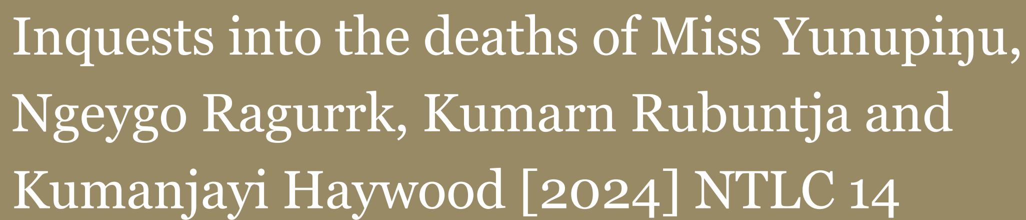

Inquests into the deaths of Miss Yunupiŋu, Ngeygo Ragurrk, Kumarn Rubuntja and Kumanjayi Haywood [2024] NTLC 14

Findings of Territory Coroner Elisabeth Armitage

IN THE CORONERS COURT

OF THE NORTHERN TERRITORY

25 November 2024

CITATION: *Inquests into the deaths of Miss Yunupiŋu, Ngeygo Ragurrk, Kumarn Rubuntja and Kumanjayi Haywood* [2024] NTLC 14

TITLE OF COURT: Coroners Court

JURISDICTION: Darwin and Alice Springs

FILE NO(s): D165/2018, D219/2019, A2/2021 and A58/2021

DELIVERED ON: 25 November 2024

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FINDING OF: Judge Elisabeth Armitage

CATCHWORDS: Coronial proceedings; inquests; deaths of Aboriginal women killed by their domestic partners; domestic and family violence; consideration of systemic failings; NT has highest rate of DFSV in Australia; NT has highest imprisonment rate in Australia; need for urgent widespread reform

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Coroners Act 1993 (NT) ss12, 34, 35, 40
Amagula v White (unrep, Supreme Court, NT, Kearney J, No JA92 of 1997, 07.01.98)
Dixon (unreported, Supreme Court, NT, Bailey J, August 1999)
Doomadgee v Clements (2006) 2 Qd R 352
Harmsworth [1989] VR 989 at 996
Inquest into the death of Anne Chantell Millar [2005] NTMC 056
Inquest into the death of HD [2021] NTLC 029
Inquest into the death of Jodie Palipuaminni [2006] NTMC 083
Inquest into the death of Reba Lakuwanga [2002] NTMC 007
Inquest into the death of Roberta Judy Curry [2022] NTLC 010
Inquest into the death of Sasha Green [2018] NTLC 016
Inquest into the death of Wayne Walker & Jacqueline Morrison [2008] NTMC 058
Inquest into the deaths of Wendy Murphy and Natalie McCormack [2016] NTLC 024
Wurramara (1999) 405 A Crim R 512

Representation

Counsel assisting:	Dr Peggy Dwyer SC Instructed by Maria Walz
For Cecily Arabie (the niece of Kumarn Rubuntja):	Mr Phillip Boulten SC Instructed by North Australian Aboriginal Justice Agency (NAAJA)
For Mr Gurumin (Steven) Marika, Ms Djatjalarrma (Julie) Marika and Ms M Marika (deceased) (the family of Miss Yunupiŋu):	Mr James Lowrey North Australian Aboriginal Family Legal Service (NAAFLS)
For Mr Tommy Madjalgaidj, Ms Mary (Malbie) Malbiynga and Ms Edna Midjarda (the family of Ngeygo Ragurrk):	Mr James Lowrey North Australian Aboriginal Family Legal Service (NAAFLS)
For the Northern Territory Police Force:	Dr Ian Freckelton AO KC with Ms Tina Tomaszewski Instructed by Police Legal
For Department of Children and Families (formerly Territory Families Housing and Communities):	Mr Trevor Moses Instructed by Solicitor for the Northern Territory
NT Health	Hutton McCarthy
NT Correctional Services	Hutton McCarthy
For Crimes Victims Services Unit	Ms Alison Phillis, Povey Stirk
For Megan Pettitt and MIYALK (Crisis Accommodation Gove)	Mr Paul Crean
For The Gillen Club	Mr Nicholas Floreani KC Instructed by Mr Luke Gardiner
For a former NT Police Constable:	Mr Luke Officer

Judgment category classification: B
Judgement ID number: [2024] NTLC 14
Number of paragraphs: 747
Number of pages: 243

I acknowledge the invaluable cultural knowledge, preserved and passed on for thousands of years, from which we all continue to learn and grow for the betterment of each generation.

Esther Bruno Nangala's artwork, *"Bush Raisin Dreaming"* (front cover), depicts the cultural knowledge, including food preparation and survival skills, she learnt from her two grandmothers while walking on country west of Kintore.

Evelyn Daniels' artwork, *"Girls Learning Ceremony after School"* (back cover), illustrates one of the artist's favourite memories of finishing school at Papunya, then the aunties taking her out on country to learn song and ceremony and dancing into the night.

Both artworks used with permission of the artist.

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IN THE CORONERS COURT
AT DARWIN AND ALICE SPRINGS
IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D165 of 2018, D219 of 2019,
A2 of 2021 and A58/2021

In the matter of an Inquest into the death of
MISS YUNUPIŊU
ON 4 OCTOBER 2018
AT PALMERSTON

In the matter of an Inquest into the death of
NGEYGO RAGURRK
ON 23 DECEMBER 2019
AT MINDIL BEACH

In the matter of an Inquest into the death of
KUMARN RUBUNTJA
ON 7 JANUARY 2021
AT ALICE SPRINGS HOSPITAL

In the matter of an Inquest into the death of
KUMANJAYI HAYWOOD
ON 7 NOVEMBER 2021
AT ALICE SPRINGS HOSPITAL

FINDINGS

Judge Elisabeth Armitage

Introduction[1]

> ***"…violence… fighting… it's got to stop… no more violence… it's not only for me it's for everyone… stop the violence."***
>
> Kumarn Rubuntja, Tangentyere Women's Group film on Hope and Healing[2]

1. Following years of abuse, 29 year old Miss Yunupiŋu was stabbed to death by her partner at a home in Palmerston on 4 October 2018.

2. On 23 December 2019, 40 year old Ngeygo Ragurrk's partner tortured her at Darwin's Mindil Beach, causing her death the following day from the horrific injuries he inflicted.

3. Kumarn Rubuntja was 46 years old when she was deliberately and repeatedly run over and left for dead by her partner, in the carpark of the Alice Springs Hospital Emergency Department on 7 January 2021.

4. On 7 November 2021, 34 year old Kumanjayi Haywood died from horrendous burns inflicted by her abusive partner of twenty years, who set fire to the bathroom she was hiding from him in, at a Town Camp outside Alice Springs.

5. These deaths were senseless and shocking. They were also preventable.

6. We must bear witness to the suffering of these women, no matter how uncomfortable it makes us. They must not be forgotten and their suffering must not be ignored. It must compel us to action. We must take the urgent action needed to stop more women from dying.

7. These women were but four of at least 87 who have been killed by their domestic partners in the Northern Territory since the year 2000, of whom

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[1] At the request of their families, the first names of the deceased have not been used during the Inquests. They are each referred to in the manner requested by their families, "Kumarn", "Ngeygo" and "Kumanjayi" are culturally appropriate words used instead of the first name of these deceased.

[2] https://www.youtube.com/watch?v=v6um1EReLs4 .

at least 82 were Aboriginal. Each of these women is remembered by her family and loved ones, and her community continues to feel her loss.

8. Some of the names and stories of these women are publicly available, but most are not. Their families may feel that these women have been erased and their suffering largely ignored. I am not able to publish many of their names and stories for legal, privacy and cultural reasons; however, each of these deaths is documented by my office and evidence about the shocking circumstances in which these women were killed was tendered in these Inquests into the deaths of Miss Yunupiŋu, Ngeygo Ragurrk, Kumarn Rubuntja and Kumanjayi Haywood.

Acknowledgment of the other women who have been killed

> ***"We are not just numbers. We are not invisible women. Our sister, another one lost to us, is not just a number and we will not let her be invisible."***
>
> Shirleen Campbell,
> Tangentyere Women's Family Safety Group co-ordinator[3]

9. The following passages contain graphic detail about the deaths of many of these women, which is likely to cause distress, particularly to people who have experienced domestic, family or sexual violence; however, I wish to publicly acknowledge as many of these women as I can, and in doing so, to highlight the horrifying reality of domestic violence killings in the Northern Territory. The recommendations I have made in these Findings are directly informed by the stories of the women who are the focus of these Inquests, and the witnesses who lent their time and expertise to this process. The time for urgent action is now.

[3] https://www.abc.net.au/news/2021-03-11/nt-vigil-for-anti-domestic-violence-campaigner-alice-springs/13237296 .

10. To respect cultural protocols, I will refer to these women by their first initial, where their names are not otherwise publicly available. I will not refer to matters that are still before the Courts.

11. This is what happened to 68 other women whose deaths were reviewed by my office.

12. E's partner beat her to the head with a stick, causing severe scalp lacerations and fatal skull fractures. He stomped on her abdomen with so much force that she suffered an extensive rupture of her mesentery, the fold of membrane attaching her intestine to the wall around her stomach area.[4]

13. R didn't do what her partner told her to, so he slapped her to the face and stomped on her stomach, fracturing her rib. He then stomped on her lower abdomen, perforating her bladder, which led to septicaemia and organ failure.[5]

14. M took a while coming home from the shops, so her partner thought she may have been seeing someone else. He became jealous and angry and beat her savagely, initially with a belt to the face then with his fists, and perhaps with his feet and maybe a weapon. He caused shocking injuries to her vagina and anal canal. She bled to death.[6]

15. M's partner became angry when she interrupted him, so to "give her a fright" he punched, kicked and stamped on her. Wearing boots, he kicked her to the face, head and chest and stabbed her to the leg with a sharpened stick. The prolonged and brutal attack caused multiple rib fractures, haemorrhages to her lung and brain, and lacerations and bruising all over her head and body.[7]

16. Ms Lakuwanga's partner pulled her hair, punched her to the neck and chin, dragged her by her neck, punched her to the chest, and kicked her

[4] Common brief: 8-15.
[5] Common brief: 8-12.
[6] Common brief: 8-16.
[7] Common brief: 8-14.

hard to the chest and maybe the back. She suffered four fractured ribs, which ruptured her spleen. This caused a massive, fatal intra-abdominal haemorrhage.[8]

17. L was murdered by her husband because "she was a rubbish wife...if she had done as she was told and had stayed where she was told, and sat where she was told, she could have been a good wife," or so he said.[9]

18. M's partner falsely accused her of sleeping with a neighbour. He beat her to the head with half of a concrete Besser block, fracturing her cheek bone and her jaw in three places. He then threw the block on her leg, causing a compound fracture to her tibia and fibula. He continued to strike her with the block, to her upper body and back, breaking her clavicle and most of her ribs, causing internal injuries to her spleen, kidneys and lungs. Her primary cause of death was bleeding from her lungs, which had been torn by the protruding ends of her 19 fractured ribs.[10]

19. J's partner became angry when she did not follow him home when he told her to, so he punched her to the head and body then kicked her to the head with steel capped work boots. She suffered fractured ribs and lacerations to her head and face. She choked on her own vomit.[11]

20. D's partner was "jealousing her" and became angry. He chased her, punched her to the face and body and hit her with a stick. She sustained injuries to 15 separate sites on her body, with lacerations, abrasions and bruises to her face, abdomen, both arms and her legs. Her cause of death was a subdural haemorrhage, which caused acute brain damage.[12]

21. J told her partner that she was leaving him to live with another man. In a fit of jealousy, he punched her repeatedly to the face, ripped her dress

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[8] *Inquest into the death of Reba Lakuwanga* [2002] NTMC 007 (Common brief: 8-1), also Common brief: 8-13.
[9] Common brief: 8-18.
[10] Common brief: 8-23.
[11] Common brief: 8-19.
[12] Common brief: 8-24.

off and beat her with a large stick. She suffered multiple full thickness lacerations to her head, multiple rib fractures with possible pneumothorax, multiple liver lacerations and a retro-peritoneal haemorrhage.[13]

22. A walked away from her partner and he became incensed. He picked up a large rock and hit her with it several times to the head. He armed himself with a large stick and hit her about the legs and body with it. The severe and prolonged beating that she suffered caused thirteen lacerations to her head and face, scattered abrasions, lacerations and bruises to her body, arms and legs. Both of her arms were broken and she suffered five broken ribs. Her cause of death was blunt force trauma to the head.[14]

23. F and her partner argued over a bottle of alcohol and she ran from him a number of times, but he kept dragging her back. He punched and kicked her repeatedly to the face, while wearing a pair of riding boots. He stomped on her head and kicked her to the abdomen. He beat her with a wooden boomerang, and then a fibreglass post, with so much force that the post splintered into pieces. Her injuries included fractured ribs, a severely fractured lower jaw with partial dislocation, subdural haemorrhage to the surface of her brain, severe bruising to her heart, severe bruising and deep ruptures to her liver, acute trauma damage to her pancreas and bruising of both kidneys. She suffered acute heart failure, severe haemorrhage into her abdominal cavity and acute hypoxic oxygen deficiency damage to her brain.[15]

24. Ms Yantarrnga argued with her partner about his drinking. Her father intervened and her partner knocked him to the ground. In a drunken rage, her partner then struck her repeatedly with a length of wood, to her head and back, and punched her numerous times to the head and abdomen. She suffered lacerations and bruises to her scalp, face, torso and limbs,

[13] Common brief: 8-17.
[14] Common brief: 8-22.
[15] Common brief: 8-25.

severe skull fractures, two fractured ribs and severe bruising to her stomach, pancreas and bowel. She choked on her own vomit.[16]

25. L's partner became angry when he saw her talking with another man and he repeatedly punched, and probably kicked, her to the face. He fractured her jaw in two places, and also fractured her collarbone. She developed adult respiratory distress syndrome as a result of the blunt force trauma to her head, and she passed away in hospital some days after the assault.[17]

26. Ms Angeles' husband violently assaulted her with an iron bar in a fit of rage. She sustained severe injuries and choked on her own vomit. After assaulting Ms Angeles, he beat her 14 year old daughter Zsa Zsa to death with the same iron bar.[18]

27. Ms Millar had tried repeatedly to leave her partner. He kicked and punched her to the head and body, and struck her with a wooden garden stake. She died from extensive multiple blunt force trauma, with acute alcohol toxicity. She had injuries including extensive bruising to her face and forearms, a black and swollen eye, cuts and abrasions to her face and arms, and lacerations to her scalp, back and legs.[19]

28. R and her partner argued about the fuel mix they were sniffing together. The argument escalated and R struck him to the shoulder with a shovel. He became incensed and stabbed her four times to the upper body, causing a collapsed lung and fatal blood loss.[20]

29. N and her partner had both been drinking when he became angry that she was intoxicated while caring for their child. They argued and he kicked her, and punched her a number of times to the head and face. She suffered a subdural haematoma, which caused her death.[21]

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[16] Common brief: 8-20.
[17] Common brief: 8-26.
[18] Common brief: 8-27.
[19] Common brief: 8-21 and *Inquest into the death of Anne Chantell Millar* [2005] NTMC 056 (Common brief: 8-4).
[20] Common brief: 8-28.
[21] Common brief: 8-31.

30. K went to sleep in the rear of a motor vehicle, and her partner became angry and aggressive, and tried to pull her out of the car by her hair. He slapped and punched her to the head, causing her to fall down. He beat her with a stick to the head and body, then dragged her by the hair and left her lying in a ditch, where she passed away after choking on her own vomit. She had sustained two fractured ribs, a fractured hyoid bone in her neck and a dislocation of her jaw, as well as lacerations, abrasions and bruising to her head, neck, body, legs and arms.[22]

31. J and her partner argued about him having another girlfriend. He became very angry and stabbed her to the ankle and once to each thigh. He told her to go to the hospital to be treated, then he left her while he went into town to drink. One of the stab wounds completely severed her femoral artery, causing her death. She was also found to have abrasions and bruises to her face, breasts, shoulder and right flank.[23]

32. Ms Palipuaminni's partner argued with her because she had not brought him a drink of water. He kicked and punched her. She suffered lacerations, abrasions and bruising to her limbs, neck and torso, three fractured ribs and a ruptured liver. Her cause of death was intra-cranial haemorrhage following blunt head trauma. There were seven separate sites of injury to her head and 17 to her body and limbs.[24]

33. Ms Albert and her partner argued over jealousy matters. He ferociously assaulted her, punching her to the face and head, then when she fell to the ground he kicked her to the abdomen and beat her with a rock. She sustained 19 separate sites of injury to her body, lacerations to her face and head, fractures to both shoulder blades and a finger, multiple fractured and displaced ribs, fractured vertebrae and a fatal skull fracture. Her liver was fatally ruptured in two places.[25]

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[22] Common brief: 8-30.
[23] Common brief: 8-29.
[24] Common brief: 8-34 and *Inquest into the death of Jodie Palipuaminni* [2006] NTMC 083 at [41] (Common brief: 8-5).
[25] Common brief: 8-35.

34. L was murdered by her partner when he attacked her in anger.[26]

35. C's partner was extremely angry after arguing with his family members about alcohol. He told C he did not want her to drink any more alcohol and they argued. He stabbed her a number of times with a kitchen knife, causing wounds to her arm and upper legs, one of which severed her right femoral artery. She bled to death within minutes.[27]

36. U's partner yelled at her out of jealousy, then beat and kicked her to death in the bedroom they shared. She suffered tears of the scalp, grazes and bruising to her face, jaw, scalp, shoulders, arms and hand. Her cause of death was blunt force head injury.[28]

37. C and her partner argued over jealousy matters and he punched her to the face, causing her head to hit the wall. Later that night he stabbed her to the arm and leg, before fleeing. The stab wound to her arm excised her right auxiliary artery. She died from catastrophic bleeding within minutes.[29]

38. Miss Tipungwuti and her partner had an argument. He punched her in the face, causing her to hit her head, and knocked her down by swinging a door into her. He then attacked her with repeated blows and kicks to her body. She suffered at least eight fractured ribs, ruptures with bruising to her liver, ruptures to both her left and right kidneys, extensive external and internal bruising, bruising inside and around her mouth, a laceration to her scalp and an injury to the back of her head extending through to her brain. The rupture to her left kidney almost broke it in half. Miss Tipungwuti did not die immediately. Her injuries caused difficulty breathing, decreased blood supply and pain for the next one to three hours, before she passed away.[30]

[26] Common brief: 8-36.
[27] Common brief: 8-32.
[28] Common brief: 8-33.
[29] Common brief: 8-38.
[30] Common brief: 8-37.

