived. Mr Dowadi said Fionica rang her grandmother, Fionica was crying, she said, "Mum left me". Mr Dowadi said they were angry his daughter left Fionica

---

[21] Transcript p 138
[22] Statement para 26

just because she wanted to drink.[23] He thought Fionica needed her mother and believed that she was afraid to go back to Warruwi. But although accepting the shortfalls of the family he also believed that there should have been someone to help her in Darwin, particularly after Territory Families were notified.[24]

83. Mr Dowadi said:

> "The government … see[s] what is happening in the community, but there aren't enough resources for the community … our people are dying and dying, and girls are getting married younger. Communities and government should make the law together, communicate better and work together."

84. He said that when government agencies visited the community they should talk to the community (not just about them). He said that elders should be sitting in the office with them. He was also of the view that interpreters and Aboriginal liaison officers would be of assistance when talking to people in the community. He thought without that assistance people did not understand what was really going on and young people wouldn't speak to the agencies about their problems.[25]

Education

85. After Fionica enrolled at St Saviour's College, Toowoomba, the Education Department was recorded by the Maningrida Safety Coordination Group as "boarding school liaison". However there appears to have been no liaising. Unknown to any of the agencies, Fionica returned to Maningrida in April 2015 and did not return to Toowoomba until October. She was back by the end of October but again none of the agencies were aware. Given the trauma she had just endured that led to her being sent to boarding school it would have been expected that she was vulnerable. The Education Department

[23] Ibid para 36
[24] Ibid para 40
[25] Ibid para 55

conceded it was "a missed opportunity to provide support to a vulnerable child".[26]

86. The problems Fionica was having in 2017 and her engagement with counselling at the College did not prompt a return to the review list of the Maningrida Safety Coordination Group or any further action by the Education Department. Nor did her failure to attend school for lengthy periods.

87. The *Education Act 2015* provided that until Fionica turned 17 years of age (on 18 February 2017) she was required to attend school.[27] There are penalty provisions to ensure that attendance could be enforced. However there was seemingly no action taken in 2015 to ensure she was at boarding school in Queensland, there was no action to ensure that she attended in 2016 after she formed a relationship with Alvester in August of that year. Even though there was no statutory compulsion on her to attend school throughout 2017, there was no attempt to check on her when she stopped attending after Alvester returned on 28 September 2017.

Top End Health Service

88. On 3 August 2012, when 12 years of age Fionica was taken to the Maningrida Health Clinic with generalised abdominal pain. She had returned from an athletics carnival the previous day that had been held in Nhulunbuy. There was no suggestion that staff considered sexual assault and there was no testing for sexually transmitted infections.

89. When 13 years of age on 5 December 2013 Fionica was evacuated to RDH suffering rheumatic fever and gonorrhoea. She tested positive another five times to sexually transmitted infections over the next four years. On each occasion the information was reported to DCF/Territory Families as required

[26] Ibid para 108
[27] Sections 38 - 40

pursuant to the mandatory reporting requirements at section 26 of the *Care and Protection of Children Act 2007*.

90. At 9.00pm on 12 January 2013 she was taken to the Maningrida Health Clinic after experiencing sharp intermittent chest pain for two to three hours. Although diagnosed with muscle pain it is possible that, as in 2017, Fionica was suffering a panic attack. The next day she was reviewed by the GP and the findings from her hospital admission were discussed with her mother. That included the sexually transmitted infection and the need for contraception. The doctor recorded, "sex apparently consensual".[28] She was provided an Implanon contraceptive implant.

91. At 1.47am on 16 April 2017 the Health Clinic had an after-hours call out. Fionica had run off into the bush with an electrical cord threatening self-harm. It was said she had been fighting with a family member and another girl. She was taken to the Health Clinic where she was treated and counselled. She was assessed as suffering from a "situational crisis". She was not however referred for support or follow-up by the visiting mental health team (as was the recommended practice).[29]

92. From 4 October 2017 until 29 November 2017 there was an escalation in Fionica's presentations to the Health Clinic. On three occasions she was questioned about domestic violence. On the last presentation when she attended with a severe crush injury she was accompanied by her partner, Alvester. The presence of a partner at such a presentation is understood to be a red flag for domestic assault. That was not identified by the doctor or the nurse.

93. On a number of the presentations there was a well-founded suspicion that Fionica had been assaulted by her partner. However, that was not reported

---

[28] Which differed from the conversation DCF had with her mother on 4 February 2014. When they asked whether the sex was consensual her mother answered, "Don't know probably forced".

[29] Statement of Dr Christine Connors dated 10 September 2020 para

despite the mandatory reporting provisions of the *Domestic and Family Violence Act 2007*. Section 124A of that Act requires that when a person believes on reasonable grounds that another person has harmed or is likely to harm their partner that belief must be reported to police.

94. On 4 October 2017 Fionica attended at the Warruwi Community Health Centre complaining of lower back pain. She said it was the result of her having been hit with an iron bar by her aunty in January 2017. She said she had had the pain for two weeks. She said the pain was constant and was interfering with her sleep. The doctor asked her about "sexual assault/coercion, domestic violence, physical assault". She was tested for sexually transmitted diseases. The results were positive for gonorrhoea.

95. The medical notes go on to state:

> "Appeared reluctant to answer.
>
> -Note history of sexual assault and domestic violence.
>
> Previously treated for disseminated gonorrhoea, syphilis, chlamydia and trichomonas."

96. On 16 October 2017, Fionica was recalled for follow up. She indicated she had unprotected sex with her partner since her treatment and so her treatment was repeated. She was counselled and provided condoms.

97. On 23 October 2017 when she attended the clinic complaining of lower abdominal pain. She said the pain had been present since last night. Her blood glucose levels were low (3.6mmol/L). She was provided biscuits and honey and was advised to eat more food, was given paracetamol and told to return if the pain got worse.

98. On 25 October 2017 she was reviewed for sexually transmitted diseases. On that occasion she still had twinges of abdominal pain. The medical notes by the doctor state:

> "Denies food insecurity but minimal intake"
>
> "Asked about DV, sexual assault – denies"

She was provided condoms.

99. On 30 October 2017, Fionica presented with a 3 to 4 centimetre laceration over her left eye. The note in the medical records by the Public Health Coordinator reads:

> "Fionica was in the shower this morning and when getting out slipped; fell back and then to the front and hit orbital socket – left with a laceration about 3 cm across the eyebrow – very superficial.
>
> Patient says that she was unconscious for some time; poor historian – was unsure whether she fell back or forward – maybe hit a broom! … denies DV"

100. She thought she had been unconscious for a few hours. By that stage it is likely the staff held the requisite belief that she had been harmed by her partner and should have mandatorily reported their belief to the police.

101. The medical notes indicate that there were attempts to recall Fionica to the Health Clinic on 9 November 2017 and 15 November 2017. The information provided was that Fionica was not in Warruwi.

102. On Friday, 24 November 2017 Fionica attended the Clinic saying she had pain to her right hand. She said she had fallen 2 – 3 days before. She said she was feeling tired. She was provided analgesia and asked to return on the following Wednesday to see the doctor to review for anaemia.

103. She presented once more at 6.47am on Wednesday 29 November 2017 with:

> "crush injury, laceration, deformity to R) hand and 4th and 5th digits – was moving a table when she accidently fell and her hand was crushed by the table".

Her partner Alvester was with her at the Clinic. At 1.17pm she was transferred for flight to Royal Darwin Hospital.

104. There is no indication in the notes that domestic assault was seriously considered and no referral to the police was made. Should there have been a report or reports to police there is a possibility that when she contacted police communications on those two occasions in the early hours of 28 December 2017 her calls may have elicited a better response. Or, when police spoke to Fionica and Alvester at 10.00am that same day they may have been more rigorous in assessing her welfare.

Territory Families

105. The Department of Children and Families, as it then was, first received notification about Fionica when she was 13 years of age and tested positive to a sexually transmitted infection. A referral was made to the Child Abuse Taskforce (CAT) for investigation. Fionica denied having sex or having a boyfriend. However while the investigation was still open Fionica's father hit her mother and on 28 February 2014 harm was substantiated on the basis of that incident for emotional harm and neglect. Nothing further happened until the file was closed on 21 November 2014.[30]

106. Prior to the date of the closure, DCF received the first of a series of further notifications on 24 September 2014. Those notifications concerned her having a boyfriend "a lot older, possibly an adult", that he had been seen stabbing her with scissors and that she had been assaulted by her mother and aunt that had resulted in a cut on her head. The notifications relating to discipline were 'screened in' (that is, accepted) but the ones relating to the adult boyfriend and being stabbed were not. Fionica's grandmother told staff that the discipline was right "cultural way". She said she wanted Fionica to stay away from the older male and for Fionica to attend school rather than get married.

107. On 5 October 2014 DCF received a notification that the older male had assaulted Fionica and forced her to follow him around and stay the night

---

[30] Statement of Karen Broadfoot para 67

with him. The following day, DCF was informed that Fionica had tested positive to three sexually transmitted infections. The notification was referred to the Child Abuse Taskforce. DCF staff ascertained that Fionica had found a place she felt safe with a non-family member 20 minutes out of Maningrida. DCF spoke to Fionica and the family. The result was that despite one of the DCF staff having "serious concerns for Fionica's mental health if she was forced to go to Warruwi" and that Fionica was "at risk of suicide if she goes", it was arranged by family that she be sent to Warruwi and then, onto boarding school. A referral was made to MOS Plus who were unable to catch up with her. She was not referred to mental health after she attempted suicide, nor was she provided with any other form of support or safety plan from that point. Professor Robinson commented:

> "Perpetrators should not be apprehended and dealt with without there also being assessment and follow-up of impacts of violence or threats on vulnerable youth and the capacity of their families to provide support. There needs to be referral, but also decision-making about appropriate response, coordinated at the community level."[31]

108. The last contact with Territory Families was on 3 December 2017 when they were contacted after Fionica had been sent to Darwin to have surgery on her hand. She had been left unaccompanied. Territory Families provided a suggestion of alternative accommodation but made no further inquiries.

Police

109. Fionica was known to Police from when she was the victim of the assaults by the older male when 14 years of age. Their next involvement was when Fionica attempted to obtain their assistance at 2.30am and then again at 3.30am on 28 December 2017. She was at her family's residence, having gone home with them rather than going back to Alvester. He wanted her to go back home with him and with weapons in hand had threatened that if she did not, there would be war between the families the following day.

---

[31] Report p3

110. She feared for herself and her family and sought to obtain police assistance. The police however were not on duty at that time and the call-takers did not elevate the calls for assessment as to whether the police should be called out.

111. Later that morning after speaking to Alvester she left and returned to him. Shortly after, the police arrived. She told them that it was not her that had called, but her family. She said she did not need their assistance. They checked the database and found no history of domestic violence and left.

Systemic issues

112. There were many missed opportunities throughout the last four years of Fionica’s life. The government agencies knew the details of her life and the trauma she was suffering. They understood that she had likely been sexually assaulted from the age of 13 years. That she had been held against her will by an older man and assaulted and likely raped. Nothing was done to alleviate or assist with that trauma.

113. Providing no support to a 15 year old being sent off to a boarding school without family or friends because she had been imprisoned and raped by an adult male is confronting. As is a child presenting time and time again with sexually transmitted infections without significant enquiry. Or, when she did not attend school in circumstances where she was known to be troubled, there being no attempt to understand or assist. Or, when presenting with injuries from likely domestic violence and having panic attacks there being no attempt to engage and no empathy or understanding or even curiosity when she finally asked for assistance from police.

114. The various agencies have accepted the significant failures and have shown a willingness to correct the issues. The Department of Education accepts there is an obligation to ensure children are at school and, if not, to understand the reasons for their absence. To do that they need robust and

transferrable records (should children and families be mobile) and auditing to ensure that what the law and policy requires is put into practice.

115. The Top End Health Service understands that they must do better to identify and assist patients at risk and make the appropriate referrals for their support. Territory Families understand the need for holistic investigations of the circumstances of a child and Police understand the need for appropriate escalation protocols.

116. All Departments say they have made changes or are in the process of making changes and all are involved in a new generation of multi-agency cooperation that will be dealt with further toward the end of these findings.

117. Pursuant to section 34 of the *Coroners Act 1993*, I find as follows:

i. The identity of the deceased is Fionica Yarranganlagi James, born on 18 February 2000 at the Royal Darwin Hospital, Northern Territory.

ii. The date of death was 28 December 2017. The place of death was Warruwi, South Goulburn Island.

iii. The cause of death was self-inflicted hanging.

iv. The particulars required to register the death:

1. The deceased was Fionica Yarranganlagi James.

2. The deceased was of Aboriginal descent.

3. The deceased was unemployed.

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

5. The cause of death was confirmed by Forensic Pathologist Doctor Marianne Tiemensma.

6. The deceased's mother was Bridgette Gurrunama and her father, Jerome James.

In the matter of an Inquest into the death of

KETURAH CHERALYN MAMARIKA
ON: 22 NOVEMBER 2016
AT: UMBAKUMBA, GROOTE EYLANDT

Short Story

118. Keturah was part of a strong family that lived in the Umbakumba Community. She was the youngest child. Her sister was five years older and the closest sibling to her in age. It is said that at 12 years of age Keturah was raped by three boys in the community. It was about that time that she was found to be suffering an immune system disorder and spent a lot of time in and out of hospital over the next 12 months.

119. She did not attend school regularly at any time, but after her illness she rarely attended. She had only a few close friends but appeared well liked in the community. She lived with her mother, sister, her sister's husband and two cousins. She was not known to threaten self-harm and had not attempted to take her life.

120. On 22 November 2016 she had stayed up all night socialising, drinking some alcohol and smoking cannabis. At about 6.00am she showered and was outside the house as the sun rose, taking selfies with her phone camera. Her sister and her sister's child were with her and can be seen in the background of some of the photographs. She told her sister that she had plans to take the community bus to Angurugu that day to visit an aunt.

121. However half an hour later she was likely raped and died shortly after. Two hours later she was found dead with an extension lead around her neck. The other end attached to the ceiling fan.

122. Her family were evasive about what happened and police have not been able to determine who raped her or the circumstances of her death.

Longer Story

123. Keturah was born 13 April 2000 at Alyangula Health Centre on Groote Eylandt to Sophie Barra and Christopher Mamarika (deceased). She was often referred to by her middle name, 'Cheralyn'. She had four older siblings.

124. She lived at Lot 185 Umbakumba Community with her mother, her sister Jesselyn, her sister's husband, Alex and their daughter, Sheetonia. Also at that house was her 14 year old cousin, Kyzach and her cousin, Sandra.

Schooling

125. Her school attendance was at best, irregular. She was sick in 2013 and attended for only 27 days. Thereafter she barely went to school. In essence her attendance rate went from 31.33% in 2011 to 5.84% in the first term of 2016. She did not attend school at all after the first term.

126. The most usual comment by teachers was, "Due to lack of attendance there is insufficient evidence to comment on progress". As at the first semester in 2016 she was in year 11. Her demeanour when at school was said to be that of a quiet student who showed a positive attitude and eagerness to learn.

Health

127. She attended the Umbakumba Clinic on 1 March 2013 with her mother and grandmother, she was 12 years of age and 36 kilograms. She said she had vaginal bleeding for three days. She said she had not had a period previously. Her mother and grandmother wanted her to have an Implanon contraceptive implant. They were concerned she would become pregnant. The notes record: "Cheralyn is sexually active. Cheralyn admits to this."

128. She was anaemic and was flown to Gove District Hospital. A diagnosis was made of severe anaemia and thrombocytopaenia with vaginal bleeding and she was Careflighted to Royal Darwin Hospital where she was diagnosed

with idiopathic thrombocytopenic purpura (ITP), an immune disorder that interferes with blood clotting.

129. At Royal Darwin Hospital she was recorded as saying that she "has boyfriends" and was sexually active. The following day she said she had had a boyfriend for a few months. The medical notes state, "admitted to sexual activity and then denied it".

130. On 8 March 2013 while in the Royal Darwin Hospital, Keturah's mother told a DCF worker that she knew her daughter was sexually active and worried that she was too young.

131. On 15 March 2013 when the Child Abuse Taskforce spoke to Keturah, she initially turned her back and refused to acknowledge them. Her mother said she did not think her daughter was sexually active but wanted Implanon just in case. She said Keturah's older sister had a child at a young age. Keturah eventually turned and said she did not have a boyfriend and was not having sex.

132. During that admission she was prescribed depot provera and the pill to "prevent further menstruation while she is thrombocytopaenic". She remained on oral contraceptives and the depot until her spleen was removed about 12 months later.

133. On 15 May 2013 (just two months later) Keturah attended at the Umbakumba Health clinic. The main reason for attendance was noted as "Test; urine; pregnancy". She was given a pregnancy test. It was negative.

134. The Royal Darwin Hospital outpatient notes indicate that an Implanon contraceptive implant was added on 30 July 2013. It seems primarily because she was non-compliant in taking the pill and was having heavy menstrual bleeding. The implant was renewed thereafter at the Umbakumba Community Health Centre. The last such time on 4 May 2016.

135. In total she had eight admissions to Royal Darwin Hospital over a twelve month period in relation to the ITP from 1 March 2013. Eventually, she was sent to Adelaide where her spleen was removed. That resolved the disorder. Thereafter she was given prophylactic antibiotics to counteract the lack of her spleen. From that time she appeared to be in relatively good health.

136. At the end of 2016 the project manager at Aboriginal Corporation advised that he had heard that a number of years ago Keturah was raped by three boys. The names of the boys were not able to be ascertained by police.

General well-being

137. On 2 March 2013 during a gynaecological review the following note was made:

> "Evidence of self-harm? Noted. Mum reports that she scratches herself. Evidence of old scars on her hands, some bruising to shins".

There was however no further investigation of those suspicions and no other evidence that she self-harmed.

138. People in her community referred to her as a happy girl:

a. Her best friend said:

> "I don't know why she did that. She was happy before she died and I got shock."

b. Her second best friend said:

> "She has lots of family in the community. Everyone likes her … She never tell me she is sad or have problem, she is happy".

c. Her mother said: "She didn't seem sad or angry about anything"

d. Her poison-cousin said:

> "I got big shock because she was too young, she never go out and she never tease other girls … I never seen [her] sad, she was always happy. She always been a happy smiley one like that".

e. Her cousin said:

> "She didn't have any problems, she was happy girl. She never tease anybody, she was a quiet and innocent girl. My cousin was naïve peaceful girl, that why I was staying with her."

139. There is some evidence that Keturah had some time before her death had a boyfriend by the name of Ziggy. He lived in Numbulwar and the relationship appears to have primarily been through messaging. She had not seen Ziggy for about 2 months at the time of her death. In the second week of November 2016 Keturah had a fight with another girl. It is likely the fight was over that girl become becoming Ziggy's girlfriend. The other girl said that after the fight she and Keturah made up and went to see a band together.

Circumstances

140. Keturah spent Monday, 21 November 2016 at home with family. Her cousin, Sandra remembered it in the following terms:

> "On Monday, me and K was playing, laughing and telling stories. We were chasing each other. She was so happy. We were playing at the house. She stay there all day."

141. At about 3.00pm she went to her friend, Reshilda's house with her best friend, her cousin Kyzach. They had a cup of tea and dinner and smoked cigarettes. They stayed until about midnight and then Keturah and Kyzach walked back to Lot 185. They sat outside with family telling stories and laughing. During that time boys from the community walked past. Keturah may have asked one of them for a cigarette but he had none. There is no evidence of any further interaction.

142. Kyzach went to bed. Keturah stayed outside with her sister, Jesselyn and cousin, Sandra for some time and then had a shower and was said to have been straightening her hair in the kitchen. She was observed to be taking selfies outside in the yard between about 6.15am and 6.30am. With her was her sister, Jesselyn and niece, Sheetonia. She told her sister that she was going to Angurugu on the community bus to see her aunt, Euna. Her cousin,

Sandra, said she was going to Angurugu to pick up her little sister, Jessie. Keturah went inside and took more selfies.

143. Alex, the husband of Jesselyn, referred to Keturah as his “young wife”. He was working as a ranger and said that a colleague always picked him up at 8.00am for work each morning. On the morning of 22 November 2016 he said he woke at 6.00am. He said he went into town to pick up a work car and returned to the residence. He saw Keturah outside with Jesselyn and Sheetonia, taking selfies. That day he was going to a Coxswains course at Alyangula that commenced at 9.00am. The driving time is just under an hour.

144. Jesselyn said that morning her daughter was “crying for school”. If her daughter attended school it was normally her mother who took her. She went for breakfast and crèche started at 9.00am. They would return at 11.00am. For the first and last time that term Jesselyn took her daughter to school.

145. Both Jesselyn and Alex left home at the same time, 7.00am. Jesselyn took her daughter to school and Alex went to his work colleague’s house and asked to go to work. They drove to their boss’s house. The boss said it was too early. Alex then wanted to be driven to the wharf. In evidence, he said he wanted to go there to look for his phone that he dropped in the water the day before. His colleague said they sat there for about an hour without talking. They then drove to work at Alyangula.

146. Sometime after 9.00am Keturah’s mother was leaving the house. She noted the door to the music room was locked. She looked through the curtains from the outside. She saw Keturah sitting on the floor with a cord around her neck. The other end was attached to the ceiling fan. She called out to a neighbour and family member at the front of the house next door. He pulled the security screen on the window back to allow access, pushed the window louvres out of the way (and into the room) and climbed through the window.

147. He saw the cord attached to the fan. He observed the cord to be, "loose from her neck to the fan. It was not pulled tight at that time". Her bottom was on the ground and her legs out in front of her. The cord was "wrapped around [her] neck two different ways, one went like clock way and the other way went opposite … it wasn't the end of the cord it was more in the middle".