39. V had separated from her partner, but he wanted her to travel with him to another community. She refused and he became angry. He obtained a knife and as she sat on the ground he stabbed her in the back, puncturing her right lung. She suffered severe internal bleeding and passed away.[31]

40. S and her partner argued for some hours, and he was abusive towards her. He punched and kicked her, rupturing her pancreas, liver and small bowel. He then struck her over the head with the glass door from a cabinet, causing lacerations to her head and face. Her cause of death was blunt abdominal trauma with compounding blunt head trauma, whilst suffering from acute alcohol toxicity.[32]

41. Ms Norman's partner falsely suspected that she had been seeing other men while he was in gaol for seriously assaulting her. He became utterly enraged and punched and kicked her. He dragged her by her hair and hit her with a stick and a rock the size of a tennis ball. He abused her and told her he was going to murder her. Bystanders intervened, but he dragged her away and continued his assault upon her. He stomped on her, beat her with a piece of rubber garden hose and inflicted at least three severe blows to her head. The last injury he inflicted in this attack of sexual jealousy is extremely distressing to repeat and read, but this is the horror she endured. The injury was caused by him taking a stick or some other object and impaling her through the vagina with it. The stab wound passed through her vagina, her rectum and into the tissue above her perineum, to a depth of eight centimetres. Ms Norman's other injuries included tearing and lacerations inside her lips, four fractured ribs, bruising to her diaphragm and pancreas, injuries to her lung cavities caused by the fractured ribs and a very serious rupture to her small bowel.[33]

42. D and her partner argued about jealousy matters and he became angry when "she didn't want to listen." He stabbed her repeatedly, on the

[31] Common brief: 8-39.
[32] Common brief: 8-41.
[33] Common brief: 8-43.

median strip of a main road, in broad daylight in front of a number of witnesses, including a group of school children. An off duty police officer and other bystanders intervened to try to stop his attack, but he fatally stabbed her to the chest in front of them.[34]

43. D's drunk partner became angry about her "irresponsible drinking" and beat her repeatedly with a blunt instrument in the presence of his drinking friends. He fractured the bone at the base of her nose and caused bone deep lacerations to her head and lip. She suffered subdural haemorrhage and injury to her brain. Hours later, he beat her again, inflicting three separate injuries to her liver and she passed away about two hours later.[35]

44. Ms Liddle-Bob was fatally stabbed to the chest by her partner, for no apparent reason.[36]

45. R's partner became angry for no discernible reason, then ripped off her clothing and burned them and her other possessions. He hit her to the face, then threw her towards the fire. She received superficial burns to her upper back and shoulders and her hair was partially burnt. He threw her again and she landed heavily on the ground, hitting her head. Although she spasmed and her breathing was shallow, he did not seek help for her. She died from acute subdural haemorrhage following blunt head trauma, while suffering from acute alcohol toxicity.[37]

46. Ms Morrison's partner became jealous and they argued. He punched her to the face, fracturing her eye socket. He then retrieved a knife and cut her throat.[38]

47. M and her partner argued for an unknown reason and he became angry. He attacked her, punching her and kicking her with his work boots. He

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[34] Common brief: 8-42.
[35] Common brief: 8-44.
[36] Common brief: 8-45.
[37] Common brief: 8-40.
[38] *Inquest into the death of Wayne Walker & Jacqueline Morrison* [2008] NTMC 058 (Common brief: 8-6).

broke her arm and caused bruising to her face and abdomen. She died from bilateral subdural haematoma caused by severe blunt head trauma.[39]

48. R's partner demanded that she cook food for him, but he became angry when she was taking longer than he thought she should. He picked up a knife and stabbed her in the back. The stab wound passed through her lung and incised her inferior vena cava and pericardial sac.[40]

49. A kept talking when her partner told her to stop. He picked up a bottle and hit her to the face and head, causing her death.[41]

50. C's partner assaulted her for an unknown reason. He punched her to the head, chest and torso, as she lay on the ground. Witnesses told him to stop, but he continued. Her injuries included lacerations and swelling to the face and a ruptured splenic vein, which caused her death by significant internal bleeding.[42]

51. R's partner became angry at her level of intoxication and punched her a number of times to the face, head and stomach. She said she needed to lie down for a while and he left her where she lay. She died there alone, as a result of severe head and abdominal injuries.[43]

52. L's partner savagely beat her to the head and body with a number of large rocks, for no apparent reason. He punched her to the mouth and kicked her to the body as she lay on the ground. She begged him "Don't hit me, I'm your wife", but he continued his attack. She died as a result of a subarachnoid haemorrhage to the brain. Her injuries also included a ragged injury to her right ankle, and a very deep cut to her left foot, which exposed her cartilage.[44]

53. S refused to get in the car with her partner, who was drunk and jealous. He lost his temper and drove his car at her, narrowly missing her and a

[39] Common brief: 8-48.
[40] Common brief: 8-46.
[41] Common brief: 8-49 and 8-50.
[42] Common brief: 8-47.
[43] Common brief: 8-53.
[44] Common brief: 8-51.

young child. He chased her inside a house and picked up a kitchen knife. He stabbed her seven times: to her neck, her shoulder and to the back of her chest. One of these cut through two of her ribs, two punctured her lungs, and another cut through her aorta and punctured her heart. She suffered immediate catastrophic bleeding and both of her lungs collapsed, rendering her unable to breathe.[45]

54. M's partner became jealous and very angry. He threatened to kill her over the course of some hours, then threw a bottle at her, slammed her against a wall and stabbed her once to her upper chest with a large knife. This stab wound punctured her heart, causing her death.[46]

55. Ms Douglas' partner became angry that she could not get herself home, as she was heavily intoxicated. He inflicted at least six deliberate and heavy blows to her, probably by kicking her or dropping knees first onto her body with his full body weight. He fractured her sternum and ribs, some of which sheared away from her spine at her back. Her chest cavity filled with blood, causing her lungs to collapse, which would have led to her death within about thirty minutes. He also inflicted fatal abdominal injuries to her, including extensive lacerations and tearing of the liver, spleen, mesentery and mesenteric arterial cascade. He ruptured her superior mesenteric artery, causing her abdomen to fill with blood. She had non-fatal contrecoup injuries inside the front of her skull, and the skin and soft tissues under her chin were detached from her jaw. She lost three teeth and clumps of her hair. It is not known exactly how he caused these injuries, but they would have required considerable force.[47]

56. Ms Dean was fatally shot with a crossbow by her estranged husband.[48]

57. A's partner found her with another man and kicked her hard to her face and ribs with the heel and toe of his steel-capped work boots. He dragged

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[45] Common brief: 8-52.
[46] Common brief: 8-54.
[47] Common brief: 8-55.
[48] https://www.abc.net.au/news/2011-01-03/town-in-shock-after-crossbow-murder-suicide/1892730 .

her some 17 metres and hit her so hard with a stick that it broke. He did not seek any help for her, but rather, left her lying in the sand and went drinking with a friend. She died alone, about two hours later.[49]

58. F's partner became very angry in an argument about their relationship and her infidelity. He took a knife and stabbed her once to the thigh, puncturing her femoral artery and causing her death.[50]

59. Ms Ashley left her partner and over the next few weeks he obsessively called and texted her, trying unsuccessfully to manipulate her into reuniting with him. After making sure that she was home alone, he entered her house armed with a knife and stabbed her while she was talking to a friend on the phone. Her injuries included numerous abrasions to her face (caused by blunt force trauma), defensive wounds to her hands and fingers, and six stab wounds to her torso, including one that cut her thoracic aorta and pulmonary artery. The final injury he inflicted upon her was a six centimetre cut across the front of her neck, which went right through into her trachea: he cut her throat.[51]

60. Ms Nelson was dancing in a large group of people when her partner saw she was near another man. He became jealous and punched her. He pulled her to the ground and punched a witness who tried to intervene. He dragged her out of the house and, as she called out for help, he picked up a piece of concrete the size of a house brick and weighing nearly two kilograms. With both hands he brought the concrete down on her head. He then hit her about the head with a stick a number of times and walked away, leaving her bleeding profusely. She suffered a fracture to the back of her skull and a massive intracranial haemorrhage. She stopped breathing and was taken to hospital, where she passed away four days later.[52]

[49] Common brief: 8-56.
[50] Common brief: 8-57
[51] Common brief: 8-67.
[52] *Inquest into the deaths of Wendy Murphy and Natalie McCormack* [2016] NTLC 024 (Common brief: 8-7) and common brief: 8-59.

61. Ms Coulthard argued with her partner about jealousy matters. He became angry and attacked her. He picked up two sticks and struck her in the head, face, arms, chest and legs. He picked up a star picket and hit her to her hip or maybe her leg. He took hold of a rock the size of a rockmelon and hit her head with it about twelve times. She suffered significant lacerations, abrasions and bruising over her face, body and limbs. Her cause of death was a subdural haematoma.[53]

62. C and her partner argued because she wanted to walk home and he wanted to get a lift. He punched her several times, then beat her to the head with a rock. She ran away, but he chased her and hit her more times to the head with the rock. She fell down and he kicked and stomped on her chest and shoulder. She suffered seventeen head and scalp wounds, a broken nose, three fractured ribs, internal bruising to her hands and shoulder and a subdural haemorrhage. She died from blunt head and chest trauma and from choking on her own vomit.[54]

63. Ms Bennett and her partner argued over jealousy. He reported that she picked up a serrated bread knife and threatened to hurt both him and herself. He grabbed the knife and penetrated her shoulder and chest cavity with it, incising her thoracic aorta. She collapsed to the ground and passed away from blood loss.[55]

64. Ms Bigfoot argued with her partner because she refused to go home when he asked her to. He became very angry and assaulted her over more than four hours. He hit her twice with a crate, kicked her to the back, punched her "real hard" to her face and to her stomach. He hit her with a stick, kicked her to the face, dragged her by her arm and stomped on her stomach. He grabbed her head and banged it on the bitumen. He jumped on her face four or five times. She begged "stop hitting me. I love you" and screamed for help, but no one who heard came to her aid and no one called police. She begged her partner for help but he walked away and

[53] *Inquest into the deaths of Wendy Murphy and Natalie McCormack* [2016] NTLC 024 (Common brief: 8-7) and common brief: 8-60.
[54] Common brief: 8-58.
[55] Common brief: 8-61.

left her to die alone. Her injuries included a broken jaw, two broken ribs, a ruptured bowel membrane, abrasions to her face and shoulder and lesions on both knees.[56]

65. Ms Driver and her partner argued over alcohol and jealousy issues. He punched her repeatedly to the face and shoulder and kicked her to the back of the head. He hit her back with a tree branch. Other people present did nothing to help her during his prolonged attack. While she was either unconscious or dead, he dragged her some 230 metres, which caused significant abrasions to her body and limbs, and extensive degloving of her scalp. Her injuries included a fractured jaw, a fractured rib and a subarachnoid haemorrhage to her brain.[57]

66. Ms Murphy and her partner argued over jealousy issues. He kicked and stomped on her, inflicting more than forty blows. She died of blunt head and chest trauma.[58]

67. Ms Sinclair's relationship broke down, and her partner became increasingly jealous and angry. He came to believe she was intending to leave him and move away, and he formed an intention to kill her. He dug a bush grave, then three weeks later, he struck her to the head, rendering her unconscious, before choking her to death.[59]

68. Ms McCormack was trying to leave her violent relationship. Her partner came to her home in the early hours of the morning and argued with her. He punched her to the back of her hands, as she put them up to her head to protect herself. He then armed himself with a kitchen knife and stabbed her to the thigh, severing her femoral artery.[60]

69. R and her partner argued about where they should live. He became very angry and punched her repeatedly to the face and head. She fell to the

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[56] Common brief: 8-63.
[57] Common brief: 8-62.
[58] Common brief: 8-7.
[59] Common brief: 8-66.
[60] Common brief: 8-80 and *Inquest into the deaths of Wendy Murphy and Natalie McCormack* [2016] NTLC 024 (Common brief: 8-7).

ground, unconscious, and he dragged her about 100 metres into a ditch. He did not seek help for her, and she passed away. She had a fractured jaw and abrasions to her face. Her cause of death was blunt force trauma.[61]

70. M's partner attacked her with a tomahawk-style axe and a knife, without explanation. She suffered at least 28 impacts over her body. Her injuries included a complete fracture of her upper arm, a stab wound to her thigh, a chip wound to the frontal bone of her forehead, three fractured ribs, three wounds to her scalp, three to her face, nine to her torso, three to each arm and three to each leg. She lost a lot of blood and the fractured ribs made it difficult for her to breathe, which restricted the level of oxygenated blood going through her body. She died from a combination of her injuries.[62]

71. M's former partner became jealous and angry with her. He threw a punch at her and told her he was going to kill her. He pushed her to the shoulders, causing her to fall to the ground. He lifted her and pushed her back to the ground a number of times, then kicked her twice to the back. As a result, she suffered three fractured ribs and a subdural haematoma. Despite emergency surgery, she passed away in hospital as a result of the blunt force trauma to her head.[63]

72. Ms Foster's partner beat her to death with a piece of Besser Block. He struck her at least thirty times, including at least four particularly ferocious blows to the side of her head. He refused to let anyone into the room and did not get her any help.[64]

73. Ms Smith left her partner and about three weeks later he went to the house she was in to take her home with him. She refused to go and he

[61] Common brief: 8-64.
[62] Common brief: 8-71.
[63] Common brief: 8-70.
[64] Common brief: 8-75.

waited for the opportunity to kill her. Some hours later, he stabbed her nine times while she was lying down.[65]

74. Roberta's former partner tracked her down upon his release from a residential rehabilitation program following a period in gaol. He then assaulted her on at least four different occasions over the course of about 12 days. They got into a heated argument in which he accused her of sleeping with other men. He became extremely angry and punched her so hard that he broke her rib. The ends of her rib lacerated her spleen and she bled internally for several hours, before passing away.[66]

75. C's partner argued with her when he ran out of alcohol and cannabis. He bashed her while she was in a bathroom and, when she tried to crawl out, he dragged her and bashed her again. He slammed her head against the wall and the ground, and beat her with a small hard suitcase. He punched her, kicked her in the back and ribs and hit her over the head three or four times with a milk crate. He chased her onto a verandah, then dragged her back inside. He punched her face and pulled her hair. He then obtained a knife and stabbed her in the back. This fatally penetrated her lung and aorta. She suffered a total of 23 separate injuries, including lacerations, abrasions and bruises. She died lying face down in a pool of her own blood.[67]

76. L ended her relationship and intended to return to her home community. Her ex partner went looking for her and confronted her about her plan to move home. She said "I'm leaving you because you keep giving me a hiding." He produced a knife and stabbed her twice to her back, then seven more times to her arms and chest. One of the stab wounds perforated her heart, causing her death.[68]

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[65] Common brief: 8-72.
[66] Common brief: 8-74 and *Inquest into the death of Roberta Judy Curry* [2022] NTLC 010 (Common brief: 8-11).
[67] Common brief: 8-77.
[68] Common brief: 8-81.

77. Ms Dhamarrandji's partner became jealous and beat her in a drunken rage, inflicting multiple blows over a prolonged period, including with a stick or pipe. She sustained a massive crush injury to her chest, causing shock, multiple rib fractures and respiratory failure.[69]

78. T's partner killed her, then himself in an act of murder/suicide.[70]

79. A was shot in the head by her partner. He also killed her fourteen week old baby, O.[71]

80. These women were aged between seventeen and sixty. Most were mothers. Almost all were Aboriginal. All of them were loved and deserved to live their lives free from the violence of men.

81. These women had been in a relationship with the man who killed them for anywhere between one month and twenty-five years, sometimes on and off. Most had previously sought help from Police in relation to the violence of that man. Many had current Domestic Violence Orders (DVOs) in place for their protection.

82. The men who killed these women were aged between sixteen and sixty-six. Most had records for violence, but many did not. Many had served time in gaol for their violence, or other offending. Most, but not all, had limited education, and a limited employment history. Most had a long history of alcohol abuse, and some also had a history of drug abuse (cannabis and/or inhalants). The available records show that many had been exposed to domestic and other violence themselves as children. Most were Aboriginal, and of these, many had strong cultural ties, while others did not.

[69] Common brief: 8-82.
[70] D0013/2022.
[71] A0049/2022; https://www.ntnews.com.au/news/bernard-john-alice-killed-alena-kukla-and-her-baby-in-domestic-violence-murdersuicide-near-alice-springs/news-story/24f4749b51b7a47593f28abf372854ec#:~:text=Bernard%20John%20Alice%20killed%20Alena%20Kukla%20and%20her%20baby%20in,brutal%20assault%20on%20another%20woman .

83. There was no lawful excuse for any of these killings. Almost without exception, the man was intoxicated by alcohol at the time he killed his partner, usually to a very significant degree. Some were also under the influence of cannabis or petrol.

84. Often there were bystanders who witnessed this violence; some tried to intervene, while many did not. Those who did try to intervene were often themselves assaulted by the man whose violence they were trying to stop.

85. After fatally injuring their partner, most (but not all) of these men felt deep remorse and many sought help for the injuries they had caused. Most (but not all) admitted their responsibility for killing their partner, including by pleading guilty in Court.

86. A careful review of these deaths shows that these men killed these women because they did not like something about what the women were doing, and it made them very angry. They were angry because the woman wanted to make her own decision about where she would go or when, or what she would drink, or who she would talk to, or when she would speak or, in a handful of cases, because she said she wanted to leave the relationship. In those moments of rage, usually while very significantly intoxicated, these men were emboldened by a sense of entitlement and showed their anger through violence of the most extreme kind, inflicted upon women who were weaker than them, and who had trusted them in the most intimate way.

87. These men are not the only ones to have inflicted extreme violence against their partners in the last twenty-five years; they are just a handful. And these deaths and serious assaults are only a tiny fraction of the full story of domestic and family violence in the Northern Territory. Every day, there are thousands of Territory women surviving domestic violence, and each of these women is at real risk of becoming another DV death statistic.