148. He removed the cord and carried her to a mattress in the living area. The Health Clinic was called and the nurses arrived a little after 9.48am. She was deceased and was found to have rigor mortis setting in. That made getting an air pipe into her throat impossible.[32]

Issues

149. The first prominent issue was that Keturah was not attending school and no person or government agency was engaged with her or her family to encourage school attendance. The second was that she had not attended for her 4 weekly penicillin injections for four months and there was no follow up to encourage her to do so. The third issue was the limited efforts of the initial police investigation to identify the circumstances surrounding her death.

Police investigation

150. The Police were called at 9.55am on 22 November 2016. They arrived at 11.15am and set up a crime scene at 11.20am. They left with Keturah's body, headed for Alyangula, at 1.18pm. Forensic investigators from Darwin arrived at 6.23pm. They found a 20 metre extension lead. One hundred and sixty five centimetres from the socket end of the lead it was wrapped around the ceiling fan. The louvres for the window that had been accessed were leaning against the wall outside the window. The crime scene was closed at 7.30pm.

151. The following morning investigators attempted to take a statement from Jesselyn. She was reluctant to do so and her mother would not allow her to

[32] Statement of Isla Attewell

be alone with police. One of the investigators commented: “It was obvious to me that [the mother] did not want Jesselyn speaking about Keturah’s relationship with boys”.[33] They took a short statement from Jesselyn, one from her mother, another from the man who pulled the security screen back to access the room and the two nurses that attended.

152. The case theory was suicide. They had no information as to why she might have taken her own life. Nevertheless, investigators left Groote Eylandt at 11.30am and returned to Darwin.

153. The day after police left the Island the family of Keturah cleaned the house. The cleaning included high pressure cleaning of floors and walls, wiping the surfaces with bleach and putting all furniture into a single room. Items were taken to the dump and burnt (including the louvres that were said to have been removed to gain access to the room).

154. Because of the case theory the crime scene was not kept open until an autopsy had been conducted and there was no urgency in obtaining the autopsy. A week after her death, on 29 November 2016 the Forensic Pathologist, Dr John Rutherford undertook an external examination of the deceased. He found significant vaginal injuries. There were lacerations, abrasions and bruising. The injuries were fresh. He contacted the Sexual Assault Referral Centre and the detectives. The following day at 1.00pm a full autopsy was undertaken. In the opinion of the doctor from the Sexual Assault Referral Centre the injuries were most likely the result of sexual assault.

155. Detectives and forensic personnel returned to Groote Eylandt on the evening of 30 November 2016. The following day they seized items, including condoms and women’s underwear found in the roof cavity. They had gained access through the manhole in Jesselyn and Alex’s bedroom. Along with other exhibits they took them back to the station at 12.40pm. However the

[33] Statement of SC Ganley para 20

exhibits had clearly been in the ceiling for some time and police decided they were not relevant to their inquiries.

156. Police went to the dump on 2 December 2016 looking for items removed from the premises including a metal bar. It was identified from photographs taken of the crime scene lying under the cot in the music room, the room in which Keturah was found. It was not found at the dump.

157. That evening for the first time police spoke to Sophia about a key for the music room door, she told them it had been lost for about 12 months. On 3 December 2016 the investigators returned to the house. They located two keys, one on the ground in front of the house and another on the kitchen bench. The first unlocked the bathroom, the second did not appear to fit any of the locks.

158. At 5.00pm that day they returned to the dump. They found the louvres from the music room. They had been burnt and were not seized.

159. On 5 December 2016 police went to the school. They were told the 22 November 2016 was the only date Sheetonia had attended the school between 24 October 2016 and that date, 5 December 2016.

160. On 6 December 2016 they obtained a DNA swab from Alex. They departed Groote Eylandt at 6.00pm on 8 December 2016. The following day it was decided that the investigation would be transferred from Major Crime to Northern Investigations. Why that happened has not been explained. But it is clear that the investigators believed that the expertise of Major Crime was no longer required.

161. On 19 December 2016 DNA samples were obtained from the other occupants of the house. The next month, on 10 January 2017, detectives went back to Groote Eylandt and took more statements. They spoke to a man who told them that on the morning of 22 November 2016 Alex and Jesselyn had gone to his house to get a smoke. The next month they sought to obtain DNA

samples from 10 males in the community. The reason for so doing was the hypothesis that she may have been assaulted by one or more of the males who were walking the community in the early hours. However no one would consent to giving the samples.

162. It is doubtful whether they would have assisted in any event because the results of the testing from the Forensic Science Branch were limited:

a. Toxicology indicated recent cannabis use and a low volume of alcohol (0.04%)
b. The extension lead arrived at the laboratory with no instructions for the scientist as to where to test. The scientist tested both ends and a smudge mark. The DNA matched that of Keturah, Jesselyn and likely another cousin. But given that it was not from the areas of concern, was of little assistance.
c. The sperm fractions identified on the vulval swab was insufficient for identification purposes. No sperm were detected microscopically, although that is not surprising given that the swabs were taken over a week after her death.
d. Her underwear showed a weak positive for semen and a tape lift from the outside surface indicated the DNA of an unknown female.
e. Oral swabs were obtained from the deceased at autopsy on 30 November 2016 but no analysis of the swabs was undertaken for semen. Those swabs were destroyed by Biology on 17 February 2017 without prior consultation with the investigation team.

163. At the end of the investigation the Police concluded that Keturah had hung herself for unknown reasons and the injuries to her genitals were caused by someone unknown. The reason for concluding that her death was self-inflicted was stated to be:

> "The room in which the deceased was located hanging was locked (from the inside), with no key access available to enable another person to have locked or accessed the room from the door. The windows were louvres with a metal screen, which had to be removed to enable access to the room when the body of the deceased was seen hanging (through the window by her mother).

As per Post Mortem report – other than the ligature marks and genital injuries, no other defensive wounds evident."

164. However those assertions were never thoroughly investigated. There were potentially two points of entrance or exit, the internal door with a lock that could only be locked or unlocked from the outside with a key, and the window through which access was gained.

165. Until the question was asked on 2 December 2016, there was no investigation as to the existence of a key and no attempt to find a key. There was of course also the issue that the room was accessible by others for two hours before police arrived. That is of some importance because it is evident that someone had accessed the room, at least to remove the louvres and had placed them against the outside wall near the window

166. The question as to why they were removed and what else may have been removed was never sought to be answered. Their removal should have raised an issue of possible staging of the crime scene (that is, there might be suspicion that a person had exited rather than entered the room if the louvres were on the inside). Suspicion over that issue would have been heightened when it was understood that the louvres had been removed from the property altogether and burnt.

167. The photographs taken of the cot inside the music room show what appears to be another louvre sitting on the mattress. Why it was there was never sought to be explained. Given the mesh covering a large hole in the security screen and the mesh only being attached by thin wires, there is a possibility that it had been used to exit or enter the property on previous occasions.

168. There was only limited investigation of whether or not there was a key available for the room. Certainly Keturah's mother indicated that it had been missing for 12 months. Whether everyone in the house was of the same view was not tested and it was not until 3 December 2016 that there was a search for keys. Photographs of the scene taken on the day of her death also

indicated there was a key on the floor in the music room. If it was the key to the door that might have supported the hypothesis that Keturah was in the room alone. However, with the possible interference with the scene it would have been less compelling.

169. The first nurse at the scene found that rigor mortis had clamped the deceased's jaw. It was not until 10 September 2020 that investigators sought the opinion of the Forensic Pathologist as to how long after death it was likely that her jaw would be affected by rigor mortis. The scenario was explained that she was possibly alive at about 7.00am and found deceased at 9.40am. The forensic scientist provided an opinion that there were many variables but thought it likely that the time from death until the muscles of the jaw being affected would be about two and a half hours. If that is the case, it would put her death somewhere around 7.00am. Alex and Jesselyn leaving the premises at that time contrary to their normal routine may provide corroboration.

170. On 28 April 2017 it was said that the phones seized by police contained no relevant information. However approaching the inquest further analysis was performed. Date stamped selfies were extracted, taken the morning of her death outside the house showing the sun not far above the horizon. Similar photos were taken by police at approximately the same time of year with the sun in the same position. Police concluded that the selfies were taken between 6.15am and 6.30am. From the photographs she seemed in good spirits. It is likely that half an hour later she was dead having just been raped.

171. Some of those photographs also showed her sister Jesselyn and her daughter in the background. That is in contradiction to the statement made by Jesselyn the day after Keturah's death:

> "The night before I was at home with K and my mother Sophia. I went to sleep at 8.00 o'clock. K was still up when I went to sleep.

I didn't see her or speak to her after that until she had passed."

Jesselyn and some of the other witnesses appear not to have been keen to share what happened that morning between 6.30am and 7.00am.

Review of Police investigation

172. Detective Superintendent Lauren Hill provided a review and was critical of the police investigation. Some of the more significant criticisms included insufficient time being spent at the scene, the scene not being adequately examined, there being no overall investigative plan to address lines of enquiry, exhibits being tested late or not at all, some family, relatives and friends being reluctant to engage with police, there being no domestic violence "lens" considered by investigators, and there being insufficient oversight by management.

Suspicious death

173. The Assistant Commissioner for Crime provided evidence at the inquest, agreeing with that assessment. However he saw a distinction between "criminality involved with the death" and "non-criminal precipitants".[34] He was of the opinion that the investigators "eliminated the prospect of criminality involved with the death".

174. The Assistant Commissioner went on to say:

> "I accept that a case theory was arrived at too early and many of the operational decisions were influenced by the determination of the case of death based on obvious indicators, which ultimately relegated the thorough collection of information and examination of lines of enquiry."

175. Her death remains suspicious and the circumstances of her death remain open.

[34] Statement of Assistant Commissioner Anticich paragraph 19

Education

176. The education system was peripheral to the life of Keturah. In reviewing the Department of Education records, the Executive Director of Early Years and Education Services, Ms Bowden said:

> "Her Attendance fell to under 10% from year 8 to year 11. No records have been found to indicate if any intervention occurred in relation to her attendance … it appears that the department failed to provide her the appropriate support to regularly attend school."

177. The Department of Education indicated that it was in accordance with the guidelines for students to be advanced to the next year to remain with their peers. However the guidelines do not appear to contemplate the situation where a student is not attending school and is not making any progress.

178. The guidelines do state:

> "Even in circumstances where a student is found to have special learning needs, the best option may not be to repeat but to promote continuity of the student's learning experiences by implementing alternative learning and engagement strategies and/or provide additional support to meet their individual needs.

No alternative learning and engagement strategies or additional support were provided to Keturah.