Extent of the domestic and family violence crisis in the Territory

> ***"Domestic violence is a contagion. In the Aboriginal communities of the Northern Territory it is literally out of control."***
>
> *Inquest into the deaths of Wendy Murphy and Natalie McCormack* [2016] NTLC 024 per Territory Coroner Cavanagh at [1]

88. Domestic violence deaths are reported to my office; however, a great many more women in the Territory are very seriously assaulted every year but perhaps more by "good fortune than any matter for which [their attacker] can claim credit"[72], they survive. Many more women are experiencing domestic and family violence that does not usually take the form of extreme physical attacks that threaten their lives.

89. During these Inquests, I received evidence that:

    a. DFSV[73] rates in the Northern Territory are far higher than in other Australian jurisdictions,[74]

    b. some estimates suggest that up to seven or eight of every ten women in the NT experience domestic, family or sexual violence,[75]

    c. in 2021, the rates of domestic and family violence related assault in the NT were three times the national average, and five times that of most other jurisdictions where data is reported,[76]

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[72] *Wurramara* (1999) 405 A Crim R 512 at [16].

[73] The term "domestic, family violence" (or DFV) is described in the NT Government's 10 year Framework as "violence targeted at spouses and partners as well as people in a family relationship, including a relative according to Aboriginal tradition or contemporary practice". See p11 (Common brief: 7-76). It is elsewhere referred to as Domestic, Family Sexual Violence (or DFSV) or "family violence". Both of those terms are used in these submissions.

[74] Brown, C and Leung, L. – The Equality Institute, *Evidence Snapshot: what we know about domestic, family and sexual violence in the Northern Territory – and what we don't* (Common brief: 11-6). See also DFSV-ICRO Mapping Report, dated 1 May 2023 at p19 (Common brief: 7-21).

[75] Statement of Dr Chay Brown dated 25 August 2023 (Common brief: 1-2).

[76] Brown, C and Leung, L. – The Equality Institute, *Evidence Snapshot: what we know about domestic, family and sexual violence in the Northern Territory – and what we don't*

d. in 2021, the rate of domestic and family violence-related homicide in the Northern Territory was seven times the national average,[77]

e. more than 63% of assaults in the NT are domestic and family violence-related,[78]

f. an estimated 60% of matters prosecuted by the Office of the Director of Public Prosecutions are domestic and family violence related,[79]

g. 40% of domestic and family-related assaults in the NT involve weapons, a higher proportion than any other Australian jurisdiction,

h. Aboriginal women in the Northern Territory are 40 times more likely to be hospitalised as a result of family violence,[80]

i. DFSV accounts for somewhere between 50 and 80% of NT police time, and

j. more than 63% of prisoners in the NT are on remand or serving sentences for DFSV related offences.[81]

90. I accept that these statistics do not accurately capture the prevalence of domestic and family violence in the Territory, as

> "less than 40% of violence against women is ever reported to anyone, and less than 10% is ever reported to police. 9 out of 10 women who have experienced sexual assault in the last ten years

(Common brief: 11-6). See also DFSV-ICRO Mapping Report, dated 1 May 2023 at p19 (Common brief: 7-21).

[77] Brown, C and Leung, L. – The Equality Institute, *Evidence Snapshot: what we know about domestic, family and sexual violence in the Northern Territory – and what we don't* (Common brief: 11-6). See also DFSV-ICRO Mapping Report, dated 1 May 2023 at p19 (Common brief: 7-21).

[78] Statement of Penny Drysdale dated 26 October 2023, at [41] (Common brief: 1-3).

[79] Statement of Penny Drysdale dated 26 October 2023, at [41] (Common brief: 1-3).

[80] Statement of Michael Torres dated 3 October 2023 p3 (Common brief: 1-9).

[81] Statement of Penny Drysdale dated 26 October 2023, at [41] (Common brief: 1-3).

in Australia have never reported the violence to formal agencies."[82]

91. The rates of underreporting are likely to be even worse in the Northern Territory, due to the additional challenges of distance, language and cultural barriers in speaking with police, medical professionals, social and other support workers.

92. Of enormous concern is that the scourge of domestic and family violence in the Northern Territory is becoming worse. NT Police figures show that:

    a. in the past ten years, NT Police recorded a 117% increase in the number of DFSV reports, and they predict a further 73% jump during the next decade,[83]

    b. for each year of the past five financial years, there has been an increase in the volume of domestic violence incidents reported to Police across the Northern Territory,[84]

    c. during 2021-2022, 31,594 domestic violence incidents were reported to NT Police, and this increased to 37,621 in 2022-2023, and

    d. between 2022 and 2023, the number of hours NT Police spent on domestic violence cases jumped from 712,649 to 882,000. Based on those statistics, the cost of DFSV to NT Police is projected to reach $156 million by 2027 and $209 million by 2030 – almost half of the entire police operating budget (and not accounting for inflation).

[82] Statement of Dr Chay Brown dated 25 August 2023 (Common brief: 1-2).
[83] Evidence of Deputy Commissioner Michael White, Inquest into the death of Ngeygo Ragurrk, 3 July 2023 at T375, T379.
[84] Statement of Deputy Commissioner Michael White, 20 October 2023 (Common brief: 2-5).

The scourge of domestic and family violence in the NT is not new

93. While we are seeing increases in the rates at which domestic violence is being reported, the scourge of domestic and family violence in the Territory is not new. It has been clear for many years that the Northern Territory is experiencing a domestic and family violence crisis.

94. More than twenty-five years ago in the NT Supreme Court, Kearney J referred to "the pervasive violence against women in Aboriginal communities" and observed that:

> "There is a fairly widespread belief that it is acceptable for men to bash their wives in some circumstances; this believe must be erased."[85]

95. The following year, in the same Court, Bailey J observed that:

> "…this court has commented repeatedly on the practice of some, even many, drunken Aboriginal men that beat and bash their wives without the slightest provocation…It seems to me that on a weekly basis, either magistrates or judges are repeating the mantra that Aboriginal women have every right to expect the law to do what it can to protect them, and punish severely those who assault them. All of this seems to make not a scrap of difference to the parade of battered, bruised and occasionally dead women presented as victims in Territory courts."[86]

96. These comments were made before *any* of the women acknowledged above were brutally killed.

97. In 2006, my predecessor observed that:

> "I think I am able to say that it is now recognised by the overwhelming majority of people in this community that there is a pressing need to recognise that domestic violence is an issue of the utmost seriousness, and it concerns every member of the community. No longer is it appropriate to view violence in the family or in a relationship as something personal or private. Like any other crime it must be regarded as a threat to the strength and

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[85] *Amagula v White* (unreported, Supreme Court, NT, Kearney J, No JA92 of 1997, 7 January 1998).

[86] *Dixon* (unreported, Supreme Court, NT, Bailey J, August 1999).

cohesion of community life. It has serious and long term consequences for the health and development of children who become exposed to it, and to avoid taking responsibility for the fact that is it occurring in our midst is to allow ourselves to become inured to violence."[87]

98. Eighteen years later, I adopt and endorse those words.

99. On 11 July 2017, hundreds of women and a smaller number of men in Alice Springs marched from the Town Council lawns to the Local Court to raise awareness about domestic and family violence. Those marching included Federal, Territory and Local government politicians and the then Police Commissioner. Tangentyere Women's Family Safety Group co-ordinator Shirleen Campbell delivered the group's message: that the women of the Alice Springs town camps were fed up with violence in their communities, and it would not be tolerated.

100. One of those marching was Kumarn Rubuntja, one of the founding leaders of the Tangentyere Women's Family Safety Group. Kumarn was also one of the thousands of women in the Territory living with, and surviving, domestic and family violence. Just four years after this march, Kumarn became the 75th woman in the NT recorded to have been killed by her intimate partner since 2000.

Why these deaths matter to us all

> ***Aboriginal people, non-Aboriginal people, small businesses, large corporations, government, non-government entities, service providers, and tourism. Every aspect of Territory life is affected by DFV and we all have a role to play to fix it.***
>
> Leanne Liddle, Director of the AGD Aboriginal Justice Unit, statement dated 8 November 2023, at [13]

[87] *Inquest into the death of Jodie Palipuaminni* [2006] NTMC 083 per Territory Coroner Cavanagh at [70].

101. Domestic and family violence is the daily horror in our Territory community. The deaths of Miss Yunupiŋu, Ngeygo Ragurrk, Kumarn Rubuntja and Kumanjayi Haywood were shocking and we cannot ignore the suffering that they experienced. They were killed where we live: at a home in Palmerston, on Darwin’s Mindil Beach, in an Alice Springs town camp, and in the public carpark of Alice Springs Hospital.

102. Although domestic and family violence affects men and women from every cultural background in the Northern Territory, it is particularly Aboriginal women who continue to endure horrifying domestic and family violence in our communities and we cannot ignore their ongoing, daily suffering.

103. Each and every loss of a woman to domestic and family violence causes untold grief to her family and loved ones. The preventable nature of each death adds to the shock and sadness it causes, and the horrific circumstances of so many of these deaths inflict added trauma. Each woman’s death sets off a cascade of sadness and grief, most keenly felt by her children, her parents, her brothers and sisters, cousins, nieces and nephews, and her friends. Each of her loved ones experiences this grief and must carry it with them.

104. We must acknowledge not only the incredible sadness caused by these deaths, but also the effect of the violence and threats that hallmarked the lives of these women, and, by extension, the lives of those closest to them. During these Inquests I heard how Kumanjayi Haywood’s mother told others of her fear that she would one day have to bury her daughter because she would be killed by Kumanjayi Dixon. It is hard to imagine the overwhelming sadness she must have felt when she had to identify her daughter’s body after he burned her to death.

105. I heard that Kumarn Rubuntja and Kumanjayi Haywood sent messages to their loved ones in the hours before they died, telling them that they believed their partners were going to kill them. How many women in the Territory have sent a message like that? How must it be for them and

their loved ones to live with the real prospect that these messages will prove true?

106. The deaths of these women are a loss to their communities. For example, Kumarn was a leader in her community: she had been elected President of her Town Camp and was an important member of the Tangentyere Women's Family Safety Group. Ngeygo Ragurrk was the only remaining holder of sacred cultural knowledge, which was lost upon her death.

107. Their communities continue to be affected by the ongoing domestic and family violence in their midst. The unrelenting presence of violence in community is a daily lived reality for so many Territorians, including countless children and young people. We must not turn a blind eye to the long lasting impact of witnessing this violence, particularly during formative years.

108. Our Police, paramedics, health professionals, Correctional Service officers, child protection practitioners, social, outreach and support workers, and many others bear the vicarious trauma that comes with being on the front line of response to this epidemic of violence in our communities. The impact of this trauma is long lasting and can be debilitating. It has led to many talented and dedicated first responders leaving their profession, and others requiring long absences from work and intensive mental health support.

109. I heard evidence from first responders across the agencies, both junior and senior, and including police officers, 000 call centre operators, crisis accommodation providers and other support workers who broke down in tears as they described their trauma, fears and frustrations. I was struck by their level of commitment and the terrible personal cost that many suffer from their dedication to their work.

110. Almost without exception, these responders are doing incredibly difficult work while under-resourced and under-supported. There is a huge unmet need for support and assistance for women and children experiencing domestic and family violence. This means that those

working in the sector simply cannot help everyone who needs it. Many of these workers told me of their fear that the one person they were not able to help might be the next person to be killed, or that the woman who is turned away may not ask for help again. These are enormous burdens for our workers to carry.

111. In particular, I acknowledge the devastating effect of the deaths of women as a result of domestic violence upon the Police officers, child protection practitioners, social and support workers and others who have tried to help keep these women safe. The resulting trauma and overwhelming sadness were clear to me in the evidence I received.

112. As a society, we bear the weight of knowing that this epidemic of violence is being experienced by women who live alongside us, and often by our most vulnerable community members. There is a real risk that as a community we may become desensitised to the violence, which can fuel racist attitudes and stereotypes; and lead to inaction.

113. The cost is also economic: it is estimated domestic and family violence costs the NT community somewhere between $457.2 and $606.1 million each year.

114. The Northern Territory has the "dubious distinction" of having the highest rate of incarceration for indigenous peoples in the world."[88] When NT Correctional Services Commissioner Varley gave evidence, there were some 2065 inmates in adult custody in the Territory and more than 60% in relation to DFSV offences or charges. The cost of detaining this number of inmates is enormous, and there are also very significant social costs caused by these rates of incarceration.

115. We must acknowledge and understand the connection between a child being exposed to domestic and family violence and that child becoming involved in the youth criminal justice system. A 2022 Australian Institute of Criminology research paper found that 65% of children

[88] Evidence of Professor Harry Blagg, 9 November 2023, at T674.

involved in the justice system had been exposed to family violence.[89] In the NT context, a recent analysis by the Office of the Children's Commissioner found that of the children aged 10-13 in youth detention in the Northern Territory who they spoke with, 94% had been exposed to family violence.[90]

116. There is frequent media reporting about young people in the Northern Territory committing crimes like house and shop breaking and stealing cars that generate fear and resentment in the community. Given the statistics, it is likely that many of these young people are on the street because their homes are not safe, as one parent is the victim of violence at the hands of the other.

117. More specifically, the analysis above shows that a great number of the men responsible for killing their domestic partners in the NT since 2000 had been exposed to domestic and family violence as children. This cycle of witnessing or experiencing family violence, then perpetrating family violence, must be broken.

118. From a national perspective, violence against women and children is a human rights issue and Australia has international obligations to tackle discrimination and violence against women and girls.[91]

119. In sentencing Ngeygo's killer for her manslaughter, Blokland J remarked:

> "I just wonder how much longer women in and from Aboriginal communities have to put up with behaviour like yours. Why do they deserve to be the victims of such atrocious actions like yours?"

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[89] Australian Institute of Criminology, Trends and issues in crime and criminal justice, No 651, *Adverse childhood experiences and trauma among young people in the youth justice system* (2022).

[90] Office of the Children's Commissioner Northern Territory, *Our most vulnerable children bearing the consequences of a failed system: A thematic analysis of the needs of children aged 10 to 13 I the Northern Territory youth detention 2022/23*, (2024).

[91] National Plan to End Violence against Women and Children 2022-2032 Common brief: 9-9 at p102-103.

120. I echo these remarks, and add these: how much longer does the Northern Territory community have to live within this epidemic of domestic and family violence? Why do the citizens of this jurisdiction deserve to live with this unrelenting horror in our midst, which stalks our women and haunts the childhoods of our children?

We are complicit if we don't act now

> ***"We are at an epidemic proportion that I can't see a way out of it unless there is a radical change."***
>
> Acting Deputy Commissioner Michael White,
> evidence 1 November 2023 at T180

121. Much work has previously been undertaken in this Court and elsewhere to investigate this epidemic of violence, and to make appropriate recommendations for what should be done to address it. I accept the submission made on behalf of the Department of Children and Families ("DCF") that there has been "considerable and valuable work of many people in the public sector who have worked very hard over many years to articulate policy objectives, guiding principles and standards, and key initiatives and actions to address DFSV."[92] I acknowledge the very substantial work that has gone into the creation of DFSV Policy Framework documents.

122. I received evidence that included the National Plan to End Violence against Women and Children its Aboriginal and Torres Strait Islander Action Plan and its Action Plans 1 and 2; the Northern Territory Aboriginal Justice Agreement; the Northern Territory Domestic, Family and Sexual Violence Reduction Framework, its action plans and the Risk Assessment and Management Framework (RAMF); the Northern

[92] Closing submissions on behalf of DCF, dated 11 October 2024 at [53].

Territory Gender Equality Action Plan; and previous findings and recommendations of this Court.

123. In particular, I heard that in May 2022, Cabinet directed the establishment of the Domestic Family and Sexual Violence Interagency Coordination and Reform Office (DFSV-ICRO) to develop and reform the NT Government's approach to domestic family and sexual violence prevention and response. The DFSV-ICRO had representatives from five Northern Territory government agencies: Police, Health, Justice, Education and DCF. The representatives from these sectors brought their considerable experience and expertise, and were met with the good-will of the sector and agencies with whom they consulted.

124. Following a comprehensive, collaborative and consultative cross-agency effort, DFSV-ICRO produced a detailed mapping report, which:

a. assessed the prevalence of domestic family and sexual violence in the Territory (as much as was possible on the available evidence given the extreme underreporting of this violence generally),

b. identified the systemic gaps and opportunities for reform in each agency,

c. proposed specific reforms, and prepared a thorough whole of government budget submission for the 2022-2023 budget, and

d. developed options for ongoing evaluation, governance and coordination of reform in the government's response to domestic, family and sexual violence.

125. The efforts of all of those involved in the work of the DFSV-ICRO is to be commended. The budget proposal that was produced is a well researched, and well considered proposal for the *minimum* action that should be taken to arrest the rates of domestic and family violence in the

Territory. It mirrored many of the recommendations made in the past by the NT Coroner,[93] Boards of Inquiry[94] and Royal Commissions.[95]

126. I received evidence that the budget proposal for that minimum response was $180 million over five years, and that was rejected. Ultimately, during the course of these Inquests it was revealed that just $20 million over two years had been approved. This was woefully inadequate and a gut wrenching discovery for the DFSV sector.

127. It was one important example, but not the only example I heard of rejection or inaction on what I consider to be reasonable recommendations or proposals being made by experts about how to respond to this crisis.

128. I adopt the observation of Senior Counsel Assisting that:

> "It is a terrible waste of money to repeat investigations that result in similar recommendations, and it is a tragic waste of lives for them to be ignored or not seriously actioned."[96]

129. The recommendations I make today are intended to complement the recommendations and action plans that have been made before and, in particular, the work of the DFSV-ICRO. My recommendations should be implemented in alignment with the Northern Territory Domestic, Family and Sexual Violence Reduction Framework, its action plans and the Risk Assessment and Management Framework (RAMF). Where appropriate, in my recommendations I have referred to specific actions from the Northern Territory Domestic, Family and Sexual Violence Action Plan 2 ("AP2").

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[93] *Inquest into the death of Roberta Curry* [2022] NTLC 010; *Inquest into the death of HD* [2021] NTLC 029; *Inquest into the death of Sasha Green* [2018] NTLC 016; *Inquest into the deaths of Wendy Murphy and Natalie McCormack* [2016] NTLC 024.

[94] For example, the 'Report of the Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse; *Ampe Akelyernemane Meke Mekarle; Little Children are Sacred* (2007).

[95] Report of the 'Royal Commission into the Protection and Detention of Children in the Northern Territory' (2016).