Top End Health Service

179. Dr Christine Connors of the Top End Health Service undertook a review of the care and treatment of Keturah. It was noted that there were a number of "red flags" for abuse and neglect in her early life, including severe growth failure, anaemia and recurrent infections that should have triggered a more comprehensive response. She stated:

> "Growth failure, anaemia and recurrent infections were very common problems for young children at that time. It reflected people living in overcrowded conditions, food insecurity and poverty, as well as dysfunction in families which would worsen the conditions. Growth failure in young children has significantly improved over the last 10

years, with a reduction in recurrent severe diarrhoea, likely due to the introduction of the rotavirus vaccine."[35]

180. She also had a greenstick fracture of the radius at her wrist at the age of one year. Dr Connors was critical that there was no documented indication as to how the injury was occasioned. Dr Connors went on to say that a fractured wrist in an infant is very unusual and should immediately have raised "red flags" as to child abuse.

181. When 12 years of age Keturah presented at two different clinics with two different injuries within a week. The first was a bump on the forehead and the second, two black eyes and a small laceration on her forehead. On the first she said she had walked into an iron bar and on the second she had run under a bar. Those presentations raised a further "red flag" that was not investigated. Dr Connors considered that a missed opportunity to inquire more deeply into the injuries.

182. On 1 March 2013 her mother and grandmother took her to the Umbakumba Health Clinic. She presented with vomiting, dehydration, headaches, palpitations and shortness of breath. Assessment showed Ms Mamarika to be seriously unwell with extremely severe anaemia (Hb 28) and she was evacuated to Gove District Hospital and from there to RDH where she was diagnosed with ITP.

183. Dr Connors was critical of the failure to understand and consolidate the information gained at each presentation. At the Clinic her mother and grandmother asked for Implanon contraception. At Gove District Hospital Keturah admitted to being sexually active. That was the basis of a notification to DCF. However at RDH the gynaecology team were unsure if she was sexually active. As such that didn't generate any further referrals or notification.

[35] Paragraphs 13 and 14

184. On 24 February 2015 Keturah was taken to the Clinic by her mother. She said she had been hit behind the right ear by her cousin. No report was made to DCF in relation to the alleged assault.

185. On 13 January 2016 Keturah presented to the Clinic for her Implanon to be removed and replaced. A routine pregnancy test was negative. Dr Connors however was critical of there being no testing for sexually transmitted infections. She said that were standard practice on contraceptive review.

186. Keturah last attended at the Health Clinic on 6 July 2016, for her four weekly prophylactic penicillin injections (due to her spleen being removed on 14 April 2014). Dr Connors was critical of there being no recorded attempt to locate her when she failed to attend for her monthly injections in August, September, October and November 2016.

187. Dr Connors said:

> "Case management discussion following the notification between Territory Families, Umbakumba PHCC, the school, Police and other relevant service providers at Groote Eylandt should have identified the multiple pieces of information available to indicate the risk to Ms Mamarika. These included signs of neglect and potential child abuse at a young age, as well recent injuries, a lack of school attendance, potential encounters with Police by other family members for violence or substance abuse, as well as the evidence of sexual activity admitted by Ms Mamarika. Putting all of this information together would have alerted service providers to a more concerning situation for Ms Mamarika."[36]

Territory Families

188. DCF only received one notification in relation to Keturah. It was on 4 March 2013. It indicated that she was 12 years of age, sexually active and that her mother and grandmother had requested an Implanon contraceptive implant. They were concerned she may become pregnant. The notifier was concerned she may have had multiple partners and indicated she was very 'worldly

---

[36] Connors para 65

wise', was not attending school, was able to do "her own thing" and it was unlikely her mother was able to protect her.

189. The investigation was referred to the Child Abuse Taskforce and the taskforce investigators attended the hospital on two occasions. Keturah told them that she did not have a boyfriend, that "no boys were giving her worries", that she was not having sex and was not attending school. Her mother said she was having sex, putting herself at risk and she wouldn't listen. Her mother thought that she was too young to have sex and wanted to protect her from becoming pregnant.

190. Keturah was assessed as "safe". The investigation did not undertake a holistic assessment. The investigators did not inquire into the allegation of her non-attendance at school or her health problems. They found that there was no abuse or neglect. She was referred to MOS Plus for further engagement but the referral was not accepted and the file closed on 24 June 2013.

Formal Findings

191. Pursuant to section 34 of the *Coroners Act*, I find as follows:

    i. The identity of the deceased is Keturah Cheralyn Mamarika, born on 13 April 2000 at Alyangula Health Centre on Groote Eylandt in the Northern Territory.

    ii. The time of death was 7.00am on 22 November 2016. The place of death was Lot 185 Umbakumba, Groote Eylandt.

    iii. The cause of death was in keeping with hanging but the circumstances of her death remain open.

    iv. The particulars required to register the death:

        1. The deceased was Keturah Cheralyn Mamarika.

        2. The deceased was of Aboriginal descent.

        3. The deceased was unemployed.

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

5. The cause of death was confirmed by Forensic Pathologist Doctor John Rutherford.

6. The deceased's mother was Sophie Barra and her father, Christopher Mamarika.

In the matter of an Inquest into the death of

LAYLA LEERING
ON: 10 DECEMBER 2017
AT: BULLA COMMUNITY

Short Story

192. Layla was 15 years of age when she died. At 12 years of age she was involved in property crimes in the Bulla community. When the child protection agency was requested to assist they did not respond.

193. Due to her problems with the justice system and concerns within the community about her escalating behaviour she was sent to boarding school. Firstly, to Kormilda College and then to Djarragun College. Boarding school for Layla was of no assistance. In essence, her attendance rapidly declined and her behavioural problems increased. Her lack of attendance and increasing problems were not addressed by the Department of Education or the child protection agency.

194. On 9 December 2017 she was in Bulla drinking alcohol and "stressing for cannabis". At about 9.30pm while at a party, she had an argument with a member of her extended family about her wanting more alcohol. She left in an unhappy state, rang a friend and went home. Later that evening she left her residence telling her grandmother that she was going to hang herself.

195. It is likely that shortly after leaving she was raped by a male that had been raised in the same household and of a similar age (15). He said he took

advantage of her being “too drunk”. That same male raised the alarm at 3.30pm. She had a rope around her neck, the other end was tied to a Boab tree in the yard of the house in which she resided.

Longer Story

196. Layla was a 15 year old female born in Darwin on 22 February 2002 to Justine Jingles and Andrew Leering. She had an older sister, Jasmine and younger sister, Keely. At the time of her birth both her parents were in supported accommodation at the Council for Alcohol Program Services (CAAPS), undertaking a rehabilitation program. Layla was taken into care before her first birthday and was placed with an aunt at Amanbidji (also known as Kildirk Station), 125 km west of Timber Creek. She moved to Bulla community, by family arrangement, to be cared for by another aunt when about 4 years of age, to facilitate her schooling.

197. Bulla is a community of approximately 200 members about 60 kilometres west of Timber Creek and 340 kilometres south west of Katherine. It has about 20 houses, a primary school and health clinic, but no police station.

198. From the age of 8 years Layla came to the attention of the authorities on a regular basis, generally for property crimes, welfare concerns or non-attendance at school. Layla attended school about 95% of the time in the first four years. Her attendance started to drop a little in year 5 (89.5%). In that year (2013) at the age of 12 years she attended the Health Clinic wanting nicotine patches to help her stop smoking.

199. It was in 2014 that she came to the notice of police with increasing frequency. On 14 April 2014 her bail conditions included attending school and a curfew. Later, on 6 October 2014, the Night Patrol team leader for Bulla, wrote to the Department of Children and Families (DCF) saying that a group of children (that included Adrian and Layla) had become “defiant, abusive and unruly”.

200. The Night Patrol leader said that over the school holidays from 29 September 2014 until 3 October 2014 they broke into the school four times and the store, three times. She wrote:

> "The children have received so many warnings they are now wondering when action from a department will happen and think we are bluffing. Bulla Community desperately needs assistance with these children and the carers/parents involved and hoping you will look into the situation that is escalating".

201. There was however no response from DCF. The case was not "allocated" due to "resourcing constraints". The file was closed on 26 September 2015 without any action. Nevertheless, during 2014 (year 6) Layla had an attendance rate of 85.5%. She finished year 6 primary school with positive marks and results.

202. The following year on 17 March 2015 an application was made for Layla to attend Kormilda Boarding College in Darwin. She commenced on 17 April 2015 and was put into year 8. By 28 May 2015 she was recorded as wagging class and running on the roof of Building 6. She refused to return to class on request.

203. On 27 July 2015 DCF contacted Kormilda College to enquire as to her welfare. They were told that in May she had brought alcohol onto the campus and there had been a few incidents of prowling and truanting.

204. On 12 August 2015 she was suspended for a week due to fighting. Things did not improve for Layla and on 19 October 2015 she was expelled. The reasons were stated to be: smoking gunja, possession of gunja, supplying gunja, fighting (3 fights in less than one week), regular and ongoing truancy, disruptive behaviour in classes, threatening behaviour towards students, disrespectful behaviour and language towards staff and other students and lack of improved behaviour in spite of support and warnings.

205. On 13 January 2016 DCF received a notification that a group of children in Bulla, including Layla and Adrian had broken into two teachers homes in the

space of three days. While in the homes they ran up a phone bill, watched movies, slept in the beds, damaged photos and graffitied the walls. The Community Elder directed the children be removed from community out of concern the school would be closed.

206. On 14 January 2016 staff from Territory Families visited the residence in which Layla lived in Bulla. They were told the kids had been taken by police to Katherine for Court. It was thought some of the children involved would be made to stay at Timber Creek as part of their punishment.

207. On 5 February 2016 staff at DCF spoke to Police. They were told that tensions in the community were not good and there was no remorse by the children: they had said their actions were to "make the teachers cry". The police said the community were not willing to have the children return to Bulla and would likely be "flogged if they returned". They said Layla had already received a flogging, and the school might not reopen for the term as one of the teachers was too stressed to return.

208. Layla was enrolled at Katherine High School for the 2016 year. It is recorded that she attended 19.1% of the time. She was living at the Corroboree Hostel with a family member but on 18 March 2016 the family member called DCF to say she could not continue looking after her. She wanted DCF to assist in discussing her return to Bulla. DCF left a phone message but did not follow up.

209. In the early hours of 30 March 2016, Layla was found by Police wandering the streets of Katherine. Police took her to the hostel where she had been staying but the hostel and the family member refused to take her back. Police then took her to the DCF office. She wasn't there long before she absconded and took a bus to Kununurra to see her father. DCF closed the file stating:

> "There is no further role for NT DCF at this time, given the child has left the state".

210. She stayed a short time in Kununurra before returning to Bulla. On both 2 August 2016 and on 8 August 2016 Layla attended at the Health Clinic for pregnancy testing. She was 14 years of age. The notes state:

> "Pt refused to give any details of sexual partner. Requesting contraception for future use."

211. DCF were notified of a request for contraception and the concerns of the notifier. It was 'screened out' (not accepted):

> "No concerns were reported to suggest any issues in relation to the care or protection of the child".

212. On 9 December 2016 Layla's grandmother lodged an Enrolment Application for Djarragun College, it was proposed she commence in year 7.