[96] Counsel Assisting's Proposed Recommendations at p1.

130. In addition, I heard evidence from National, Territory and local community experts in relation to programs that have already been developed, what has been learned from them, and other approaches that have been proposed in the fight against domestic and family violence. The experts are telling us what is effective, and what they think is likely to be.

131. This is a "crisis we cannot arrest our way out of", because it is fundamentally a social problem, which the criminal justice system alone cannot fix.

132. I accept the submission of NAAFLS that the responses of our government agencies to this epidemic are subject to scrutiny under the international human rights framework and that our country's leadership in the field of human rights, and standing in the international community will also be subject to scrutiny, unless appropriate action is taken to fulfil those human rights responsibilities. As has been said before, this epidemic is our national shame.

133. We must not look away, and we must not be complicit in the suffering of women experiencing domestic and family violence by refusing to do the things that the experts tell us need to be done.

134. We must take urgent action, as a community, to make the changes necessary to prevent further deaths, and further suffering.

These Coronial Proceedings

> ***I invite all the accountability that this inquest can possibly create, and then some more, so that no more lives are lost.***
>
> Dr Chay Brown[97]

[97] Statement dated 8 November 2023 (Common brief: 1-2BBB).

135. The deaths of Miss Yunupiŋu, Ngeygo Ragurrk, Kumarn Rubuntja and Kumanjayi Haywood were unexpected and violent, so were reportable to me pursuant to s12(1) of the *Coroners Act 1993* ("the Act"). I have jurisdiction to investigate a death if it appears to be a reportable death, and I must investigate such a death if it is reported to me: s14 of the Act.

136. These four deaths were reported to me, and I directed that Police investigate each of them. The Police investigations were thorough and I had the benefit of detailed Coronial reports from Detective Sergeant Isobel Cummins, Detective Senior Constable First Class Andrew Dudley, Detective Senior Constable Nigel Bennett and Detective A/Sergeant Janice Kershaw. I am grateful for the expertise and assistance of these investigators, as well as the ongoing assistance of Detective Senior Constable First Class Natashia Wood, Detective A/Senior Sergeant Juanita Bauwens and Detective A/Sergeant David Young.

137. Section 34(1)(a) of the Act requires that I make findings, if possible, as to the identity, date, and place of death; the cause of death, and that I must, if possible, find:

(i) the identity of the deceased person; and

(ii) the time and place of death; and

(iii) the cause of death; and

(iv) the particulars needed to register the death under the *Births, Deaths and Marriages Registration Act 1996*; and

(v) any relevant circumstances concerning the death.

138. The Act also provides that I may comment on a matter, including public health or safety or the administration of justice, connected with the death being investigated,[98] and that I may report to the Attorney-General on a death[99] and make recommendations to the Attorney-General on a matter,

[98] *Coroners Act 1993,* s34(2).
[99] *Coroners Act 1993,* s35(1).

including public health or safety or the administration of justice connected with such a death.[100] I accept that my "power to comment arises as a consequence of the obligation to make findings…It is not free ranging"[101] and it must be "directed to specific ends."[102]

139. Death prevention is a major part of my function and I intend to make recommendations aimed at saving lives.

140. Pursuant to my discretion under s15(2) of the Act, I held a public Inquest in relation to each of these deaths, and I heard them together, because the deaths raised similar issues. Each of these women had suffered years of domestic and family violence before their deaths, and had been engaged with frontline service providers, to varying degrees, during those years. An examination of the circumstances of their deaths permits me to consider the systemic responses to the epidemic of domestic and family violence in the Northern Territory, and how these can be improved to prevent further deaths.

141. The public Inquests were heard as follows:

   a. from 13 to 16 June and 22 to 23 June 2023 at Alice Springs Local Court in relation to the death of Kumanjayi Haywood,

   b. from 26 to 30 June and 2 to 3 July 2023 at Darwin Local Court in relation to the death of Ngeygo Ragurrk,

   c. from 14 to 18 August 2023 at Darwin Local Court in relation to the death of Miss Yunupiŋu,

   d. at Alice Springs Local Court from 21 to 25 August 2023 in relation to the death of Kumarn Rubuntja, and

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[100] *Coroners Act 1993,* s35(2).

[101] *Harmsworth* [1989] VR 989 at 996. See also *Doomadgee v Clements* (2006) 2 Qd R 352 at [24]-[25].

[102] *Harmsworth v State Coroner* [1989] VR 989 at 996.

e. from 30 October to 10 November 2023 and on 20 May 2024 at Darwin Local Court in relation to "common" or "systemic" issues.

142. The following parties sought and were granted leave to be represented at the Inquests:

a. Cecily Arabie (the niece of Kumarn Rubuntja),

b. Mr Gurumin (Steven) Marika, Ms Djatjalarrma (Julie) Marika and Ms Munurrgitji (Susan) Marika (deceased) (the family of Miss Yunupiŋu),

c. Mr Tommy Madjalgaidj, Ms Mary (Malbie) Malbiynga and Ms Edna Midjarda (the family of Ngeygo Ragurrk),

d. the Northern Territory Police Force,

e. the Department of Children and Families ("DCF") (formerly Territory Families Housing and Communities),

f. NT Health,

g. NT Correctional Services,

h. Crimes Victims Services Unit ("CVSU"),

i. MIYALK (Crisis Accommodation Gove "CAG") and Megan Pettitt,

j. the Gillen Club, and

k. a former NT Police Constable.

143. The Inquests heard from 95 witnesses, and received written statements from many more. These were witnesses of fact, in relation to the deaths of the four women, and a range of witnesses with roles and expertise in the field of domestic and family violence. The witnesses included (in no particular order):

a. family members for each woman,

b. civilian witnesses to the deaths and events leading up to the deaths,

c. from NT Police: Commissioner Michael Murphy, A/ Deputy Commissioner Michael White, A/ Assistant Commissioner Sachin Sharma, Commander James O'Brien, Superintendent Kirsten Engels, a JESCC supervising Sergeant, Arrernte man Senior Constable Brad Wallace, and individual attending Police officers, including an Aboriginal Community Police Officer,

d. from DCF: Executive Directors for DFSV Reduction Gabrielle Brown and Seranie Gamble, Director of DFSV Reduction Division Anna Davis, and individual child protection practitioners,

e. from NT Health: Acting Regional Executive Director of Top End Regional Health Service Dr Luke Butcher and Acting Executive Director of Medical and Clinical Services for Central Australia Dr Richard Johnson,

f. from NT Correctional Services: Commissioner Matthew Varley, and Director of Offender Services & Programs Dr Natalie Walker,

g. Leanne Liddle, the Director of the Aboriginal Justice Unit, Department of Attorney-General,

h. representatives (and former employees) of women's crisis accommodation and support services, including from the Women's Safety Services of Central Australia (WoSSCA), Tangentyere Council Indigenous Corporation, Gunbalanya Women's Safe House, Anglicare Nhulunbuy, Crisis Accommodation Gove, Darwin Aboriginal and Torres Strait Islander Women's Shelter Indigenous Corporation (DAIWS), Katherine Women's Crisis Centre, Tennant Creek Women's Refuge and Ngaanyatjarra

Pitjantatjara Yankunytjatjara Women's Council Aboriginal Corporation (NPY Women's Council),

i. Aboriginal men working in the DFSV sector, including anti-family violence campaigner Mr Charlie King, Darwin Indigenous Men's Service founder, coordinator and counsellor Michael Torres, Tangentyere Council Men's Behaviour Change program manager Michael Brandenburg, and Code for Life founder and facilitator Michael Liddle,

j. Forensic pathologists Dr Marianne Tiemensma and Dr John Rutherford,

k. Commonwealth Domestic, Family and Sexual Violence Commissioner Micaela Cronin,

l. Researchers Professor Marcia Langton, Professor Harry Blagg, Professor James Smith, Dr Chay Brown and Sarah Clifford,

m. Queensland Police Assistant Commissioner Christopher Jory,

n. Our Watch CEO Patty Kinnersley and Head of Aboriginal and Torres Strait Islander Strategy Regan Mitchell,

o. Domestic Violence Registrar Maria Le Breton,

p. Acting Director of Crimes Victim Services Unit ("CVSU") Steven Wheelhouse,

q. Former DSFV-ICRO and Territory Families senior policy lawyer Penelope Drysdale, and

r. Peacemaking expert Justine Davis.

144. In addition, lengthy briefs of evidence were tendered in each of the four individual Inquests, and a common brief that related to systemic issues relevant to all four deaths.

145. I had the benefit of a detailed review of Police involvements in relation to each of the four domestic relationships relevant to these Inquests, which was conducted by Detective Superintendent Kirsten Engels and her Project Freya team.

146. DCF provided me with helpful practice reviews in relation to its involvements with the women who had children.

147. I also received detailed institutional responses from NT Police, DCF, NT Health, NT Correctional Services and CVSU.

148. I have had the benefit of receiving nearly 1000 pages of detailed written submissions from Senior Counsel Assisting me, and on behalf of the family members of Kumarn Rubuntja, Miss Yunupiŋu and Ngeygo Ragurrk; NT Police, DCF, NT Health, NT Correctional Services, CVSU, the Gillen Club and a former NT Police Officer. I have read and considered all of them.

149. I am grateful for the assistance and expertise of the witnesses who provided evidence, and the parties and their representatives. I am particularly grateful to the families of Miss Yunupiŋu, Ngeygo Ragurrk, Kumarn Rubuntja and Kumanjayi Haywood for generously sharing with me their memories of their loved ones and trusting me with their important stories of enormous loss. Later in these findings I set out more detail of their involvement in these Inquests.

Important things to note about these findings

Non publication orders

150. I note the existence of a number of non publication orders in relation to these Inquests. It is because of these non publication orders that some redaction has been necessary to the publicly available Findings in these Inquests; however, those redactions have been limited to the "Longer

story" annexures containing the findings relating to the deaths of the individual women.

We need to confront the systemic failings, not to blame or stigmatise individuals

151. My function is very different to the function of a criminal court. I am not concerned with punishing the men who used domestic violence against these four women; the three surviving men have already been dealt with at law for their offences.[103] Nor is it my function to award compensation under a civil scheme, or to shame individual decision-makers working for Government agencies or services who are working to help stop the cycle of violence and to protect victims. I recognise the huge task that policy and strategy makers have in determining how to reduce domestic violence deaths and I do not seek to criticise the individuals making these decisions; rather, my aim is to identify matters, including of public health or safety or in the administration of justice that are connected with the death, which can help us to understand and prevent further deaths.[104]

152. In the Inquests into the deaths of Kumanjayi Haywood, Kumarn Rubuntja, Miss Yunupiŋu and Ngeygo Ragurrk there were service providers asking themselves what, if anything, they could have done differently, to prevent the final acts that caused their deaths. While it is worthwhile asking those questions for the purpose of identifying problems in our systems, and opportunities to improve them, these Inquests have been conducted in a way that aims to avoid focus on individual blame, and to recognise the heroic efforts of so many frontline workers across the professions in the NT, to try to prevent injury and death.

[103] *Coroners Act 1993,* s34(3).
[104] *Coroners Act 1993,* s34(2).

153. I accept that during the course of the evidence in each of these Inquests, the actions of named officers were examined and many of these individual officers were called to give evidence.[105] Some of these named officers were also the subject of criticism in the closing submissions of Counsel Assisting and other parties;[106] however, consistent with my aim of identifying systemic failings, rather than blaming or stigmatising individuals, I have referred in these findings to individuals involved in the frontline responses by their rank or position, rather than by name. In doing so, I am mindful of the submission made on behalf of one former officer that it would be unfair to descend into critical findings of individuals.[107] I do not accept this submission; however, I do accept that it is unnecessary to name individual frontline officers in these findings when my focus is on systemic failings and necessary systemic change.[108]

154. While I will not name individuals who may have made mistakes, or failed to adequately respond to the situation with which they were faced, I will highlight many of the mistakes or failings that I received evidence of, to demonstrate the need for reform. I accept that some may view these as

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[105] I note that one former NT Police Constable was offered the opportunity to provide evidence, in the form of a written statement or by oral evidence as a witness in the Inquest into the Death of Kumarn Rubuntja. He declined this invitation, but filed closing submissions.

[106] I note that many individual officers were named, while some were not, across the four sets of individual submissions that Counsel Assisting provided in relation to the individual circumstances of each death. On behalf of the former NT Police Constable referred to in the preceding footnote,, it was submitted that there was an inconsistent manner in which other police officers' shortcomings were approached and that, in effect, he was subjected to a greater level of criticism than other officers in those submissions (that he was "unfairly singled out"); however, upon my review of Counsel Assisting's submissions in relation to the death of Kumarn Rubuntja, this submission is not born out and I reject it. Other individual officers are named, their actions analysed and their actions criticised. Their actions or failings are placed in the context of systemic problems, such as lack of training, resourcing or experience, just as this particular former Constable's were (at [91]). In addition, I understand that this former Constable did not have Counsel Assisting's other three sets of submissions in relation to the specific evidence concerning the deaths of the other women, as he was not a party to those individual Inquests (nor did he have access to the briefs of evidence in those individual Inquests. He did, though, have access to the entire transcript of these four Inquests). I note that Counsel Assisting's submissions in relation to those other three individual deaths examined and criticised the actions of other named individual officers, in the same way that this former Constable's actions were examined. Therefore, I reject his submission that the criticisms levelled at him are in any way a "greater attack on his person than others": see submissions on behalf of former NT Police Officer, dated 18 October 2024 at [12], [30].

[107] Submissions on behalf of former NT Police Officer, dated 18 October 2024 at [25].

[108] Submissions on behalf of former NT Police Officer, dated 18 October 2024 at [22].

"retrospective criticisms with the benefit of hindsight" in the "calm and leisurely atmosphere of a courtroom";[109] however, they are not "minute" criticisms and, taken as a whole, these mistakes and failings are properly characterised as evidence of systemic failings. To dismiss them as "minute retrospective criticisms" fails to understand the significance of the systemic failings that these mistakes or inadequate responses represent. The systemic failings may be in the form of failing to properly understand and recognise the complexity of domestic and family violence, or under resourcing, or inadequate training, but it is only by identifying and confronting these systemic failings that we can hope to address them, and therefore, that we can hope to save lives.

Short story of Miss Yunupiŋu

> ***I did not start this problem, Neil did. I am not strong enough to fight back against Neil Marika. I do not like getting hurt and did not give Neil my permission to hurt me. I am so sore from being hurt by Neil.***
>
> Miss Yunupiŋu statement to Police 23 June 2017

155. Miss Yunupiŋu was a Yolŋu woman born on 17 July 1989 in Yirrkala, to A Marika, of the Rirratjinju clan and Dhuwa moiety and Rrawa Yunupiŋu, of the Gumatj clan and Yirritja moiety.

156. When she was fifteen, she started a relationship with Gayurruy Neil Marika, from Nhulunbuy, who was about 21. In January 2006, when Miss Yunupiŋu was just sixteen, Mr Marika became jealous and beat her with a large aluminium garbage bin. Her injuries included a collapsed lung, from which she would have died without medical treatment. He was arrested, charged and sent to gaol. His family blamed her for this and caused trouble for her. Despite completing the Indigenous Family

[109] Submissions on behalf of former NT Police Officer, dated 18 October 2024.

Violence Program in custody, Mr Marika maintained that Miss Yunupiŋu was to blame for his offending.

157. Mr Marika was released from custody in September 2007, and repeatedly breached his supervision order by failing to attend rehabilitation, consuming alcohol and committing further offences. He completed the Indigenous Family Violence Program again in 2009 and attempted alcohol rehabilitation programs.

158. In January and February 2010 Miss Yunupiŋu again needed medical treatment for injuries that Mr Marika had caused, including by stabbing her to the legs and back with a pair of scissors, narrowly missing her spine. He said he did this was because he was angry out of jealousy, and she had refused to make him dinner. He was sent back to gaol, where he stayed until May 2013. While in custody he undertook further alcohol counselling, and the Indigenous Family Violent Offending Program. Over the course of nearly two years, he repeatedly applied for parole and was unsuccessful each time due to his "unacceptable attitude" toward Miss Yunupiŋu. This meant that he served his complete sentence, so when he was released, he was not subject to any supervision or parole conditions.

159. In November 2013, Mr Marika assaulted Miss Yunupiŋu at a licenced Club, apparently because he was angry when she asked him for some money to play the poker machines. He was in custody until January 2014, when he was released on an unsupervised suspended sentence.

160. He was returned to custody in May 2014 after assaulting her in a Night Patrol vehicle while he was intoxicated. Despite independent witnesses to the aggravated assault, Police withdrew that charge at Court when Miss Yunupiŋu refused to give evidence.

161. On Christmas Eve in 2014, Miss Yunupiŋu sought medical treatment for deep lacerations to her face that Mr Marika had caused by punching and kicking her as she lay asleep, while he was intoxicated. Despite having told Hospital staff that Mr Marika was responsible, she refused to

provide a statement to Police the next day because she "didn't want to send Neil to Court", so charges were not laid.

162. In August 2015 Miss Yunupiŋu sought refuge from Mr Marika by attending the Nhulunbuy Police Station. Police witnessed her crying and cowering from him. They were both intoxicated. Police did not take a statement from her due to her intoxication, but they charged him with breaching a DVO that was in place. He was subject to a twelve month supervised sentence, during which he completed the Family Violence Program and alcohol counselling sessions. As of April 2016, he was noted to be "taking positive steps in the right direction" and "there were no indications of trouble" in the relationship, but in May and June he was found to be in breach of alcohol protection orders.

163. Just before 3am on 30 June 2016, Miss Yunupiŋu called 000 begging for Police help, because Mr Marika was drunk and violent. He could be heard yelling at her in the background. Police did not attend until after 7am, when they found Mr Marika intoxicated. They cautioned him for breaching an existing Alcohol Protection Order, but took no further action. In particular, no DVO was sought.

164. In September 2016 Miss Yunupiŋu rang 000 after Mr Marika pushed her while he was drunk. Police attended quickly, but she denied that he had pushed her. Instead, she asked Police to take her to family in Yirrkala, which they did.