213. On 18 April 2017 Layla attended at the Health Clinic for a pregnancy test and Implanon contraceptive implant. Two days later (20 April 2017) she commenced at Djarragun College in year 10. The reason for starting in year 10 was stated in the following terms:

> "Layla Leering started this week in Boarding. In TASS her year level is listed as year 7 but her DOB is 22/02/2002 making her 15.
>
> She is age appropriate for year 10 and given that she will be grouped in subjects based on her ability I would suggest she is changed in TASS to year 10 so she progresses through school with an age appropriate cohort."

214. On 24 April 2017 Layla was found with three other girls out the front of the school. They said they wanted to go home because they didn't like being taught by white people and that the Arukun girls were bullying them. On 26 April 2017 she was seen by the doctor. The medical notes include the following:

> *"Apparently expressed some emotions and comments to Alex in Wilderness Centre*
> *Did not know she was being sent to Djarragun*
> *Thought she was going to Shalom College*

> *Sent here by a judge for failing to appear in court on 3 different occasions (car theft charges)*
> *Difficult family/home situation*
> *Raised by aunty*
> *Wants to be in room on her own, not shared*
> *Needs additional support*
> *For MHCP/Psychologist referral"*

215. She said she had no sexual history and a Mental Health Care Plan was prepared. She was diagnosed as suffering from adjustment disorder and referred to a psychologist. She saw a psychologist on 28 April 2017. She said that she had been in youth detention for 3 months for stealing cars (not true) and the court required her to be at a boarding school "far away" from home. The psychologist wrote:

> "Layla presented with symptoms of depression, Oppositional Defiance Disorder (ODD) and withdrawal symptoms. She was also experiencing literacy and numeracy difficulties. Layla had disengaged from school. Layla had been involved in the juvenile justice department for stealing cars. A condition of her release was to attend a school away from her home and her cousins. She reported that her family had tricked her to attend the current school.
> Layla refused to attend classes. Layla wants to attend another boarding school with her cousins. Given that she is disengaged from school, I recommend that she returns home to discuss with her carers the most suitable educational options for her. Layla requires ongoing psychological and academic support to engage in the educational system."

216. On 5 May 2017 she had a second session with the psychologist. She cried throughout the session. She said she wanted to go home. The only friends she had made at the school had left a few days ago. She said she wanted to "burn the school down" if she couldn't go home. Over the next few days she wagged class, absconded from the school grounds and then refused to attend class.

217. On 12 May 2017 she had her third session with the psychologist. She was withdrawn and did not engage. She said she wanted to self-harm when angry

and she was angry about not being returned home. She said she was feeling lonely, homesick and sad.

218. On 13 May 2017 while on a school outing Layla and another girl left the group. Layla said they walked around and got drugs and then smoked them and walked back to find the group, but they were gone so they went to the police station and asked them to call the College. She was grounded the following day and then refused to go to class or student services. She continued to abscond. She was asked to leave the College and returned home on 30 May 2017. She did not undertake any form of education thereafter.

219. A letter detailing Layla's psychological issues was sent from Queensland to the Katherine West Health Board. The note made in the receiving doctor's record is in the following terms, "Counselling provided by psychologist in Qld for "anxiety smoking cessation and engaging with school". The letter itself was not on file. [37] The letter read:

> "Layla Leering has been receiving counselling for anxiety, smoking cessation and disengagement from school. She requires learning support to address learning difficulties. Ongoing counselling will be beneficial to assist her with managing symptoms of anxiety."[38]

220. Layla did not receive any counselling or support and there is no indication in any records that she or her carers were spoken to about the prospect of counselling. There were no visits to the Health Clinic by Layla after her return from boarding school. On her return Layla stayed at Amanbidji with her aunt for two weeks before returning to Bulla.[39]

221. In mid-November 2017 her aunt ran into family at Saddle Creek turn off. Layla was with another aunt and a number of her female cousins. Also with them was her cousin's boyfriend. He was wanting to go back to Kununurra

---

[37] Email from KWHB 27 September 2019. But copy obtained from sender.
[38] Additional documents file 1 tab 5
[39] Statement of Alice Leering paragraphs 5 and 6

and was said to be angry and swearing at the females. Layla had gone into the bush and yelled out, "you mob don't like me, I'm going to kill myself".[40]

222. On 9 December 2017, Layla was working at the Bulla Community Store. She had been helping out her cousin, who ran the store, for the previous two weeks. She closed the store and left at 4.00pm. She went to the residence of Jeremiah and Miriam. She was often there at least three times a week. She was known to look after their children while they drank alcohol. Indeed, it was said that she had expressed unhappiness about how often she was left minding the children.

223. Jeremiah, Miriam and Miriam's father along with Layla left for Timber Creek during the evening. There they purchased a bottle of Jim Beam and a carton of 30 VB cans. All but Miriam's father drank alcohol on the way back to Bulla.

224. They went to Lot 39, the residence of Jeremiah and Miriam, where they continued to drink. Jeremiah said he was not aware of her drinking in the back seat of the car (he was blamed for providing alcohol to her). They later went to a party at Lot 26 where there was more alcohol that had been brought back by others from Darwin.

225. While at the party, Jeremiah told Layla she was not to have any more alcohol. A short time later he saw her with a can of VB and argued with Miriam who he said had given her the alcohol. Layla then joined the argument which was said to have become heated. Layla is said to have asked another male to punch Jerimiah. The male refused.[41] There is conflicting evidence on whether the argument ended with a physical hit to Layla's face[42], push to the body or Layla slipping. However she then left.

---

[40] Ibid paragraph 11, Statement of Betty Laurie
[41] Statement of Marcus Laurie paragraph 10
[42] There was no such injury or bruising found at autopsy

226. Raised with Layla in the same household was a young male, named Adrian, just a little younger than Layla. He had been with her in the same classes at Bulla Camp School and involved with her in some of the incidents that brought her to the attention of police. He was considered in the Aboriginal way to be her brother. As she left the party following the argument with Jeremiah, Adrian said he heard her say, "I am going to hang myself". He watched her walk back to her residence and go through the hole in the fence. He described the residence as the house with the big Boab tree.

227. At 9.40pm Layla left her residence to make a phone call. The only place where phone reception was possible was at the back of the church. She called a friend in Katherine. They spoke for about 15 minutes. Layla said she was drunk and had been kicked out of the party by Jeremiah. She said he wouldn't give her any more alcohol. Her friend said Layla was stressing for cannabis as there wasn't any in the community.[43] Layla said she would go back to her residence and sleep. Adrian said he heard Layla talking on the phone.[44]

228. Later, back at her home, possibly around midnight, she had a conversation with her grandmother. At that time she is said to have smelt of alcohol, but looked neat and tidy with no debris on her clothes. During that conversation she said, "You mob don't like me, you mob just pretending to like me". She then walked off saying, "I am going to hang myself".

229. There is some evidence that at 1.00am the next morning there was arguing in the street. It was between a man and a woman and went on for about 10 minutes. It quietened down and then the woman was heard to say "Fuck you Jerro you big hole".[45] Some witnesses say they saw Jeremiah in the early hours going down to bottom camp with a stick, pointing toward Layla and

[43] Katrina Gundari para 10
[44] Transcript p39
[45] Margarette Beebe

swearing loudly.[46] It was said that Layla was screaming, “Jerro’s trying to kill me”. There is evidence that Layla went home and Jeremiah continued to look for her at bottom camp.

230. Adrian said that soon after Layla left the party Jeremiah and Miriam went home to their house and everyone else at Lot 26 went to sleep. However Adrian said he couldn’t sleep. He said he was worried for Layla and got up. He said he looked over toward her house and saw “the shadow of a person near the tree”. He walked over to the hole in the fence and saw that Layla was at the tree hanging by a rope. He went inside her house and woke her grandmother. He got a knife and cut her down. That was at about 3.30am. The police and Health Clinic staff were contacted. They arrived from Timber Creek at 4.30am. She was found to be deceased.

231. An autopsy was conducted on 11 and 12 December 2017. Apart from the ligature mark around her neck there were found to be fresh injuries to her vagina and anus. Sperm and semen were found inside her vagina. A large amount of plant material and debris was on her back, beneath her bra and T-shirt, between her buttocks and protruding from her anus. There were fresh abrasions and contusions to her back.

232. On 5 February 2018 investigators went to the community to obtain buccal swabs for DNA testing from various witnesses, including Adrian. On 5 April 2018, DNA from Adrian was identified as being a match for that on swabs taken from Layla.

233. Police contacted Adrian and said they would need to speak with him as it appeared he had sex with Layla. On 21 June 2018 police conducted a record of interview. During the interview Adrian said that in the afternoon, when the sun was going down, Layla said to him, “let’s go inside the room and have sex”. He said they hadn’t had sex before and he didn’t tell anyone

---

[46] Joekum Bareney, Lazarus Beebe p. 6, 7, 10, 11

about it afterwards because they were cousins. He said she was “drunk, maybe too drunk”.

234. He said they had sex on the bed in his room at the yellow house for a couple of minutes. They then went to the kitchen and Jeremiah and his wife were arguing and then Layla got involved and Jeremiah hit her in the face. He then said he heard Layla say she was going to hang herself. He said he thought she was telling lies. About midnight he had a feeling about her hanging herself and got up and saw what he thought was an old man sitting under the Boab tree. He wanted a cigarette and so he went to ask for one. He found Layla hanging from the tree. He said her feet were on the ground and her knees bent and almost on the ground. He cut the rope and she fell sideways and then he undid the rope around her neck. She was not breathing. He said her grandmother and another male were there when he cut the rope.

235. The two significant issues with that version, were that the foliage under her underwear indicated that the sex was unlikely to have happened inside a house and if she was “maybe too drunk” was likely to have happened later in the night, after she had spoken to her friend in Katherine by phone.

236. During his evidence at the inquest, Adrian indicated that they had in fact had sex outside on the ground and he had taken advantage of her being drunk.[47] However he continued to maintain that it occurred before she had the argument with Jeremiah. There may have been reasons why that timeline was important to him.

237. After her death many in the community blamed Jeremiah because it was said he supplied the alcohol to Layla. He had also then had an argument with her that made her angry. Jeremiah was concerned that there was no Aboriginal law that operated after her death. He believed that the leader in the community should have called the community together to work out the law and ask people what happened. That didn’t occur. Instead, he said, people

---

[47] Transcript pp 39, 43

just blamed him.[48] Although Jeremiah was willing to agree that because of his intoxication he couldn't recall everything that happened that night, he was adamant that he had done nothing to hurt Layla.

238. There is no doubt there was a lot of alcohol in Bulla that night. Even taking into account the impact that might have had on memories, there was a reticence by some to tell police what they saw and heard.

Police Investigation

239. In response to a phone call to emergency services at 3.37am the Timber Creek police travelled to Bulla. They went with staff from the Health Clinic. On arrival at 4.30am it was obvious that Layla was deceased. After the Health staff pronounced her deceased, police inspected her body for any injuries. No injuries other than the ligature marks around her neck were found.

240. The yellow rope was cut from the tree and with the other length on the ground, put into an exhibit bag. Photographs were taken by the police but no crime scene was declared. Detectives arrived that afternoon (10 December 2017). They left the next day. Different detectives returned on 18 December 2017 and again in February 2018.