165. Miss Yunupiŋu sought refuge at the Crisis Accommodation Gove (CAG) on 6 October 2016, following assaults by Mr Marika. She stayed there for three nights, before a "white man from the church" came to the refuge uninvited and pressured her to leave the refuge and return to Mr Marika. Miss Yunupiŋu returned to CAG on 10 October and gave a statement to Police, in which she said:

> "I need to be free of Neil…I don't want him to come near me…I don't want Neil locked up. His family make me big trouble if he

gets locked up. I need that DVO to keep Neil away from me, I don't want him anywhere near me."

166. Mr Marika was charged with the recent assaults and sent to gaol for three months. A full non contact DVO was made. A referral was made to the Family Safety Framework (FSF), as a risk assessment (RAF) had been completed that indicated Mr Marika posed a high level of imminent risk to Miss Yunupiŋu. While he was in custody, services in Nhulunbuy worked closely with Miss Yunupiŋu to develop a safety plan in anticipation of his release. They were removed from the FSF agenda on 2 November, due to Mr Marika being in custody; however, alerts were entered on the Police PROMIS information system to indicate that they were at high risk of domestic violence.

167. Mr Marika was released from custody in January 2017. In March 2017, Miss Yunupiŋu applied to the Local Court for the non contact DVO to be reduced to a non harm and non intoxication DVO, so that she could reunite with him. At around the same time, Anglicare in Nhulunbuy started working closely with Miss Yunupiŋu.

168. In May 2017, Miss Yunupiŋu called 000 begging for Police help. She said that Mr Marika was drunk and trying to kill her. Police attended and found that Mr Marika was in breach of an alcohol protection order; however, Miss Yunupiŋu refused to provide a statement so he was not charged, and Police did not apply to upgrade the DVO to a full non contact DVO.

169. Following this incident, Anglicare asked that Miss Yunupiŋu and Mr Marika be put back on the FSF agenda. A RAF completed on 20 May had a score of 70, which was in the "high risk" range, so the referral was accepted.

170. In the early hours of 12 June 2017 Mr Marika assaulted Miss Yunupiŋu again, and she called 000 for help. When police attended about three hours later they noted that "by the time police arrived the couple had a

chance to discuss their issues and work things out". Miss Yunupiŋu did not make a statement.

171. It appeared to Anglicare staff that Mr Marika's violence was escalating and they raised those concerns with other agencies in Nhulunbuy, including Police. They were right to be concerned. On 17 June Miss Yunupiŋu called police for help in relation to a verbal argument and her fears that he was going to "bash her up"; on 19 June he burned her identification and bank cards; on 20 June he screamed at her "I'm going to kill you one day!" and bashed the walls of their house; and on 23 June he followed her to the clinic and in front of witnesses punched her to the head repeatedly and kicked her to the face. He was charged for this and sent to gaol for twelve months.

172. During the time that Mr Marika was in custody, the agencies in Nhulunbuy worked closely with Miss Yunupiŋu. They tried to help her to move away, but felt pressured by Mr Marika's family. The agencies put various local supports in place for her and a full non contact DVO was made for five years. She told them that she did not want to return to the relationship. In April 2018, she was removed from the FSF, as Mr Marika was not due to be released until June 2018 and, essentially, the agencies did not think that being on the Framework added any further support or protection for her at that time.

173. Mr Marika was refused parole, because he blamed Miss Yunupiŋu for putting him in gaol and "felt he had the right to be angry and punish her." Community Corrections held grave concerns for Miss Yunupiŋu's safety if he returned to Nhulunbuy, and noted that his family's strong support of him extended to bringing her back to the area whenever she left for her own safety. The refusal of parole meant that Mr Marika served his complete sentence and when he was released on 15 June 2018, it was without supervision or conditions. He had returned to Nhulunbuy by about 12 July.

174. Miss Yunupiŋu and Mr Marika were discussed at the FSF meetings on 17 and 31 July. Anglicare expressed their concerns that Miss Yunupiŋu was experiencing enormous pressure from Mr Marika's family to return to the relationship. At this time, Miss Yunupiŋu was effectively receiving daily visits from the agencies in Nhulunbuy, who were monitoring her closely because of the level of risk Mr Marika posed to her.

175. On 2 August 2018 Miss Yunupiŋu called 000 for help, because Mr Marika was drunk and threatening her. He was charged with breaching the non contact DVO and sent to gaol for fourteen days, from 6 to 19 August. Upon his release, he stayed with family in Palmerston and was not subject to any supervision or conditions.

176. On 8 September, Miss Yunupiŋu attended the Crisis Accommodation Gove and said that her mum had kicked her out. Her own mother had passed away the year before, so it is not clear who she was referring to. Miss Yunupiŋu told that service that she was suicidal, because of the pressure she was under from Mr Marika's family. She asked for their help to leave Gove. Without undertaking a risk assessment, or any checks about her FSF status or DVOs, CAG arranged for Miss Yunupiŋu to be transported to the Darwin Aboriginal and Torres Strait Islander Women's Shelter (DAIWS), where she stayed for less than 24 hours before meeting up with Mr Marika in Palmerston.

177. When the Nhulunbuy agencies discovered that Miss Yunupiŋu had been transported to Darwin, they understood the very serious danger that she was in. They knew that Mr Marika was there and that he had recently been released from custody, which is a period of particularly high risk in a relationship with domestic and family violence. They worked frantically to find out where she was, and they referred her to the Darwin FSF. Unfortunately, that referral was not adequately actioned, which meant that the Darwin agencies did not understand that she was in serious danger.

178. On 4 October, Miss Yunupiŋu and Mr Marika were with family and he consumed alcohol throughout the day. That night at the home where they were staying, they argued because he wanted to get more alcohol. He punched her in the face and told her "I will stab you before I go to gaol". He picked up a kitchen knife and grabbed her by the hair. He stabbed her three times: once to the back near her right shoulder blade, once to the back of her arm, and once to her chest, perforating her left lung and heart. She died within minutes.

179. Mr Marika was arrested at the scene and ultimately pleaded guilty to her manslaughter. He was sentenced to nine years imprisonment with a six year non parole period. He became eligible for parole on 3 October 2024.

180. While the response of agencies was not always perfect, the Nhulunbuy FSF stakeholders worked closely together to support Miss Yunupiŋu as best they could. Miss Yunupiŋu's death was a terrible loss for her family and community, and for the members of the Nhulunbuy FSF. It was shattering to those who had attempted to protect her when they found out that their efforts had not been enough to keep Miss Yunupiŋu safe.

Formal findings

181. The formal findings that I make are:

   a. The identity of the deceased is LW Marika, also known as LW Yunupiŋu, born on 17 July 1989 at the Yirrkala Health Centre in the Northern Territory.

   b. The time of death was 9:38pm on 4 October 2018. The place of death was 5/23 Cornwallis Circuit, Gray, in the Northern Territory.

   c. The cause of death was a stab wound to the chest.

   d. The particulars required to register the death:

i. The deceased was LW Marika, also known as LW Yunupiŋu.

ii. The deceased was of Aboriginal descent.

iii. The deceased was unemployed.

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

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

g. The deceased's mother was AMarika and her father was Daniel Rrawa Yunupiŋu.

Short story of Ngeygo Ragurrk

> ***"I need help, I need help"***
>
> *Ngeygo Ragurrk to security officer on 11 January 2018*

182. Ngeygo Ragurrk was a strong cultural woman who was born in Darwin on 31 January 1979. Her mother and father were members of the Mirrangangu tribe and the Mandjungung clan and she spoke three traditional languages: Mawng, Kunwinjku and Kunbalang. She was cherished as a sister, daughter, mother, and grandmother, although she never had biological children of her own.

183. Ngeygo was a traditional owner and djungkay (matrilineal land manager) of the lands and waters of Junction Bay and Arrla Bay, between the Goulburn Islands and Maningrida. She worked to protect and preserve important cultural spaces and shared her languages, skills, and understanding of country with her people. Important cultural knowledge was lost when she passed away.

184. Ngeygo lived on Croker Island with her parents until they passed away, then moved to Oenpelli (Gunbalanya) in 2009 with her sister Edna, and Edna's young family. In 2010 Ngeygo moved with Edna's family to Manmoyi where she became a Warddeken Ranger. In 2016, Ngeygo moved to Maningrida to live with her father's brother Tommy, who is considered her only living father. From there she travelled on to Darwin, where her sister Mary was living.

185. Soon after arriving in Darwin, Ngeygo met Garsek Nawirridj (also known as Garsek Moreen), who had just been released from gaol in June 2016. She was 37 and he was 35. Mr Nawirridj had a lengthy history of alcohol and substance abuse, and of committing serious acts of domestic and family violence against his first wife. During the years before he met Ngeygo, Mr Nawirridj had spent significant periods of time in gaol for offences that included serious assaults upon that lady. He had undertaken programs in custody in relation to his violence and his alcohol and other drug use. He had attempted but failed to complete residential alcohol rehabilitation and had generally responded poorly to the supervision of Community Corrections. Although he had just been released from gaol when he met Ngeygo, he was not subject to parole or other conditions.

186. Police were first called in relation to Ngeygo and Mr Nawirridj on 18 January 2017, following a report that they were intoxicated and fighting on a road in Darwin. They were both fined for disorderly behaviour. Five months later, in June 2017, Ngeygo sought medical treatment for swelling to her face, head, back and hand, which she said Mr Nawirridj had caused by bashing her. Gunbalanya Health Clinic made a mandatory report to Police. Ngeygo refused to make a complaint to police so no charges were laid, but the attending Police officer did seek a non intoxication / non harm DVO against Mr Nawirridj.

187. A little over a month later, Ngeygo attended the Gunbalanya Women's Safe House and reported that she had been drinking with Mr Nawirridj and there had been an argument between them. She stayed at the Safe

House while Mr Nawirridj settled down, but the staff at the Safe House did not know about the DVO so Police weren't called.

188. Later that month, Mr Nawirridj was charged for breaching the DVO when Police found him intoxicated in Ngeygo's company. Further calls were made to Police in December 2017 to report that Mr Nawirridj had physically assaulted Ngeygo, but each time Police spoke with her, she denied that he had.

189. In January 2018, a distressed Ngeygo ran up to a security guard at the Palmerston bus exchange seeking help. She tried to hide behind the guard as Mr Nawirridj approached and started punching her. The guard told him to stop, but Mr Nawirridj said "Get fucked she's my wife" and repeatedly punched the guard. Police attended and detained Mr Nawirridj in the back of the Police truck. While standing near the truck, Ngeygo started to tell Police what had happened, but was interrupted when Police realised that Mr Nawirridj had attempted to hang himself inside the vehicle. He was taken to hospital for observation, then released. Ngeygo refused to tell the Police anything further. Despite CCTV and independent witnesses who had seen Mr Nawirridj assault Ngeygo, he was only charged with breaching the non intoxication condition of the DVO, and with assaulting the guard, for which he was sentenced to seven days and three months gaol respectively. It is not clear to me why Police decided not to charge Mr Nawirridj with assaulting Ngeygo, or to upgrade the DVO to a full non contact order.

190. In April 2018, Mr Nawirridj again breached the non intoxication DVO, by being intoxicated in Ngeygo's company. After serving a short sentence of imprisonment for this and other offences, he was released subject to a twelve month suspended sentence. The DVO expired on 25 July 2018 and no further DVO was ever sought for Ngeygo's protection.

191. In late August 2018, Ngeygo told Mr Nawirridj that she wanted to end the relationship. On 27 August he attempted suicide and was airlifted to

Royal Darwin Hospital, where he remained for five days. Ngeygo was with him when he returned home after being discharged.

192. Police were not called again until about 1am on 13 July 2019, when Ngeygo called 000 for help. This was the first and only time she personally called for help. She said she had had an argument with Mr Nawirridj. The JESCC call taker asked Ngeygo questions to try to ascertain where she was. Due to difficulties in Ngeygo and the call taker understanding each other, it took nearly six minutes for the call taker to identify that Ngeygo was at Lake Alexander in Darwin, it was only then that she asked Ngeygo why she was calling. Ngeygo said that Mr Nawirridj had burned her "on the hot sand, on the fire", then clarified that he had thrown hot sand at her head. She said that he had removed her top, before confirming that she had taken it off herself, and that she was wearing a sports bra. At about eight minutes into the call, Ngeygo became frustrated and said she needed police now, because she was worried Mr Nawirridj might come and punch her, or do something else.

193. The broadcast to Police at 1:18am included the allegation that Mr Nawirridj had held Ngeygo's head into the fire; however, at 1:19am this was corrected to "POI threw hot sand from the fire onto the compl head".

194. Four Police officers arrived at 1:25am and found Ngeygo sitting with a group of people. They did not try to speak with her away from that group, or find out who the others were to her. From the evidence before me, it appears that one of this group was a "poison cousin" to Ngeygo. The attending Police had understood that the report to 000 was, essentially, that Mr Nawirridj had held Ngeygo's head in a fire, and had removed her top. When they attended, they saw that she was fully dressed. She said that her head was hurting and they examined her head under torchlight. They were able to see a section of singed hair but no other injury. The attending acting Sergeant formed the view that Ngeygo did not appear distressed, that she did not appear to want to speak with Police, and that her presentation was inconsistent with the complaints that her head had been pushed into a fire and that her clothing had been removed.

195. Ngeygo did not want to provide a statement to Police, but asked for them to take them to her family in Palmerston, before changing her mind. She indicated that she did not want to speak with Police any further and walked away from them. By 1:28am the attending officers finalised the job noting "no visible injuries…it would appear Ragurrk was seeking a lift to Palmerston…not as reported."

196. The Police response to this incident was clearly inadequate. The attending officers failed to understand the complaint that Ngeygo had made to the 000 call taker, then in the very limited time that they were at the scene, they failed to appropriately engage with her. They questioned her and examined her head under torchlight in the presence of a group of people who they had not identified. They did not build a rapport to facilitate her telling them what had happened. I expect that had they done so, they then would have understood the significance of Ngeygo's singed hair as corroborating her complaint that Mr Nawirridj had thrown hot sand at her. Instead, the job was finalised as a "Disturbance General" meaning that no review ("DV audit") was undertaken, no DVO was considered, and no further investigation took place.

197. In the days before Christmas 2019, Ngeygo bought a Daihatsu Feroza. She was at Edna's home in Gunbalanya when Mr Nawirridj came and convinced her to leave with him. They travelled to Darwin in the Daihatsu and parked it in Banyan St, Fannie Bay, then visited Ngeygo's sister Mary who was long grassing nearby.

198. At 2:32am on 23 December, Police received a 000 report that Mr Nawirridj was fighting with Ngeygo near the monument at Fannie Bay. The call taker had trouble understanding the names that she was given, and the caller hung up. Due to a lack of available Police units, the JESCC supervisor changed this "Domestic" report to a "welfare check" and downgraded it from a Priority 1 to a Priority 2 dispatch.[110] Police

[110] I received evidence from the JESCC supervisor who downgraded the call, who accepted that this was in error. I accept his explanation for his actions. I accept that no police unit

attended at 3:01am but were unable to find Mr Nawirridj, Ngeygo or the caller. Due to it being classified as a "welfare check", attending police were not required to locate and speak with Mr Nawirridj. They left the scene.

199. Some time later, Ngeygo and Mr Nawirridj approached a group of people sleeping near the monument. Mr Nawirridj was drunk and aggressive. He was angry and demanded to know who had called police on him and his wife. He grabbed Ngeygo and took her to the back of the shops.

200. At about 5am Police were called to Banyan St, because Ngeygo's Daihatsu was on fire. After the fire was extinguished, Police located Mr Nawirridj near the car. He told them that it was his car and that Ngeygo had given it to him as a Christmas present. He repeatedly told them that he had had an argument with her, and had threatened to burn the car. He repeatedly told them that he had then set the car on fire and that Ngeygo had run away from him. He repeatedly told them that she was hiding in the bush nearby. Despite what Mr Nawirridj told them, the attending Police officers allowed him to walk away, and they did not make any effort to locate Ngeygo and check on her welfare. They told me that they did not believe they had the power to detain him for arson of the car, disorderly behaviour or take him in to protective custody. Even if that was true, they failed to recognise the seriousness of his actions towards Ngeygo. They failed to recognise the danger she was in.

201. After walking away from Police, Mr Nawirridj approached the same group of people near the monument. Ngeygo was not with him. He was very intoxicated, aggressive and yelling, asking where Ngeygo was. He assaulted Ngeygo's 58 year old grandmother and had a short fist fight

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was available for him to dispatch in the time required for a priority one callout, and that he knew he could be disciplined for failing to dispatch a unit within that time. He also knew that a "disturbance – domestic" classification placed additional requirements upon the responding members, who he knew were already over stretched. His direction to the attending officers to check if the incident should be categorised as a "disturbance – domestic", was, in effect, a safeguard to ensure that the job would be recategorized to a "disturbance – domestic" if attending officers confirmed that it was. I find that he should not be subject to any criticism, and his actions are explained by how overloaded police are, at JESCC and in the field.

with that lady's partner, before walking away. At 5:23am one of the group called 000 to report this.

202. Two officers who had initially attended the vehicle fire responded to that call, at about 5:37am. They located Mr Nawirridj and observed him to be very intoxicated, with a large bleeding cut on his forehead. He said he had been fighting, but that he didn't want an ambulance. Mr Nawirridj told the officers that they should lock him up for fighting, but they did not think they had any power to arrest him. They informally cautioned him about his behaviour, then left the area.

203. Due to Mr Nawirridj's behaviour, the group of people from near the monument had moved closer to a service station a short distance away. As he continued to look for Ngeygo, Mr Nawirridj came across this group again. It was at about 6am and the sun was coming up. He was angry and swearing for Ngeygo. He started pushing one of the group around and blaming them. The group crossed the road towards the service station and Mr Nawirridj followed. There, he picked up a fuel bowser and took a lighter from his pocket. He placed the lighter on the pump and flicked it, saying "I'm going to light this place up...and you will all die". After being shouted at to stop, he put the pump back and went back across the road. Police were called and the same two officers attended at 6:25am. They observed that the cut to Mr Nawirridj's forehead was much larger than it had been fifteen minutes before. He told them that the injury was from a car crash and they transported him to Royal Darwin Hospital, before leaving him there.

204. By this time, within a few short hours Mr Nawirridj had set fire to a car in the middle of a public street, assaulted a number of people and tried to light a fuel bowser on fire. Yet these officers failed to speak with the witnesses at the service station or to view the available CCTV. I find that had they done so, they would have had evidence of, at the very least, a serious offence of attempted arson at the petrol station. Rather than considering whether to detain him by arrest for that offence, assault, fighting in a public place or disorderly conduct, or for a s41 DVO, or for

protective custody or in accordance with the *Mental Health and Related Services Act 1998*, they took him to the hospital and left him there.

205. Mr Nawirridj underwent tests at the hospital, but was found not to have sustained a significant injury. Bloods taken at 9:30am showed that he had a blood alcohol reading of 0.15. He was discharged at about 2:30pm and spent the next four or so hours moving about the city and drinking more alcohol.

206. At about 6:50pm Mr Nawirridj was in a mini bus taxi that drove past Ngeygo, who was with her grandmother, her cousin sister and another family member on the footpath outside the United Petrol Station on Smith St, Darwin. He got out of the taxi and ran towards Ngeygo. He punched Ngeygo and her cousin sister, then dragged Ngeygo away, down Mitchell Street towards Mindil Beach.

207. Despite members of the public witnessing this, no one tried to intervene or call Police.

208. Over the next two and a half hours, Mr Nawirridj viciously assaulted Ngeygo. First, in a secluded garden area in the carpark near Mindil Beach Casino. A member of the public heard a female's voice coming from that area sounding like "someone was fighting or having sex forcefully", but she did not call Police. About twenty-five minutes after entering the garden area, Mr Nawirridj dragged Ngeygo through the carpark toward Little Mindil Beach and beat her amongst the trees at the beach, using a weapon or weapons. He inflicted multiple blunt force injuries to her head, chest and upper limbs, as well as internal bruising to some of her organs. During the prolonged attack, he also stabbed her to the leg and hit her with a rock, as she raised her arms to defend herself. It is likely that she lapsed in and out of consciousness. Next, Mr Nawirridj dragged Ngeygo about 70 metres along the beach and undressed her. He took her into the shallow water and tried to strangle her with her skirt, while holding her under the water.

209. At about 9:40pm he sought help from two people on the beach, telling them that his wife had drowned. Police and ambulance attended and worked to resuscitate her. Mr Nawirridj told them that Ngeygo had had a fight with other people, then gone for a swim before he found her face up in the water. Despite the suspicions of attending Police that Mr Nawirridj was responsible for Ngeygo's injuries, he was permitted to leave the scene. She was taken to hospital, where she passed away from her injuries at 12:30am on 24 December.

210. An autopsy showed that her cause of death was most likely blunt force head injury, but other conditions that may have contributed to her death were multiple blunt force injuries, pressure to the neck and immersion in water. She had numerous other injuries that included extensive bruising, swelling, lacerations, and other internal injuries.

211. Mr Nawirridj was subsequently arrested and pleaded guilty to reckless manslaughter, arson, and threats to use fire to cause damage. He received a total sentence of thirteen years imprisonment, with a non parole period of eight years. He will be eligible to apply for parole in January 2028.

212. Ngeygo's suffering was extreme and Mr Nawirridj showed her no mercy.

Formal findings

213. I make the following formal findings:

   a. The identity of the deceased is S Ragurrk, also known as S Warramangoidji, born on 31 January 1979 at Darwin in the Northern Territory.

   b. The time of death was 12:30am on 24 December 2019. The place of death was Royal Darwin Hospital, in the Northern Territory.

c. The cause of death was blunt force head injury, with multiple blunt force injuries, pressure to the neck and possible drowning as other conditions present.

d. The particulars required to register the death:

   i. The deceased was S Ragurrk.

   ii. The deceased was of Aboriginal descent.

   iii. The deceased was unemployed.

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

f. The cause of death was confirmed by Forensic Pathologist Dr John Rutherford.

g. The deceased's mother was B Warramangoidji and her father was N Ragurrk.

Short story of Kumarn Rubuntja

> ***"I want him to go. He's gonna fucking kill me."***
>
> *Kumarn Rubuntja to 000 10 February 2020*

214. Kumarn Rubuntja was born in Alice Springs on 20 December 1974 and was raised on the lands of the Western Arrernte people. She was a strong Arrernte woman, who was loving, kind and funny. She was smart, courageous and resilient. She adored her family and was an inspiration to them. She liked painting and to go out bush, taking all the kids to go swimming in the waterholes.

215. Kumarn was a fierce advocate for her fellow Alice Springs town campers and for other women who had experienced domestic and family violence, particularly in her work as a founding member and leader of the

Tangentyere Women's Family Safety Group. In 2019 she was elected President of Anthepe Town Camp.

216. Kumarn experienced serious domestic and family violence in different relationships during her life, and in 2013 she was accepted onto the Family Safety Framework as a Family Violence Victim, which reflected the high risk of imminent serious harm or death to her at that time.

217. In 2019, when she was 44, Kumarn started a relationship with Malcolm Abbott (also known as Malcolm Topora), who had also been born in Alice Springs but was raised in Papunya, Haasts Bluff and Hermannsburg. He was three years older than she was and he had a long history of alcohol abuse and criminal offending, including shocking violence against women.

218. In 1996, when he was just 24, Mr Abbott had argued with his wife about alcohol and money, and he hit her. When she ran away from him, he stabbed two women, and tried to stab a third. One of these women suffered a fatal perforation to her aorta. For these offences, Mr Abbott was sentenced to a total of ten years imprisonment, with a non parole period of six years.

219. After serving this sentence, Mr Abbott committed a number of other serious assaults: in 2002 he stabbed a man during an ongoing family feud; in 2008 he stabbed his new partner, seriously injuring her to the back, leg, chest and hand; in 2014, he struck his sister in law to the head with a pair of bolt cutters and hit her with a stick and in 2016 he assaulted a new partner by punching her to the mouth while he held a piece of metal.

220. Between 1993 and 2018 Mr Abbott went to gaol thirteen times, spending almost twenty out of those twenty-five years in prison. At times he became eligible for parole, but either breached it shortly after release or was refused parole altogether. He undertook programs in gaol that included anger management and alcohol awareness programs, the Indigenous Family Violence Offender Program and the Violent Offender

Treatment Program. He was assessed to have generally poor attitudes towards his partners, blaming them for his offending, and he had ongoing anger, drug and alcohol abuse problems. By 2016 his profile on the NT Police PROMIS system included two alerts that he was a repeat domestic violence offender. He had repeatedly demonstrated a lack of insight and a lack of willingness to take steps to address the issues underlying his criminal behaviour.

221. It is not clear exactly when Kumarn started a relationship with Mr Abbott but Police were first called on 16 May 2019 and over the course of the next twenty months they were called a total of forty-seven times. Most of these calls were from Kumarn to 000, seeking urgent help. Many of these calls demonstrate real difficulties in the communication between Kumarn and the call takers; often this was because Kumarn was distressed and unresponsive to their questions, and she seemed intoxicated at times, and in other calls the call takers are overly frustrated with her and respond inappropriately. I find that these difficulties at times affected the quality of information that the JESCC call takers were able to elicit from her, and, accordingly, the quality of information that attending Police were provided with prior to their arrival.

222. Despite the number and frequency of calls to Police, no charges were ever laid against Mr Abbott, no DVO was ever sought to protect Kumarn and no risk assessment was ever undertaken. They were never referred to the Family Safety Framework. Despite Mr Abbott having a long history of very serious violence against women, the agencies in contact with Kumarn did not recognise the grave risk he posed to her.

223. That first call to Police, on 16 May 2019, was from one of Kumarn's family members. They called to report that Mr Abbott had smashed her power box with a stick and was threatening to stab her. Police attended about forty minutes later and spoke with Kumarn and Mr Abbott. They denied that they had been arguing, but Mr Abbott admitted that he had hit the power box with a stick. Despite this, the attending officers did

not inspect the power box or speak with Kumarn's family members who were witnesses. I find that attending Police did not meet the minimum standards of investigation that were required. Those officers finalised the job by indicating "no offences disclosed" and no Supportlink referral required. They noted that Kumarn and Mr Abbott both had significant domestic and family violence histories "but not with each other". The officers took Mr Abbott to Abbotts Camp.

224. Due to the incident's categorisation as a "disturbance – domestic", it was subject to a review by a supervising officer, also known as a DV audit. That supervising officer – a sergeant – noted that there was information to corroborate that domestic violence had occurred, and noted that Kumarn and Mr Abbott had both previously been on the Family Safety Framework; however, he found that there was no prima facie evidence of a criminal offence or sufficient evidence to support a Police initiated DVO, despite Mr Abbott's admission to smashing the power box. He did not require any further investigation, but submitted the incident to the Southern Domestic Violence Unit (SDVU) for review.

225. A sergeant at the SDVU reviewed the incident and found that no offences had been disclosed. She recognised the risk of domestic violence between Kumarn and Mr Abbott, due to their significant individual histories; however, she determined that no further police action was required.

226. I find that the Police response to this incident was inadequate. It reflects a failure to understand the significance of Mr Abbott's extensive history of committing serious offences of domestic and other violence. Upon recognising that there was a risk to Kumarn, there should have been a police response or a referral.

227. In July 2019, Kumarn called police to report that a man (not Mr Abbott) had assaulted members of her family. When Police attended, she recanted that complaint. As a result, attending Police added a "may make false complaint" alert to her PROMIS record. This meant that this alert was

displayed whenever Police subsequently conducted a "person check" in relation to Kumarn. I heard evidence about some of the reasons why women may call Police for help about a violent incident, but then deny their complaint or refuse to provide a statement to attending Police. That Kumarn recanted her initial complaint does not mean that it was false. It is regrettable that this alert was added to her PROMIS profile, as I am satisfied that it affected the attitude of some police who subsequently attended when she called for help in relation to Mr Abbott.

228. In September and October 2019, Kumarn called Police for help four times, telling 000 variously that Mr Abbott had assaulted her, was threatening to stab her, was threatening to smash her power box and was spitting at her. On each occasion when Police attended, she denied these complaints and the attending officers believed that she was being dishonest.

229. On 5 November, Kumarn called 000 and reported that Mr Abbott had punched her in the face and threatened to kill her. She wanted him removed from Anthepe Camp. When Police arrived Kumarn and Mr Abbott confirmed that they had been arguing but said "it was all sorted now". Police finalised the incident with no further action.

230. Two days later, Kumarn called Police to report that Mr Abbott was trying to kill himself. She and Mr Abbott can be heard speaking and yelling in language during the call, and she was at times unresponsive to the call taker's questions. During the call, Kumarn reported that Mr Abbott was trying to hit her, which prompted the call taker to respond "ma'am, are you lying about the suicide?" I find that this was inappropriate, disrespectful and destructive to any efforts to obtain further information from Kumarn. It demonstrated a shallow understanding of domestic violence by the call taker. In addition, it was another example of Police telling Kumarn that they didn't believe her.

231. Police arrived about ten minutes after Kumarn's call. The officers who attended had both been to callouts during the previous month in which

Police formed the view that Kumarn had not told the truth about Mr Abbott. On the way, they checked Mr Abbott and Kumarn's PROMIS histories, which showed that he was a "FV repeat offender" and that she was a "FV repeat victim". I accept that the officers would have known of the "may make false complaint" alert on Kumarn's profile, but that they probably did not know of Mr Abbott's manslaughter conviction or the full extent of his previous violence against women. I find that they were not told that Kumarn had told 000 that he was trying to hit her, in addition to threatening suicide.

232. Of all the many Police attendances upon Kumarn, this is the only one for which body worn video was still available at the time of this Inquest. Accordingly, I have had the benefit of seeing the interaction between Police, Kumarn and Mr Abbott on this occasion. I am mindful that the attitudes displayed by the officers on this occasion are not necessarily representative of police at other attendances; however, having reviewed the available documentary evidence for all of the other attendances, including Police notes and medical records, I am satisfied that it is likely that other officers displayed similar attitudes at other times.

233. The body worn video of this interaction shows that when Police arrived, they spoke with Mr Abbott first, as he was at the fence line of the property. The Constable established that he was Malcolm Abbott, then the very next words spoken were by that Constable asking him "is she being annoying, eh?" I find that this was an example of inappropriate collusion.

234. Mr Abbott's response was "no, she's been drinking". He told the officer that Kumarn was inside and had "grog", and later, that she had a bottle of rum. I find that these comments were attempts by Mr Abbott to deflect Police attention, from investigating him and instead led Police to investigate Kumarn for a possible breach of the alcohol ban.

235. After asking Mr Abbott if he was suicidal (which he denied) and checking if he had a knife (he did not), that Constable joined his partner,

who was with Kumarn near the house. I accept that she did not appear obviously distressed.

236. The first words this Constable then said to Kumarn were "why'd you call us, [Kumarn]? Now you're going to lose all your grog, just cause you called us and made silly story." Not only did he make no attempt to build rapport with Kumarn, but from his very first words he made it clear that he did not believe her.

237. The body worn footage shows that Kumarn initially denied having alcohol, but then *immediately* led the officers into the house and showed them where two cans of beer were. The two officers then said to her "where'd you hide it? Tell the truth?" and "Where's the rum bottle? We're not leaving till it's found. Give it over, come on. Don't make this hard for us. Make it easy for me." The officers searched but did not find any other alcohol. Clearly, Mr Abbott had lied to them about there being a bottle of rum in the house.

238. The first Constable then said "why'd you tell us silly story on the phone?" During the following exchange, Kumarn said "he tried to do a suicide", to which the Constable immediately replies "No he didn't, no he didn't." That Officer then opens the bathroom door and says "We're gonna have some shower beers later? We're gonna have some shower beers, eh?"

239. After carefully reviewing the available body worn footage, I am satisfied that was a rude and disrespectful engagement, which may, in part, be explained by the "may make false complaint" alert, and previous interactions with her, neither of which is an excuse.

240. More concerningly, this officer made it clear to Kumarn that he thought she was making up "silly stories" about Mr Abbott. He made no real attempt to obtain a version of events from her, and neither did his partner. The manner in which these officers engaged with Kumarn would likely have disempowered her from telling Police what had happened, on this occasion and likely in the future.

241. I find that these officers exercised poor judgment in the way that they spoke with both Mr Abbott and Kumarn. I am satisfied that this poor judgment reflects a lack of adequate training and experience in understanding the complexities of domestic violence, and in speaking with women who have experienced domestic and family violence. I am also satisfied that the attitude of these two officers was likely affected by the "may make false complaint" alert and by their previous attendances upon Kumarn when they had been satisfied that the incidents were not as she had reported.

242. Had those officers checked the criminal history for Mr Abbott and reflected upon it, they might not have been so dismissive of her, particularly if they understood that Mr Abbott had previously served time for the manslaughter of another women, and had violently assaulted (including by stabbing) many other victims.

243. The officers transported Mr Abbott to Abbotts Camp, at his request, and finalised this matter as "not as reported". A DV audit did not identify any deficits in the police response. I accept the submission of Counsel Assisting that, on paper, it may have appeared that this was a minor matter with no requirement for further involvement, but the situation was in fact far more complex and the audit process on this occasion did not provide an effective way to mentor or teach young police officers.

244. Between December and February, Kumarn called Police at least five times, reporting that Mr Abbott was threatening self harm, that he was trying to stab her and that he had been hitting her. Police attended each time, but their responses did not go beyond speaking with Kumarn and Mr Abbott, when they could locate them.

245. On 18 February 2020, a member of Kumarn's family called 000 to report that Mr Abbott was hurting her with a stick. Police attended and spoke with Kumarn and Mr Abbott, who confirmed that they had argued. Police determined that no offence had been committed, but submitted a Supportlink referral. Unfortunately, due to systems failings by the

agency that received that referral, no support was provided to Kumarn at that time.

246. Between 29 February and 30 May 2020, Kumarn called Police at least eleven times, reporting that Mr Abbott was threatening suicide, assaulting her, damaging her property and threatening to kill her. Police attended eight times. Whenever they spoke with Mr Abbott he denied the allegation she had made. On a number of these occasions, Police could not locate Kumarn. On at least two occasions, she told attending Police that her 000 report was true: that he had assaulted her and that he had damaged her property. Police did not observe any injuries to Kumarn, and it seems believed that the property damage was pre-existing. She did not provide a statement on either occasion, so these incidents were finalised without charges or DVO applications.

247. At about 9pm on 9 June 2020 a bystander called 000 for Kumarn, who reported that Mr Abbott had kicked her in the chest. Police arrived and she told them that he had kicked her to the chest and she was in pain. They took her to Alice Springs Hospital, and sent a request for the Hospital Based Constable to speak with her the next day. Kumarn also told hospital staff that she had been kicked to the chest. She was observed to be tender but without significant injury. She was offered a social work referral but declined it. She was admitted but discharged at 6:30am the next day. By the time the Hospital Based Constable started her shift at 7am, Kumarn had already left. That officer sent the job back to the attending Police but Kumarn was not spoken to until 14 June, when she denied having been assaulted. Police did not speak with the bystander, or give consideration to seeking a DVO. Attending police should have tried to take a statement from Kumarn on the night. I find that these were missed opportunities by NT Police.

248. On 24 August 2020, an application was made for Kumarn to be placed on the Banned Drinker Register. A second application, intended to be in relation to Mr Abbott, was inadvertently made in relation to a different member of Kumarn's family. These applications were granted on 25

August, placing Kumarn and her family member on the Register for six months.

249. On 12 October, Kumarn called 000 to report that Mr Abbott was threatening suicide, and that she was scared he might stab her. Kumarn sounded confused during this call and it was categorised as a welfare check. Attending Police confirmed that Kumarn was not at risk of self harm, misunderstanding who was threatening self harm. No further police action was taken.

250. Between 15 June and 31 December 2020, Police received some fifteen calls that they believe were from Kumarn in relation to Mr Abbott; however, the call takers were largely unable to obtain sufficient information to identify the caller or why they were calling.

251. On 7 January, Kumarn and Mr Abbott travelled together in his brother's green Ford Falcon and went to the Gillen Club in Alice Springs, where they spent about seven hours drinking and socialising with family, as well as playing the poker machines. Kumarn was on the Banned Drinker Register ("BDR") at this time, but was able to purchase and consume alcohol because she was consuming it on premises. The legislation only requires licensees to conduct BDR checks for takeaway alcohol purchases.

252. At about 6:40pm, Kumarn won $550 on the poker machines. Mr Abbott demanded that she take the money out of the machine and give it to him. She refused and they argued. A security officer told them to keep it down, and warned them that if the arguing continued, they would have to leave. About thirty minutes later, he heard them arguing again. I heard evidence that Mr Abbott was the angry one, not Kumarn.