241. In the review of the investigation Superintendent Hill indicated that the initial time on the ground was insufficient and there was a delay in testing the exhibits to inform the investigation. She also noted that witnesses in the community appeared reluctant to provided truthful and factual information.

242. Police considered the possibility of charges against Jeremiah for an assault, however the evidence was inconsistent as to whether he had hit Layla or not. They considered sexual assault by Adrian but were of the opinion they could not prove lack of consent.

---

[48] Transcript p26, 27

Family

243. Layla's mother, Justine Jingles and her sisters, Jasmine and Keely attended the inquest. Her sisters provided evidence in the following terms:

> "Firstly, I would like to acknowledge the traditional owners of this land, past, present and future. I wish to thank your Honour, the lawyers and everyone that has taken part in this Inquest. Thank you for the opportunity not to only speak for my sister but to be a voice for all young Indigenous women and men in Australia. Layla Evette Jingles was the name our mother gave to you. You were born on 22 February 2002 in the early hours of the morning. I was seven years old when I remember mother telling me I was going to be a big sister.
>
> I came home, I was proud to have you as part of my life. Then we were blessed with another sister, Keely Marie Jingles. You brought joy and laughter to our grandparents. Pop bought you a pram and it had a squeaky wheel and Nan said, "I'm not putting my granddaughter in that." Our family celebrated your birth with songs and dancing. As you got older you went to live in your father's country with Aunty Betty and her family.
>
> You grew into a loving, strong, beautiful young lady. Family is like a puzzle and now the picture will never be complete because you are a piece that will always be missing. I will be your voice today, make sure you know you are loved, cherished and you will always be in our hearts and minds until we meet again".

244. Layla's aunt, Betty Laurie also provided a statement. Betty worked as an Aboriginal Health Worker at the local health clinic. She said in part:

> "Gulum came to live with me in Bulla from when she was around 3 or 4 years of age.
>
> Gulum lived with me and my mother, Brenda Laurie, who also helped to grow her up. My ex-husband, Stan Rechford, also supported us to look after her but he did not live with us. My mother and I looked after 17 children in our house when Gulum was growing up. We cared for all of the children in our family, including my children, my brother's children and my cousin's children. The big kids were in boarding school some of the time.
>
> Gulum was a very happy and an outgoing child. She was always playing and laughing; she was never quiet. When she was a child, my mother, my late brother and I would take her out and all of the

other children out bush to go camping. She loved camping, especially hunting and fishing. Gulum had a very close relationship with my mother and me. She was also very close to her aunts, Clarissa, Alana, Sarema, Brenda (Junior) and Jadine who were around the same age as Gulum or older. She spent a lot of time with them. She got along well with everyone.

Gulum went to primary school in Bulla. She used to get good reports and got on well with the other children. My mother remembers one time at school when Gulum sang a song with all of the other children about their school and their home. She liked the song and she enjoyed joining in activities. When she got into high school, that's when the problems started.

"My daughters, Clarissa and Alana, ran the shop in Bulla and Gulum was helping them out at the shop in the last couple of weeks before she passed away. She really enjoyed working at the shop. Gulum also used to help out her cousin, Miriam Chungulla look after her three young children, a son, and twin little girls. She loved helping out with those kids. She was still the same happy and outgoing girl.

Even though Gulum seemed happy, I was worried that she might do something silly. Around three weeks before she passed away, I was bringing her back from Kununurra and we stopped in Saddle Creek. Gulum was drunk and upset; she walked away from me and I heard her say, 'I'm going to hang myself.' That was the only time I'd heard her say something like that, but my daughter Clarissa told me that she had heard her say similar things before when she was drunk. I did not feel like there was anyone at the school, the health clinic or otherwise who I could talk to about these things. I did not think there was anyone who could help."

Health Provider

245. The health provider for Bulla and Timber Creek (among other communities) is the Katherine West Health Board Aboriginal Corporation. They have provided the health services to that area for the last two decades.

246. On 2 August 2016 Layla attended the clinic requesting a pregnancy test (14 years of age) and seeking contraception. She is recorded as refusing to give the details of a sexual partner and said that the contraception was for future use. That was notified to DCF on 8 August 2016. On 18 April 2017 an Implanon contraceptive implant was provided to Layla.

247. During the course of the inquest Counsel for Betty Laurie urged that recommendations be made in relation to testing for foetal alcohol spectrum disorder (FASD). However there is no evidence that Layla suffered from FASD. The only mention of FASD in the medical records is an entry on 20 September 2010 that indicates "GP review FASD". At that date there was also an entry for "715 child health check". Two days later there is another entry in relation to the health check stating "only a doctor can complete this" and the entry into the GP review of FASD was cancelled. The 715 child health check appears to have been carried out on 18 January 2012. The suggestion of review for FASD was not revisited between 2010 and her death in 2017.

248. Her carer, Ms Laurie, also indicated that in primary school she was a good student, a happy girl and there were no concerns until high school. When she was seen by doctors and a psychologist in Queensland on multiple occasions in the first part of 2017, suspicions relating to FASD or testing for it were not raised. The handover letter from the psychologist to the Katherine West Health Board also made no reference to FASD.

Education

249. In the early years of school, Layla had good attendance from years 1 to 6. She generally attended more than 90% of the time. Her behaviour in the community was good in her younger years. Her first engagement with the law commenced after she broke into the Bulla Store overnight on 5 April 2014. However, her schooling remained positive until the last semester in 2014 (year 6). On 10 October 2014 DCF received a notification that Layla and other children had broken into the school on four occasions. She was 12 years of age. Between 20 October 2014 and 21 November 2014 there were 7 reports about Layla's behaviour at school. She was sent home on 8 December 2014 due to her behaviour.

250. After completing year 6 at the Bulla Camp School in 2014 things seemed to fall apart. On 17 April 2015 she commenced at Kormilda College. That did

not work out well and she was expelled on 19 October 2015. She did not attend school again until 19 August 2016 when she was enrolled at Katherine High School. However her attendance was only 19.1%. She did not attend at all in 2017 and her enrolment officially ended on 7 April 2017. She then went to Djarragun College from 20 April 2017 until 25 May 2017. She was asked to leave. She was 15 years of age. She did not attend school thereafter.

251. There was no attempt to engage Layla in the educational system when she wasn't attending, no curiosity as to why she wasn't attending and very little effort to require her attendance.

252. Ms Susan Bowden of the Education Department undertook a review of Layla's school experience. She identified a failure to address Layla's lack of engagement in her middle and senior years and no early intervention or support from the school or counsellors when her behaviour became an issue. She said there seemed to be limited understanding of her disengagement from education or her vulnerability.[49]

Territory Families

253. On 10 October 2014 DCF received a notification that Layla and others had broken into the Bulla school on four occasions and the general store on three occasions during the school holidays. The notification was screened in for assessment of neglect-inadequate supervision and inadequate basic care. However the case was not allocated and did not progress "due to resourcing constraints in the office". Her case was closed on 26 September 2015 as part of a "case closure strategy" to close a backlog of unallocated cases.[50] In the view of Ms Broadfoot that was a missed opportunity to provide a positive intervention to Layla's life.

---

[49] Paragraphs 29, 94, 138, 164

[50] Statement of Broadfoot p27

254. On 13 January 2016 a further notification was received, stating that over three days children including Layla, had trashed two teachers' homes. The notification stated that the children had no supervision for extended periods and appeared to have no adult guidance. The similarity to the previous notification was recognised and the notification screened in. DCF staff visited Bulla the next day and spoke to police a week later. However, very little happened in the months that followed. On 18 March 2016 Layla's carer called DCF saying that she could not continue to look after Layla. Even that did not stimulate activity. In the opinion of Ms Broadfoot, once again an opportunity was missed for engagement with Layla and those around her to "verify her safety and wellbeing and intervene if necessary".[51]

255. On 30 March 2016 police found Layla wandering the streets of Katherine. Her carer and the hostel she had been staying at were unwilling to take her back. Police notified DCF and it was screened in for neglect. Police took Layla to the Katherine DCF office. Layla was due to go to boarding school in Townsville in another two weeks and arrangements were being made to take her into provisional care and place her in accommodation in Darwin. However, she left the office and caught a bus to Kununurra to see her father. Ms Broadfoot was of the opinion that DCF staff should have done more to locate Layla and should have communicated their concerns for her welfare to child protection workers in Kununurra.

256. On 8 August 2016 there was a notification to DCF that Layla, then 14 years of age, had sought contraception. The concerns related to neglect and sexual exploitation. The notification was referred to CAT for assessment. The police advised that the notification did not meet the threshold to investigate and subsequently DCF screened the notification out. In the view of Ms Broadfoot more should have been done to understand whether Layla was at risk of harm, given her age and known history.

---

[51] Ibid p28

Justice system

257. On 6 April 2014, with four others, Layla broke into Bulla Store. Court dates were 13 May 2014, 9 July 2014, 3 September 2014 and 5 November 2014. She was referred for diversion.

258. On 28 December 2015 Layla with four others broke into the school houses, made a mess and graffitied walls. Court dates were 21 November 2016, 16 December 2016, 20 January 2017, 17 February 2017, 1 March 2017, 17 March 2017, 13 April 2017, 28 April 2017 (did not attend) warrant issued but not returned before her death. The court was clearly unaware that on that last occasion she did not attend because she was at Djarragun College in Queensland.

259. On 25-28 March 2016 with five others Layla broke into a clothing store in Katherine and stole $3400 worth of clothing and removed and damaged the cash register, $500. Court dates were 3 June 2016, 1 July 2016, 20 July 2016, 21 September 2016, 23 November 2016, 16 December 2016, 20 January 2017, 17 February 2017, 17 February 2017, 1 March 2017, 17 March 2017, 3 April 2017, 28 April 2017 (did not attend) warrant issued but not returned before death.

260. On 19 September 2016 at 2.30am with four others, Layla broke into and stole food and cigars from the Shell Service Station in Katherine and later that morning at 4.00am they broke into a cabin at Riverview Caravan Park and stole alcohol ($600), cash ($1000) and a bike ($50). The Court dates were 20 January 2017, 17 February 2017, 1 March 2017, 17 March 2017, 13 April 2017, 28 April 2017 (did not attend), warrant issued but not returned before death.

Formal findings

261. Pursuant to section 34 of the *Coroners Act*, I find as follows:

    i. The identity of the deceased is Layla Leering, born on 22 February 2002 at Royal Darwin Hospital in the Northern Territory.

ii. The time of death was 3.30am on 10 December 2017. The place of death was House 54 Bulla Community, Northern Territory.

iii. The cause of death was self-inflicted hanging.

iv. The particulars required to register the death:

1. The deceased was Layla Leering.
2. The deceased was of Aboriginal descent.
3. The deceased was unemployed.
4. The death was reported to the Coroner by Police.
5. The cause of death was confirmed by Forensic Pathologist Doctor Marianne Tiemensma.
6. The deceased's mother was Justine Jingles and her father, Andrew Leering.

General Issues

Suicide

262. The age standardised suicide rate in Australia is 12.9 per 100,000. For Aboriginal and Torres Strait Islander people the rate is almost double that, at about 25 deaths per 100,000. In females the rate is highest in the 15 – 24 age group being 27.7 per 100,000. [52]

263. In the Northern Territory over the last 10 years, 24 females aged 12 – 17 years took their lives. The rate is 62.5 per 100,000. [53] Half of those lived in the East Arnhem region. In that same period 21 males in the same age group took their lives. The rate is 52 per 100,000.[54] Seven of those lived in East Arnhem (33%).

---

[52] Australian Bureau of Statistics
[53] 24 deaths in an estimated age population group of 3840.
[54] In an estimated population group of 4026.

264. In the last five years there have been 9 deaths of females in that age group: 46.88 per 100,000. However seven of those deaths were in the East Arnhem region (77%).[55] In contrast, in the last 5 years there have been 4 males in that age group that took their lives: 19.87 per 100,000. Only one of those lived in East Arnhem (25%).

Trauma

265. The reasons for the greater prevalence of suicide in Aboriginal and Torres Strait Island populations has been the subject of a great deal of commentary and research. Much of that was helpfully collated by the State Coroner for Western Australia, Ms Fogliani on 7 February 2019 in her excellent findings into the deaths of *Thirteen Children and Young persons in the Kimberley Region, Western Australia*.[56]

266. During this inquest I heard from two of the witnesses who provided significant evidence in that inquest. I heard from Professor Pat Dudgeon as to how the experience of Aboriginal and Torres Strait Islanders from colonisation to this day had been one of disempowerment and dispossession that had resulted in continued and every day, "loss, grief and disconnection, trauma and helplessness, powerlessness and lack of control" along with socioeconomic disadvantage, an additional risk factor for suicide.[57]

267. Emeritus Professor Valerie Atkinson spoke of the intergenerational and collective trauma that had fractured the family and social systems leaving it an unsafe environment for children and their continued trauma not being met because of the failure of government services to respond to their needs.[58]

268. One of the significant issues she raised was about 'health and wellbeing'. She said:

---

[55] Fionica and Keturah died in East Arnhem.
[56] Ref Nos: 25/2017
[57] Page 2 of report
[58] Ibid page 13

> "Health and wellbeing is not just the absence of disease or illness. The complex combination of physical, mental, emotional factors which is also culturally based is relevant. Wellbeing is strongly linked to happiness and life satisfaction … it is hard to contextualise the prescription of birth control for a thirteen year old without checking to see what is happening in her life. There is, in my opinion criminal negligence when it is felt easier to write a prescription for birth control without checking on the physical-sexual wellbeing of the child who has multiple sexually transmitted diseases."[59]

She also spoke of the overwhelming need for, and the clear lack of, trauma specific cultural training and skills for persons working with children.[60]

269. Professor Gary Robinson, Director of the Centre for Child Development and Education at the Menzies School of Health Research, provided evidence. He noted that in the cases at the inquest there was significant trauma in the children's lives that had been identified by government services years before the children's deaths. He said:

> "There were many early signs of risk for these children in the years and months before their deaths, any of which could have served as prompts for an active, sustained response … The critical point is that school disengagement and substance abuse … physical and sexual assault of a prepubescent child or adolescent, threats of suicide and self-harm, exposure to coercive family violence, and numerous other indicators of risk should and must lead to proactive, assertive and sustained responses."

Stress and Distress

270. Professor Robinson also spoke of the high levels of stress and psychological distress of children in communities. He spoke of a project that found that young people aged 12 – 14 years in remote communities are subject to high levels of life stress. He said:

> "Over 500 boys and girls in all communities surveyed reported similar levels of exposure to serious stressors at two points in time: over one quarter reported having been bullied in the last month; two thirds being affected by the loss of someone close; under half by

[59] Ibid page 14
[60] Ibid

illness; one third by exposure to suicidal behaviour in family or among kin; just under a half reported recent exposure to family violence; a third were exposed to police intervention directed at their home or a relative; and well over a third to heavy drinking by family members. Students of all schools surveyed reported being affected by an average of 3.5 stressors in the last month.

> These stressors are so widespread as to be normative in many remote communities; students develop coping strategies in a stressful environment. For some students, these coping strategies are maladaptive, in terms of school attendance and social participation; inability to sustain stable connections to family/significant others; and antisocial behaviours such as early substance misuse usually in the context of peer activities."[61]

271. That view was supported by Dr Christine Connors, the Executive Director of Population and Primary Health Care for the Top End Health Service. She said:

> "Extremely high levels of disease and premature death inhibits community members from functioning and causes persistent high levels of grief and distress."[62]

Government agencies

272. Four government agencies were invited to participate in the inquest: Education, the Top End Health Service, Territory Families and the Police. The response to these deaths by all of the agencies was sincere and it was evident there had been a significant amount of analysis of the failures to understand the plight of these young people and assist them to cope with their evident problems and in the case of Police, the poor initial investigations.

Police

273. Assistant Commissioner Nick Anticich noted the following common threads through the three investigations:

    a. The presence of investigative or unconscious bias;

---

[61] Report pages 10, 11
[62] Statement para 54

b. Insufficient reporting, planning and oversight;

c. Insufficient community engagement;

d. Process failure and delays; and

e. A focus on investigating criminality rather than factors likely to have caused the suicide.

274. He said that following two inquests that raised the issues of investigative and unconscious bias in 2018,[63] Police have undertaken a significant education program. He went on to say:

> "It is acknowledged that well documented precipitants to youth suicide such as social education disadvantage, childhood and family adversity, individual and personal vulnerabilities, impaired parenting, exposure to stressful life events and circumstances and social cultural contextual factors seem to have been present in these lives and may have contributed and should have been thoroughly investigated."

275. He explained that in 2016 and 2017 there were a large number of investigations on foot at a time when there were significantly reduced resources in the Major Crime division. He referred to that period as "tumultuous" with "no stability in the leadership from Commander through to the Sergeant level". The resources had been lost due to internal complaints, transfers out (forced and otherwise) and key members being stood down. The loss of investigative skills and knowledge was significant.

276. The Assistant Commissioner accepted that due to the role police play in the criminal justice system there was often a lack of trust of police in communities and that resulted "in the inability at times to engage with the community and obtain [evidence]". He said that police were committed to developing relationships with communities and were pursuing a number of strategies to achieve that outcome including recruiting more Aboriginal Community Police Officers, using multi-faceted teams and remote stations

[63] Inquest into the death of Sasha Loreen Napaljarri Green [2018] NTLC 016; Inquest into the death of Matthew Leonard Rosewarne [2018] NTLC 024

with two officers being expanded to three officers so as to increase the officers living and working in communities.

277. As to the Forensic Science Branch he said that since August 2018 a review of Forensic Services had been underway and the final report was received in April 2020. It included 41 recommendations and those would be implemented as resourcing allowed.

278. There was reference to the Multi-Agency Community and Child Safety Management Group of which Police were a part that had been established in response to these deaths to overcome identified problems of coordination of services and information sharing.

Territory Families

279. Territory Families was the most responsive of the government agencies. They undertook thorough reviews of their interactions with all three of the girls, provided information and assistance to the investigation in a timely manner and were the driving force behind the establishment of the Multi-Agency Community and Child Safety Management Group. The reviews undertaken were objective and genuinely sought to establish the failings in the interactions with the girls and their families.

280. Territory Families believes that their new triage tool, the ‘Signs of Safety Model’ requires a more holistic assessment and will assist their staff being better able to discern the children that need assistance.

281. They are also intent on having a great many more Aboriginal and Torres Strait Islander staff in the remote areas and have run programs in recent years to improve capacity to recognise cumulative trauma and sexual harm.

282. Territory Families was formed in 2016 and I was told that since that time there has been ongoing and significant changes. It was said that the current system would have provided a different service to Fionica and Layla.

283. What this inquest has shown is that the trauma and stress pervading Aboriginal and Torres Strait Islander communities had not been understood in the assessment of the troubled youth. Should that have been, it might be thought that it would have been more easily recognised in spite of the assessment tools. In essence, it should have been at the forefront of the assessment, possibly an initial presumption. These girls and their families needed assistance.

Top End Health Service

284. Dr Christine Connors undertook reviews into the care and treatment provided to Fionica and Keturah by the Top End Health Service. Again, the reviews were thorough and objective and of assistance to the investigative process.

285. She said that improvements required included:

a. Further training of primary health care (PHC) staff and paediatricians in recognising abuse and mandatory reporting obligations;
b. Strengthening the consultation process between PHC Teams and the Sexual Assault Referral Centre;
c. The finalisation of the Social Emotional Well Being Program (SEWB) that included training for staff, referral pathways, complex case conferences and greater recognition of distress due to abusive relationships;
d. Primary Health Care Division was finalising an audit tool to monitor the prescription of Implanon in girls under 16 years. That was to ensure that the guidelines were followed that require a comprehensive assessment that includes recognition of potential sexual abuse and adherence to mandatory reporting.
e. Better case management discussion between agencies to be seen in the Multi Community and Child Safety Teams Framework.

286. The Chief Operating Officer of the Top End Health Service, Michelle McKay also gave evidence. She said that she has worked in other states and territories as well as in England. In her opinion a finding that there is "very limited evidence of sharing information and joint planning across government agencies" is not an unusual finding. She preferred the 'Safeguarding' model utilised in England. The model is embedded in legislation that makes it explicit that everyone that works with children has a duty of care to keep them safe. Adherence to the Act is overseen by regulators that Ms McKay believed were important in keeping the system functioning appropriately.

287. She saw similarities with the new Multi-Agency Community and Child Safety Management Framework and indicated that the Department of Health was committed to implementing the model.

Education

288. Ms Susan Bowden undertook reviews of the Department of Education's engagement. She said:

> "In conclusion, the department's consideration of the educational experiences of the three decedents has revealed a number of areas where significant work is required to improve upon school attendance and engagement. It has highlighted areas of system improvement regarding data management and information sharing and improved partnerships between agencies in the Northern Territory and Commonwealth agencies and between the department and the non-government schooling sector, both within the Northern Territory and interstate. It has highlighted areas for improvement in regards to the supports, programs and staff training relevant to vulnerable children."

289. The summary of actions to be undertaken included:

a. Monitoring and responding to poor attendance;

b. Improvements in data collection;

c. Engagement of remote students in their education by supporting and monitoring their achievement;

d. Support for remote Aboriginal students attending boarding schools;

e. Active participation in the Multi-Agency Child Safety Management Framework;

f. Develop tools to identify supports and referral for vulnerable children.