253. I heard evidence that if a patron is intoxicated but there is no issue with their behaviour, the licensee has a discretion to allow them to remain in the venue, but they cannot have any more alcohol. A patron must be removed if they are intoxicated and violent, quarrelsome, disorderly or incapable of controlling their behaviour.

254. Kumarn asked the security officer to remove Mr Abbott because he was causing issues and was too drunk. The security officer told Mr Abbott that he had to leave because he was too intoxicated and arguing. Mr Abbott continued arguing with Kumarn as he walked toward the reception area. He pointed his finger at her and said "I will kill you" in Arrernte. I accept that the security officer did not understand what Mr Abbott said to Kumarn, but he would have observed his aggressive and threatening nature towards her. Mr Abbott was refusing to leave without Kumarn and said to the security officer "I'll go get a gun and shoot you". Another patron assisted security to remove him, but he stayed hanging around the entrance to the Club.

255. The Club manager spoke with Kumarn about giving Mr Abbott the car keys. He then suggested to the security officer that Kumarn should also be removed from the Club, as she appeared intoxicated and "the man hanging around would only cause more problems for staff and other people inside the club".

256. I am satisfied that Kumarn was intoxicated, but not quarrelsome and was not otherwise non compliant. I am satisfied that it was a matter of discretion (that is, it was not required under the legislation) for the Club's employees as to whether she could remain. I am satisfied that she was removed from the Club because the Club employees thought that this would make Mr Abbott leave as well. I am also satisfied that, given Mr Abbott's aggressive and threatening behaviour, Kumarn would have been much safer if she had been allowed to remain at the Club. I find that in removing Kumarn from the Club in these circumstances, the employees of the Gillen Club failed to take adequate care of Kumarn, who was a Club member, and that this failure reflects that the Club's employees had a lack of awareness and training in relation to domestic and family violence at that time. I accept that the failures of the Gillen Club's staff were due to them not being "DV Aware". I note that since the conclusion of evidence in this Inquest, the Club has engaged Dr Chay Brown to

provide domestic and family violence awareness training to its employees, and I commend this action.

257. The evidence does not allow me to find that the actions of the Club's employees in removing Kumarn are attributable to racial bias, as NAAJA invited me to do. The Club's Manager specifically denied that this was the case; however, I do find that the Club's staff may have been assisted in their dealings with Kumarn and Mr Abbott if they had undertaken training in culturally appropriate communication techniques. I have been told that the Club has since implemented training in these techniques, and in anti-discrimination.

258. Kumarn and Mr Abbott walked together to the green Falcon and the car left the carpark at 8:19pm.

259. During the course of the night, Kumarn spoke with a family member and told her "Malcolm is half killing me" and "I can't tell you where I am because Malcolm is going to hit me in the car".

260. At 8:49pm Kumarn walked into the carpark of the Emergency Department of Alice Springs Hospital and sat on the pavement adjacent to the road. Mr Abbott drove the Falcon into the carpark at about 9:06pm and she got in. They then travelled across the road to a service station, where Mr Abbott put petrol in the car, then left without paying.

261. Kumarn walked back to the Emergency Department carpark and Mr Abbott then drove three loops of that carpark, before entering a separate carpark. He got out of the car and sat on a retaining wall. Kumarn told him to move the car closer.

262. Mr Abbott returned to the car and drove a further three loops of the carpark, before exiting. At 9:37pm he drove back into the carpark, toward where Kumarn was sitting on the footpath. She tried to stand, and he accelerated towards her, causing the car to mount the gutter and strike her and a fence behind her. He reversed the car a short distance, with Kumarn trapped underneath it. He accelerated forward again, then once

more, before reversing the car away from the fence and driving another loop of the carpark. Kumarn's body was trapped under the car and was dragged some distance, until becoming free near the doors to the Emergency Department. Mr Abbott kept driving, leaving her body on the bitumen.

263. Kumarn received initial treatment in the carpark, then was taken into the Emergency Department but passed away from massive multi-organ failure at 10:10pm.

264. An autopsy found that she had extensive injuries, including numerous fractures and catastrophic internal injuries, and deep abrasions all over the surface of her body.

265. Mr Abbott drove to Abbott's Camp and told family members that he had bumped a gate, causing damage to the front of the car. He was arrested a short time later and ultimately pleaded guilty to murdering Kumarn. He received a mandatory life sentence, with a non parole period of twenty-five years. He has been assessed as a high risk of violence recidivism, but will become eligible for parole in 2046, when he is 74 years old.

266. Despite Mr Abbott's extraordinary history of violence and Kumarn's frequent calls to Police for help, not one person recognised the danger that she was in. For some reason, she did not tell her friends or colleagues what was happening and the agencies missed opportunities to intervene to help her. As a result, she did not receive the support she helped provide for others.

Formal findings

267. I make the following formal findings:

a. The identity of the deceased is R Rubuntja, born on 23 October 2074 at Alice Springs Hospital in Alice Springs in the Northern Territory.

b. The time of death was 10:10pm on 7 January 2021. The place of death was Alice Springs Hospital Accident and Emergency Department carpark, 6 Gap Road, Alice Springs in the Northern Territory.

c. The cause of death was multiple blunt force (crush-type) injuries.

d. The particulars required to register the death:

    i. the deceased was R Rubuntja.

    ii. the deceased was of Aboriginal descent.

    iii. the deceased was unemployed.

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

f. The cause of death was confirmed by Forensic Pathologist Dr John Rutherford.

g. The deceased's mother was M Rubuntja and her father was A Inkamala.

Short story of Kumanjayi Haywood

> ***"I felt very scared, I thought Mark was going to kill me. He said to me when he was hurting me "I'm going to kill you."***
>
> *Statutory declaration of Angela Haywood dated 9 October 2007, at [12]*

> ***"I don't want to die"***
>
> *Kumanjayi Haywood to 000 call taker, 28 September 2021*

268. Kumanjayi Haywood was an Alywarr woman, who was born on 10 September 1987 at Alice Springs Hospital. She was a much-loved daughter of her mother J Haywood, also known as J Martin, and her father, also J Haywood. Kumanjayi had two older brothers. She grew up in Tennant Creek, where she went to school with her sister-cousin Subella Duggie, who described Kumanjayi as a really happy person. Kumanjayi loved spending time with her family.

269. When she was just 13 years old, Kumanjayi Haywood commenced a relationship with Kumanjayi Dixon, who was 16 years old. The relationship continued on and off until their deaths, 21 years later.

270. Kumanjayi Haywood and Kumanjayi Dixon used to fight and argue a lot, particularly about jealousy matters. There were 47 recorded Police incidents involving their relationship.

271. The first report of violence to Police was on 19 November 2003, when she was 16 and he was 18. Kumanjayi Dixon was trying to drag Kumanjayi Haywood away from her mother and he punched her to the face, then punched a police officer who intervened. He was charged with assaulting police, but not Kumanjayi Haywood, and no DVO was sought.

272. Two years later, he repeatedly punched Kumanjayi Haywood to the face. When Police attended she told them what had happened, but refused to provide a statement. No charges were laid and no DVO was sought.

273. In August 2006, Kumanjayi Haywood called Police for help and subsequently gave them a statement that set out the history of domestic violence she had experienced from Kumanjayi Dixon. A full non contact

DVO was granted for twelve months, which he breached in July 2007 and was sent to gaol for seven days.

274. In July 2007, Kumanjayi Dixon assaulted Kumanjayi Haywood on two occasions, by kicking and punching her to the face, and breaking a chair over her back. Police observed bruising to Kumanjayi Haywood on one of these occasions; however, assault charges for each were ultimately withdrawn and Kumanjayi Dixon was sentenced to seven days gaol for each breach of the DVO.

275. Most of the violence between Kumanjayi Dixon and Kumanjayi Haywood was perpetrated by him; however, there were occasions when she became the offender. In 2007 she was charged with assaulting Kumanjayi Dixon after cutting his arms with a broken bottle, and on a second occasion she was charged with assaulting him with a stick, causing lacerations to his head. Both charges were ultimately withdrawn.

276. Kumanjayi Dixon served further short sentences for breaching the DVO in September and October 2007. Three days after being charged with one of these offences, Kumanjayi Dixon approached twenty year old Kumanjayi Haywood at the Tennant Creek Food Barn. When she ignored him, he punched her to the face, then dragged her to a second location. There he punched her repeatedly and beat her with a rock and a plastic pole. Kumanjayi Haywood told him that she needed to go to the toilet, and used the opportunity to escape to the Women's Shelter. Police were called and she gave them a statement about the prolonged assault. They took photos of her injuries and he was charged, but the assault charge was withdrawn when Kumanjayi Haywood was later unwilling to give evidence. A further full non contact DVO was made.

277. Police were called a number of times in the next year, sometimes because of Kumanjayi Haywood's behaviour, sometimes because of Kumanjayi Dixon's and sometimes both. Following another complaint in February 2008, attending Police submitted a task to the Tennant Creek Domestic Violence Unit ("DVU") seeking "oversight" of the repeat domestic and

family violence between them; however, no further action was taken. This was a missed opportunity for Police to review the information they had, and to consider what support or intervention they could offer.

278. Police were again called in July and twice in October 2008, in relation to reports that Kumanjayi Dixon had assaulted Kumanjayi Haywood. When Police attended, she denied that he had done anything, and refused to provide a statement. On one of these occasions he was charged with breaching the non contact DVO, as Police had found him with Kumanjayi Haywood.

279. On 8 November 2008, Kumanjayi Dixon beat Kumanjayi Haywood and her mother with a rock, causing both women to require treatment in hospital. He later received a one month gaol sentence for this.

280. One year later, he went to her home "full drunk" and threatened her, her mother and her 89 year old grandmother with a rock. He pushed the elderly lady over, hit Kumanjayi Haywood to the back with a broken chair and punched her several times. She provided a statement to police about this assault and he was sent to gaol for six months, then was released on 27 May 2010.

281. By 25 September 2010, Kumanjayi Dixon was back in custody for breaching the non contact DVO by attending Kumanjayi Haywood's home.

282. In December 2010, Kumanjayi Dixon subjected Kumanjayi Haywood to a prolonged assault in which he pulled her to the ground by her hair, punched her repeatedly, scratched her arms and legs with a broken bottle, threatened her with a tyre iron and struck her repeatedly with a broken paver. A stranger intervened to stop the attack. Kumanjayi Haywood provided a statement to Police, and Kumanjayi Dixon was charged but granted bail. A non intoxication DVO was made.

283. In May 2011, while on bail, he attacked Kumanjayi Haywood again. He told her to go inside the house, and she refused, remaining seated outside

the house with her mother and elderly grandmother. He became angry and hit all three women with the handle of a broom or shovel. He split Kumanjayi Haywood’s head open and fractured her arm and finger, for which she required surgery. A worker saw the attack and intervened, and also called Police. Kumanjayi Dixon ran away, but was arrested a few days later. He was sentenced to 24 months imprisonment with a non parole period of twelve months, and was also sentenced to six months for the December assault.

284. In August 2011, Kumanjayi Haywood assaulted her mother and was sent to Alice Springs Correctional Centre for three months. Kumanjayi Dixon was serving his sentence there as well and on 18 November he came across her in a common purpose area. He yelled at her “you should have dropped the charges for me” then attacked her with his fists and feet. For this vicious and brazen assault, he was sentenced to an additional nine months gaol. After serving his minimum sentence, Kumanjayi Dixon was released to parole, but subsequently breached it and was returned to custody. He was released on 7 August 2015.

285. In October 2015 Kumanjayi Haywood called 000 twice to report assaults by Kumanjayi Dixon. Police attended each time but could not find either of them. When they were later located, they both denied any incident.

286. On 17 December 2015, Kumanjayi Haywood and her mother both called Police to report that Kumanjayi was at Wycliffe Well Roadhouse and had been assaulted by Kumanjayi Dixon. Police attended and observed that she had injuries to her lip and forearm. She told them that he had assaulted her with a rock. Due to Kumanjayi Haywood’s level of intoxication, they took her into protective custody. The next morning she refused to provide a statement, so Police did not charge Kumanjayi Dixon; however, they thought it appropriate to seek reciprocal non intoxication DVOs. I cannot see the basis for Police seeking this DVO against Kumanjayi Haywood; however, the reciprocal DVOs were made on 21 December. Police were unable to locate Kumanjayi Haywood to serve her with the order.

287. On Christmas Day 2015, Kumanjayi Haywood called Police from Wycliffe Well to report that Kumanjayi Dixon had assaulted her again. It appeared to attending Police that he had punched her to the head. Police observed them both to be heavily intoxicated so took them *both* into protective custody and charged them *both* with breaching the reciprocal DVOs. Kumanjayi Dixon was also charged with a serious assault upon another female family member at the same time, which had caused a suspected broken jaw. He was sentenced to twelve months gaol for these assaults and breach of DVO, and was released on 24 December 2016. Kumanjayi Haywood was convicted and fined for breaching the non contact DVO. It is appalling that after twice calling Police for help (which it appears she genuinely needed) and in the absence of any complaint or evidence against Kumanjayi Haywood, she was made subject to a DVO, and was then charged and convicted of breaching it, for no more than being intoxicated and in circumstances where she may not have even been aware of the existence of the DVO. At least in part, this is likely the product of inadequate domestic and family violence training of the attending Police.

288. On 8 April 2017 Kumanjayi Dixon again seriously assaulted Kumanjayi Haywood, this time by stabbing her fifteen times to the legs. He told the 000 call taker that she had caused the injuries to herself, but this was a lie. He was arrested and sentenced to twenty months gaol, with a fourteen month non parole period.

289. Kumanjayi Haywood moved to Mt Isa in 2018 and, after his release from custody, Kumanjayi Dixon moved there also. While in Queensland, both were charged and spent time in custody for offences. These included assaults that Kumanjayi Haywood committed against Kumanjayi Dixon, and an assault that he committed on another woman.

290. In early 2021, Kumanjayi Haywood returned to Tennant Creek and was reportedly happy to be home with her mother. Kumanjayi Dixon also made his way back to Tennant Creek around this time.

291. On 14 July 2021, Kumanjayi Haywood's mother called 000 from Tennant Creek to report that Kumanjayi was in Haasts Bluff and was scared that Kumanjayi Dixon was going to stab her. Unfortunately, the call taker had trouble understanding what J Haywood was saying, and recorded Haasts Bluff as "ice block". It took Police two days before they were able to confirm that J Haywood meant Haasts Bluff, and another four days for them to make enquiries in the Haasts Bluff community at which time they were unable to locate Kumanjayi Haywood or Kumanjayi Dixon. This incident was classified as a "disturbance-domestic", which required Police to locate and speak with both parties; however, I am satisfied that Police made no further substantive efforts to find them, and the job was finalised on 19 August. This was a failing of NT Police officers to comply with the DV General Order and it was an inadequate response to this incident, likely in the context of heavy workloads.

292. On 15 September, J Haywood called Police again to report that her daughter had been missing for two months and was "staying with a bad man, named [Kumanjayi] Dixon" in Haasts Bluff. Again, the call taker did not understand what she was saying and again it was recorded as "ice block". Checks showed a full non contact DVO was in place to protect Kumanjayi Haywood; however, a decision was made that an after hours police callout was not required, and the local members were directed to follow up when next on shift. Unfortunately, that did not happen and Police effectively did nothing in response to this call. I find that this was unacceptable, particularly given the existence and significance of the five year full non contact DVO.

293. On 28 September 2021, Kumanjayi Dixon brutally attacked Kumanjayi Haywood. He beat her with a tree branch and threw a vacuum cleaner at her. His uncle tried to intervene but Kumanjayi Dixon pushed him away. Like she had done before, Kumanjayi Haywood escaped to the toilet, but she couldn't lock the door. Kumanjayi Dixon found her there and continued to beat her with the branch. An aunty arrived and told him to

stop or he might kill her. The aunty then took Kumanjayi Haywood to another house.

294. I have heard the five 000 calls that Kumanjayi Haywood made from Haasts Bluff in the hours following this assault, between 12:32 and 2:13am. I have also heard the two 000 calls that her mother made at 1:17am and 1:37am from Alice Springs Hospital, where she was herself receiving treatment. Both women were distressed and both were reporting that Kumanjayi Dixon was trying to kill Kumanjayi Haywood. When J Haywood said that her daughter needed help in Haasts Bluff, it was again recorded as "ice block".

295. Kumanjayi Haywood told the call takers that Kumanjayi Dixon was "jealousing" and trying to kill her, that he had a knife and broken bottle and that he had stabbed her in 2017. She said he was hiding and she thought he would surprise and kill her. She told the operator that she didn't want to die. I accept that Kumanjayi's demeanour in these calls varied from sobbing and resisting answering questions, to being warm and talkative. I accept that she sounded intoxicated. I also accept that the call takers' responses varied from empathetic and rapport-building, to inappropriate. Clearly, more than one of these call takers did not understand the very serious danger that Kumanjayi Haywood was in. For example, a JESCC supervisor spoke with her at 2:25am and told her that it was "not likely" that Kumanjayi Dixon would come find her as he hadn't in the time she'd been calling 000, and she should sit on the verandah of the Haasts Bluff shop to wait for Police. He questioned why she remained in the relationship with Kumanjayi Dixon. None of these comments were appropriate.

296. Neither was the police response to these calls. In addition to the seriousness of what was being reported, there was a full five year non contact DVO in place, and a very serious history of domestic violence. In these circumstances, I find that the on call local members should have been sent to look for Kumanjayi Haywood; however, rather than do this, JESCC downgraded the incident from an automatic priority 1, and did

not dispatch any Police to respond. The job was sent through to Papunya police to follow up when members were on duty.

297. Not realising the seriousness of this incident, the local members did not attend until 12:45pm on 28 September, some twelve hours after the first 000 call. In the meantime, Kumanjayi Haywood had attended the local clinic for treatment to her injuries, including a cut to her shin and a haematoma on the top of her head. She told the nurse that the injury had been caused by her partner the night before when he hit her with a stick. Unfortunately, none of this information was passed on to police by way of a mandatory report, as Kumanjayi Haywood told the nurse that a police report had already been made.

298. When Police attended upon Kumanjayi Haywood in Haasts Bluff that afternoon, they found her lying on a mattress on the floor with an injury to her leg. I have had the benefit of reviewing the body worn video that is available from this interaction and I have observed that the officer who spoke with Kumanjayi Haywood stood over her as she lay on the mattress, and spoke with her in a blunt tone that lacked compassion. In addition, there were at least two other people present in the house. For these reasons I am satisfied that this officer demonstrated little understanding of the environment needed for Kumanjayi to be able to disclose what had happened to her.