Multi-Agency Community and Child Safety Management Group (Safety Management Group)

290. There have been local multi-agency meetings held in relation to children in the past. However, the vision of a more complete framework was put in place leading into the inquest. It is an attempt to coordinate government services. There are two aspects to the new framework:

a. The first are Multi-Agency Community and Child Safety Teams (Teams) based in remote communities. The teams are envisaged to consist of the following persons at the local level where relevant:

i. Groups and individuals with cultural authority including:

1. At least two Aboriginal members of Aboriginal Controlled Organisations; and/or

2. Community members with cultural authority.

ii. Territory Families, Housing and Community;

iii. Northern Territory Police;

iv. the Department of Health, and/or the Aboriginal Medical Service;

v. the Department of Education, and/or the Independent School;

vi. the Department of Local Government;

vii. the Department of the Chief Minister;

viii. the Manager of the Children and Families Centre;

ix. the Manager of the Women's Safe House (NGO);

x. Commonwealth and NT Government funded social services; and

xi. the Government Engagement Coordinator (Commonwealth).

b. The second is the Safety Management Group providing the oversight and governance. Its members consist of Deputy CEOs of all involved departments as well as AMSANT. Currently the membership involves:

   i. Territory Families;
   ii. Attorney General and Justice;
   iii. Correctional Services,
   iv. Health,
   v. Education,
   vi. Housing
   vii. Department of the Chief Minister
   viii. Aboriginal Medical Services Alliance Northern Territory (AMSANT).

291. The Teams will deliver case based services to children and families and community based services to groups of children and families. The idea is that the agencies will work collaboratively and share information providing a 'holistic response'.

292. The teams will be set up at regional 'Hubs" and at the date of the inquest there were said to be a minimum of 24 Hubs. Most meetings would be conducted every two weeks. For present purposes it was confirmed that there would be teams in Timber Creek, Maningrida and Groote Eylandt.

293. The framework is in part modelled on the Kununurra Project from Western Australia. At the time of the inquest, Ms Jeanette Kerr, the Deputy CEO of Territory Families was the Chair of the Safety Management Group. She said that there was already a trial in Wadeye and the setting up of the rest of the Teams was imminent.

The last two decades

294. In inquest findings on 24 November 1999 relating to the suicide deaths of four Aboriginal youths, on the Tiwi Islands[64], I quoted Justice Muirhead, who said:

> "… in dealing with Aboriginal children one must not overlook the tremendous social problems they face. They are growing up in an environment of confusion. They see many of their people beset with the problems of alcohol, they sense conflict and dilemma when they find the strict but community-based cultural traditions of their people, their customs and philosophies set in competition with the more tempting short-term inducements of our society.
>
> In short the young Aboriginal is a child who requires tremendous care and attention, much thought, much consideration." [65]

295. During this inquest I also recited my own observations from page 11 of my 1999 findings in the following terms:

> "In my view, the starting point for identifying strategies for the prevention of suicide and self-harm on the Tiwi Islands is to realise the great stresses upon the population. It may be obvious, however, it ought be said that their traditional culture and beliefs exist uneasily in today's modern world. Western ideas of individual achievement, competitiveness, work ethics, definitions of success, ownership rights, and just what is important, are all there and learned by the youths, reinforced by daily access to satellite TV's, television, video, movies, radio, telephone and newspapers. At the same time the people are proud of their Aboriginality, history and culture. The elders and their authority are generally respected, concepts of community/kinship/extended family/sharing are very much a part of everyday life."

296. I asked the witness, Professor Dudgeon about that quote from 1977 and my own observations in 1999. She agreed that there had been a tension but went on to provide a more optimistic outlook. She said:

> "I think cultures aren't static … they change, and I think they can move on and still be grounded in culture … Any culture doesn't stay still, they change over time …I think that we are at a crossroads. I think there's much better respect and a difference in the race

---

[64] Inquest into the deaths at Nguiu, Bathurst Island of Tipungwuti, Kerinaiua, Puantulura and Orsto, 25 November 1999

[65] Jabaltjaril v Hammersley (1977) 15 ALR 94 (NT) at 98

relations in our country, so I am optimistic. I think that things can be turned around but I think they need to be seriously considered and our approach has to be different in order to turn it around." [66]

297. In 2007 the *Little Children are Sacred Report* (the Report) was published along with 97 recommendations. In the Overview of that report the authors stated:

> "The Inquiry accepts that sexual abuse of Aboriginal children is *common, widespread and grossly under-reported*" [67]

298. The recommendations included:

> 5. That the government develop a whole-of-government approach in respect of child sexual abuse. Protocols should be developed as a matter of urgency to enhance information sharing between agencies and the development of a coordinated approach in which all agencies acknowledge a responsibility for child protection. The approach might build on the work of the Strategic Management Group and Child Abuse Taskforce but needs to extend well beyond those initiatives.
>
> 11. That FACS maintain a role in responding to cases of extra familial sexual abuse, develops and evaluates therapeutic support plans for the child, family (and community, where necessary).
>
> 17. That DHCS lead the development of enhanced information sharing between FACS, health (hospitals and health centres, including Aboriginal medical services) and community services (mental health, alcohol and other drugs, aged care and disability), Police and Education in support of more effective coordinated case management practices.
>
> 18. That FACS explore the possibility of providing confidential feedback on the progress and outcome of investigations to key service providers and notifiers, with a view to increasing communication and effective partnerships between FACS, Police and professional notifiers in particular.
>
> 45. That, as soon as possible, the government, in consultation with Aboriginal communities and organisations, develop, implement and support programs and services that address the underlying effects of both recent and "intergenerational" trauma suffered in Aboriginal

[66] Transcript p247
[67] Page 16, their emphasis

communities and enhance the general emotional and mental wellbeing of all members of those communities.

50. That, given that children and young people who chronically non-attend or are excluded from school are severely disadvantaged and that there is a correlation between school non-attendance and criminal activity, poverty, unemployment, homelessness, violence and sexual abuse, the government must as a matter of highest priority ensure:

    1. the Department of Employment, Education and Training (DEET) implements the attendance strategies set out in the Education Chapter and any other strategies required to ensure all children of school age attend school on a daily basis, in accordance with DEET's responsibilities to provide compulsory education for all school-age children.

Comment

299. None of those excellent recommendations from more than a decade ago appear to have gained any prominence or sustained action. It is also evident that the difficult conditions for children in remote communities have not changed a great deal in the last two decades. It remains an external model for the communities where services and support are determined and controlled in Darwin.

300. The most unsettling aspect of this inquest has been the blindness of the government agencies to the obvious trauma suffered by these girls. All of the usual red flags were there including sexual exploitation, STI's, suspicious injuries, behavioural issues, disengagement from school and notifications to the child protection agency. Failing to recognise trauma cannot be isolated to the failure of training or induction, the misapplication of a policy or lack of resources. It is more than that.

301. Sexual abuse appeared the most difficult aspect for the agencies. Indeed there seemed little capacity of the services to assist in relation to protecting the girls from sexual predation. In Fionica's case, where sexual abuse was most evident, the issue was never tackled and open cases relating to sexual

abuse were quickly diverted by allegations of parental violence or over-zealous discipline.

302. The representations made by the child protection agency to the *Little Children are Sacred Inquiry* also appear to have stumbled. The Inquiry reported:

> "In 2006 however, as part of the justification for the development of the Child Abuse Taskforce joint investigative Police-FACS team, it was recognised that FACS could play an important role in interviewing and supporting victims. Further, it found that organising child, family (and at times whole-of-community) therapeutic responses following allegations of child sexual abuse matters must be given greater prominence. As a result of the development of the CAT and the number of complex sexual abuse incidents that have been investigated in the last 12 months, FACS now takes a greater role in the investigatory process for all sexual abuse cases, including those where the protective concerns are minimal, including cases where the matter may not be able to be substantiated or criminal charges laid."[68]

303. That certainly sounded encouraging. But in relation to these girls it did not happen. It is tragic and frustrating that the lessons of the past have gained so little traction.

304. There is one other theme. The communities must have some real control. The Report quoted with approval the comments of Mr Fred Chaney on the ABC's 7:30 Report on 19 April 2007. He was being asked why successive governments had failed in turning the story of Aboriginal deprivation around. I quote from the Report that except in full:

- *And one of the things I think we should have learned by now is that you can't solve these things by centralised bureaucratic direction. You can only educate children in a school at the place where they live. You can only give people jobs or get people into employment person by person. And I think my own view now is that the lesson we've learned is that you need locally based action, local resourcing, local control to really make changes.*

[68] p240

- *But I think governments persist in thinking you can direct from Canberra, you can direct from Perth or Sydney or Melbourne, that you can have programs that run out into communities that aren't owned by those communities, that aren't locally controlled and managed, and I think surely that is a thing we should know doesn't work.*
- *So I am very much in favour of a model which I suppose builds local control in communities as the best of those Native Title agreements do, as has been done in the Argyle Diamond Mine Agreement, as is being done in Kununurra. Not central bureaucracies trying to run things in Aboriginal communities. That doesn't work.*
- *They're locked into systems which require central accounting, which require centralised rules and regulations. They're not locally tailored. The great thing about working with a mining company in an Aboriginal community is that the mining company has the flexibility to manage towards outcomes locally with that community.*
- *The great thing about the education projects in which I'm involved is that we can manage locally for the outcomes that we want to achieve locally. Once you try and do it by remote control, through visiting ministers and visiting bureaucrats fly in, fly out – forget it.*

305. Thirteen years later the evidence is replete with government services flying in and flying out of communities. I was told that the research indicates that there is a significant connection between suicide and a lack of self-determination. Measures of self-determination include Aboriginal peoples having some control over health, education and policing. [69]

306. All of the agencies involved in this inquest expressed their support for the Multi-Agency Community and Child Safety Framework. The speed at which the project has progressed is impressive and I noted the high hopes that coordination and cooperation would increase. However such coordination and cooperation groups are not novel. Indeed, the evidence is that such a group in Maningrida discussed the issues Fionica was having at the time when she was being assaulted by an older male.

[69] Pat Dudgeon p3

307. There are three aspects that in my view are important for the success of the new framework:

  a. That the framework and its requirements be legislated; and
  b. That the framework have sufficient flexibility so that there is a measure of control for communities (as opposed to just participation). Without it, the framework is likely to further entrench the problems so eloquently stated by Mr Fred Chaney; and
  c. That the framework have a system to evaluate and review its effectiveness.

308. The problems faced by these girls are still apparent today and real action has to occur immediately. The time for expressions of sorrow and promises of action in the future, commissions of inquiry and the like are long gone. I implore action rather than words.

Recommendations

309. I **recommend** that the Multi-Agency Community and Child Safety Framework be legislated so as to ensure mandatory cooperation, coordination and information sharing in a timely manner.

310. I **recommend** that the Department of Education ensure appropriate and continued engagement with all children and their families who are of compulsory attendance age in remote communities.

Referral

311. I believe that offences have been committed in connection with the deaths of Fionica Yarranganlagi James, Keturah Cheralyn Mamarika and Layla Leering and in accordance with section 35(3) Coroners Act I report my belief to the Commissioner of Police and the Director of Public Prosecutions.

Dated this 15th day of December 2020.

____

GREG CAVANAGH
TERRITORY CORONER