299. In these circumstances, I am not surprised that Kumanjayi Haywood did not tell Police about the beating she had sustained. When she was not forthcoming, the officers told her that there she had an outstanding warrant and they were arresting her. She then told them that Kumanjayi Dixon was in the community, and that she wanted to make a statement. The officer said "So you want to make a statement on the matter now, do you? And you only said that after he told you about the warrant." I find that at the very least this conveyed to Kumanjayi Haywood that Police were frustrated with her, but that it likely also indicated to her that Police were going to be sceptical about what she told them.

300. As they were obliged to do, the officers arrested Kumanjayi Haywood in relation to the outstanding warrant. She was put in the back of a locked police truck and taken to Papunya Police Station. Once there she still refused to provide a statement or complaint about Kumanjayi Dixon, which was unsurprising in the circumstances.

301. No risk assessment was undertaken; however, the officers asked Kumanjayi Haywood if she wanted to go to the women's refuge in Alice Springs (WoSSCA). She said that she did and they took her there, which was a three hour drive. In considering this response in the context of how Police interacted with Kumanjayi earlier in the day, I find that these officers are examples of Police members who clearly care and want to help, but whose training has not sufficiently equipped them with the knowledge or skills to consistently respond appropriately to women experiencing domestic and family violence.

302. When Kumanjayi Haywood arrived at WoSSCA, she was given dinner and settled into her room. No risk assessment was conducted due to the time of day that she arrived, and before one could be conducted in the morning, WoSSCA staff had arranged for her to be transported to hospital because she was in pain from the injury to her shin.

303. Kumanjayi Haywood was in Alice Springs Hospital from 29 September until 4 October for treatment to the wound on her leg. During that admission she did not see a social worker and she was not re-referred to WoSSCA on discharge. Instead, she made her way back to Tennant Creek. Unfortunately, an abscess formed on her shin and she was taken by ambulance to Tennant Creek Hospital on 23 October, then was transferred to Alice Springs Hospital where she remained until 30 October.

304. While in the hospital, Kumanjayi Haywood called 000 twice to report that Kumanjayi Dixon was calling and threatening her. These 000 calls were on 25 and 27 October. On 28 October the Hospital Based Constable attended and Kumanjayi Haywood told her about Kumanjayi Dixon's

assault on her on 27 September and the threats he had been making to her since then. The Officer typed the information into a statement, but Kumanjayi refused to sign it. She said that this was because a family member had begged her not to have Kumanjayi Dixon charged, as he needed to attend a funeral in Papunya.

305. Despite the Hospital Based Constable recognising that there appeared to be significant domestic violence, no risk assessment was conducted and no referral was made to the Family Safety Framework. It does not appear to me that Kumanjayi Haywood was seen by a hospital social worker.

306. When she was discharged on 30 October, Kumanjayi was not re-referred to WoSSCA. She called them herself seeking assistance, but the WoSSCA worker misunderstood why she was calling and told her that there was no accommodation available for her. Kumanjayi Haywood made her way back to Tennant Creek, arriving 1 November.

307. On 2 November, Tennant Creek police investigating the threatening calls on 25 and 27 October found Kumanjayi Dixon asleep at the Haywood home, in breach of the non contact DVO. He was arrested and charged, but granted bail. I find that in granting bail the Police officers did not appreciate the significance of Kumanjayi Dixon’s history of violence, or the threat that he posed to Kumanjayi Haywood.

308. Early the next day, Kumanjayi Haywood called Police to report that Kumanjayi Dixon was at her house in breach of the full non contact DVO. The call was terminated and when JESCC called back, the female who answered denied any issue. Police categorised this as an “information only” event, which failed to recognise the significance of this report. More should have been done by Police to identify who was involved, which would have confirmed the existence of the DVO.

309. Later that day, Kumanjayi Haywood went to the Tennant Creek Women’s refuge with her sister-cousin Subella Duggie, as she was scared that Kumanjayi Dixon would come home from the pub and hurt her. They stayed one night, but unfortunately, no risk assessment was conducted.

The next day, Kumanjayi Haywood left the refuge to get her keycard from Kumanjayi Dixon. Ms Duggie expected her to come right back and, when she didn't, Ms Duggie called Police. The Police officer who responded spoke with the Refuge and was told that Kumanjayi Haywood had gone to the shops. The officer failed to make efforts to locate and speak with Kumanjayi Haywood herself to confirm that she was not at risk.

310. Kumanjayi Haywood had in fact been picked up Kumanjayi Dixon, who was a passenger in a vehicle driven by a family member. That vehicle travelled to Alice Springs, stopping on the way to buy alcohol. Kumanjayi Haywood and Kumanjayi Dixon were dropped off at a house in Hidden Valley Camp, where they stayed with some of Kumanjayi Dixon's family that night.

311. The next afternoon, Kumanjayi Haywood and Kumanjayi Dixon shared a bottle of black market bourbon with others from the Hidden Valley Camp house. At 9:07pm, Kumanjayi Haywood sent a family member a text message that read "[Kumanjayi Dixon] is going to kill me tonight. Love you so much. Don't cry for me, babe." The family member called Kumanjayi Haywood at 9:25pm and she said "[Kumanjayi Dixon] is going to kill me tonight". The family member spoke with Kumanjayi Dixon who said he would look after Kumanjayi Haywood. They were both drunk.

312. Kumanjayi Dixon and Kumanjayi Haywood returned to the Hidden Valley Camp house. There were other people there, including some elderly people and at least one child inside the house.

313. Kumanjayi Dixon became angry with Kumanjayi Haywood and started "jealousing" her. He punched her then hit her repeatedly with a piece of wood and a plastic chair. She fell over and hit her head, causing her to bleed profusely from a large cut. He told her he was going to kill her.

314. As she had done before, Kumanjayi Haywood tried to escape the attack by running into the toilet. Kumanjayi Dixon pursued her and demanded

she open the door, but she refused. He retrieved a container that contained some petrol and poured it under the toilet door. He said "Open the door and I won't hit you." She said "I'm scared."

315. Motivated by jealousy and rage, Kumanjayi Dixon lit the fuel with a cigarette lighter, intending to kill or seriously wound Kumanjayi Haywood.

316. This caused a massive explosion and fire in the house. Witnesses tried to put the fire out, and one neighbour dragged Kumanjayi Haywood and Kumanjayi Dixon out the front door.

317. Kumanjayi Haywood sustained burns to 90% of her body. When Police arrived, she told them that her husband had burned her because he was jealous. Kumanjayi Dixon suffered burns to more than 70% of his body, and told first responders that he had been lighting a cigarette when a mattress caught on fire. This was a lie.

318. Every effort was made to save Kumanjayi Haywood and Kumanjayi Dixon, by emergency services and hospital staff; however, Kumanjayi Haywood succumbed to her horrific injuries on 7 November in Alice Springs Hospital, and Kumanjayi Dixon succumbed to his on 13 November at Royal Adelaide Hospital.[111]

319. When considering what could have been improved in the response to Kumanjayi Dixon's domestic violence, it would be easy to focus on the mistakes or omissions that were made in the immediate leadup to Kumanjayi Haywood's death, but the true story is that over the course of twenty years, Kumanjayi Haywood, her mother and even complete strangers, asked for help to protect her from Kumanjayi Dixon. In the end, none of these efforts was enough.

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[111] Separate findings will be provided to Kumanjayi Dixon's family in relation to his death.

Formal findings

320. I make the following formal findings:

a. The identity of the deceased is A Haywood, born on 10 September 1987 at Alice Springs Hospital in Alice Springs in the Northern Territory.

b. The time and place of death was 10:35am on 7 November 2021. The place of death was Alice Springs Hospital, in Alice Springs in the Northern Territory.

c. The cause of death was burn wounds and the complications thereof.

d. The particulars required to register the death under the *Births, Deaths and Marriages Registration Act*, the evidence are:

    i. The deceased was A Haywood.

    ii. The deceased was of Aboriginal descent.

    iii. The deceased was unemployed.

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

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

g. The father of the deceased was J Haywood and the mother of the deceased was J Hayward (also known as J Martin).

Common Issues

321. Domestic and family violence is complex, and no two people, their lives or relationships are the same; however, running through the extensive evidence that I received during these Inquests were "common issues" in relation to these four deaths and the circumstances in connection to them.

322. I am able to use real life examples from the evidence I heard in these Inquests to identify and try to understand these common issues. I am not hypothesising. I am not considering concepts in a vacuum. I can use examples from the lives of these women to show where our systems are consistently failing to adequately respond to the domestic and family violence crisis and to highlight where and how things can be done better, so that no more lives are lost. The next section of these Findings examines these common issues.

1. Societal Issues

(a) What underpins men's violence against women: women's place in society

323. I recognise that both women and men use domestic violence, and both women and men experience violence, but male violence differs in important respects and is much more likely to be deadly. Violence used by men and women differs in its motivations, frequency, impacts and severity. As Dr Chay Brown explained:

> "Men's violence against women is more likely to result in hospitalisation, injury, long-term disability, and death. Men's violence against women is most commonly motivated by entitlement, power and control, whilst women's violence is most commonly motivated by self-defence, either pre-emptive or retaliatory."[112]

[112] Statement of Dr Chay Brown dated 25 August 2023 (Common brief: 1-2).

324. WoSSCA CEO Larissa Ellis was asked "What are the underlying causes in domestic violence?" Her answer was:

> "…women's place in society. The expectations and roles of what women will and will not do…this is a vulnerable group of people who actually have a low place in society in the first place. So without addressing those, without addressing awareness in domestic and family violence, that's a community responsibility around how we respond to domestic and family violence, we are not going to get anywhere."

325. NT Correctional Services Commissioner Matthew Varley expressed it this way:

> "…there needs to be a shift in the community's thinking, and the behaviour approach of men towards women … The use of violence [and] coercive control, ultimately comes down to some sort of perverse distortion of power, and the subjugation of women."

326. There is a significant need for a community education campaign, designed with and for each distinct community and delivered in language, which aims to help all members of the community understand the factors that lead to domestic and family violence, and how and where to get help.

(b) Why is the NT and its Aboriginal women so grossly overrepresented in the DFV figures?

> ***"The frequency and the voracity of Domestic Violence-associated crime in the Northern Territory is nothing short of horrific and reflects strongly the significance of the current social, housing, health, education and justice issues faced by remote, regional and urban Aboriginal women, children and men."***
>
> Senior Constable Brad Wallace, NT Police Force,
> statement 3 November 2023

327. Domestic and family violence is perpetrated across Australia by people of all cultural and socio-economic backgrounds; however, the rates are so much worse in the Territory than anywhere else in the country. This is due to a variety of socio-economic, historical and cultural reasons.

328. During these Inquests, I heard expert evidence that these reasons include:

   a. the ongoing impacts of colonisation, including the impact of intergenerational trauma on Aboriginal people in the Territory since colonisation and the lack of culturally appropriate healing services needed to respond to that trauma,

   b. systemic disadvantage and discrimination,

   c. cultural dislocation and removal of children,

   d. entrenched community attitudes toward violence and inequality and community condonation of violence,

   e. the expense of service delivery and the challenges of recruiting and retaining skilled labour,

   f. geographical distance and remoteness of some areas, and

   g. lack of basic infrastructure.

329. Additionally, given the gross overrepresentation of Aboriginal women in the Territory's domestic and family violence statistics, there must be factors that contribute to their unique vulnerability. I accept the Children's Commissioner's recent observation that:

> "Aboriginal families are strong and resilient, however some experience chronic disadvantage in many forms including poverty, housing instability, family violence and mental illness."[113]

[113] Office of the Children's Commissioner Northern Territory, *Our most vulnerable children bearing the consequences of a failed system: A thematic analysis of the needs of children aged 10 to 13 I the Northern Territory youth detention 2022/23*, (2024) at p5.

330. Professor Harry Blagg gave evidence before me that high rates of domestic and family violence are largely traceable back to trauma, loss and grief in communities and families.

331. I accept the submission of Counsel Assisting me that:

> "An inescapable truth, evidenced in these Inquests and in the deaths over the last two decades, is that most Aboriginal women killed by a violent partner in the Northern Territory are killed by Aboriginal men. That fact should not be used to demonise Aboriginal men or women…To own that truth does not denigrate Aboriginal men, and nor does it excuse the violence. It is simply part of the factual matrix that, if responded to with good will, commitment and compassion, will help lead to the right actions to reduce violence."[114]

332. Another important concept is that of "lateral violence", which impacts upon many Aboriginal families in the NT and contributes to DFSV:

> "Lateral violence, also known as 'horizontal' or 'sideways' violence or intra-racial conflict, is a product of a complex mix of historical, cultural and social dynamics that results in a spectrum of behaviours that include: gossiping, jealousy, bullying, shaming, social exclusion, family feuding, organisational conflict and physical violence. Lateral violence has sometimes been described as stemming from "internalised colonisation" and/or "internalised sexism"."[115]

(c) Racist attitudes

333. During a day of hearing in May 2024, Commissioner Murphy gave evidence concerning whether there was racism in the NT Police force. During questioning by Phillip Boulten SC, counsel for the family of Kumarn Rubuntja, it was revealed that an officer in Alice Springs was disciplined by the Professional Standards Command (PSC) after circulating a photo of a topless Aboriginal woman on a social media chat

[114] Counsel Assisting closing submissions – common issues, at [15].

[115] NT Domestic, Family and Sexual Violence Reduction Framework 2018-2028, p30 (Common brief: 7-76).

with fellow officers in 2022. Commissioner Murphy acknowledged there were some "cultural issues" but insisted that there were changes being implemented. Earlier in the year, he had denied knowing about instances of racism in the Police Force.

334. Shortly after giving evidence in these Inquests, Commissioner Murphy appeared again at another Inquest, by which time he had accepted that there was evidence of more widespread racism in the NT Police, and that he had effectively "gaslit" the community by his earlier denials.[116] The Court could take judicial notice of the fact that since giving that evidence in May, the Commissioner has made public statements acknowledging that racism is more widespread than he initially appreciated, and committing to further reform.[117]

335. Our Watch, a national peak body targeting the prevention of domestic violence against women and children, recommends that to prevent violence against Aboriginal and Torres Strait Islander women, programs must challenge misconceptions about the violence perpetrated against them. These misconceptions include that violence is a part of traditional Indigenous cultures, that violence against Indigenous women is exclusively perpetrated by Indigenous men, and that violence against Indigenous women is caused by alcohol or other substance abuse.[118]

336. Through her research, Dr Chay Brown found that these racist attitudes and stereotypes also meant that violence against Indigenous women in the NT was "minimised or dismissed", because of the attitude that violence against women is 'an Aboriginal problem'. She advised the Court that "[m]any Indigenous women in this research expressed

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[116] Evidence of Commissioner Murphy in the Inquest into the Death of Kumanjayi Walker, 29 May 2024, (Common brief: 2-3).

[117] Garma Festival Speech of Commissioner Michael Murphy dated 3 August 2024 (Common brief: 2-3B).

[118] (Our Watch, 2018), cited by Dr Chay Brown, statement dated 25 August 2023 at [16] (Common brief: 1-2).

repeated concern that violence against Indigenous women was being ignored and allowed to 'fly under the radar'."[119]

337. While I have not received direct evidence of racism affecting agencies' responses to the violence experienced by these four women, I accept the acknowledgement that the Commissioner has now made publicly with respect to racism in the NT Police Force.

338. I also find that there is evidence of clear structural racism within the Territory's Joint Emergency Services Call Centre ("JESCC") in the form of the lack of availability of Aboriginal language speakers / interpreters within JESCC (apart from two small trials, discussed below). Ms Leanne Liddle, then the Director of the Aboriginal Justice Unit within the Department of Attorney General and Justice, gave evidence that JESCC policy allowed a link in the system to access an interpreter for 54 international languages, but there was no link to the Aboriginal Interpreter Service to access an Aboriginal interpreter. This is despite more than 15% of the NT population speaking an Aboriginal language at home.[120]

339. Thirdly, the shocking rate of Aboriginal women being killed as a result of domestic violence in the NT has largely been met with silence from the broader Territory and Australian communities, and a persistent inadequate allocation of resources to address this complex issue. I take judicial notice of the public outpourings of grief and outrage following the deaths of non Aboriginal women, most often in other parts of Australia, and the political and legislative responses triggered by these deaths. That the deaths of Aboriginal women in the NT does not evoke the same reaction is indicative of systemic racism in the way their voices go unheard: the belief that these women are somehow less deserving of our grief, outrage and our collective response.

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[119] Dr Chay Brown, statement dated 25 August 2023 at [17] (Common brief: 1-2).
[120] Exhibit 23a 000 Aboriginal Interpreter Project - Project Summary, p1.

(d) The need for a coordinated and a whole of government approach

340. The response to this crisis requires a consistent, coordinated and cooperative approach between government agencies, and between government and the non-government sector. I accept that the Territory's DFSV Policy Framework provides a set of common actions, standards and priorities, and that it aligns closely with the National Plan to End Violence against Women and Children 2022-2032.

341. I also accept that there must be coordination between short and long term strategies: there must be adequate crisis support to assist those immediately at risk, as well as a long-term, co-ordinated approach focused on prevention of further violence. Long term planning is critical and formalised policy is required to ensure that progress in responding to domestic and family violence is not undermined by changes in staff or organisational changes.

342. I have outlined above the important work of the DSFV-ICRO. That body no longer exists and since 1 July 2023, the ongoing coordination of DFSV reform has been the responsibility of the Domestic Family and Sexual Violence Reduction Division (DFSVR) of the Department of Children and Families.

343. I find that it is important that the whole of government approach that is necessary to respond to this crisis needs to be reflected in a stand-alone interagency body. I recommend the reinstatement and permanent funding of the DFSV-ICRO to coordinate and oversee the NT Government's DFSV response, and to annually publicly report including on relevant DFSV statistics and the implementation of these recommendations.

344. As submitted on behalf of the NT Police Force, "it is important that a DSFV-ICRO receive genuine and committed contributions from all relevant stakeholders."[121]

[121] Closing submissions on behalf of NT Police Force, dated 11 October 2024 at [466].

Recommendation 1: *Permanent DFSV-ICRO*

The NT Government should establish a sustainable permanent DFSV whole-of-government coordination mechanism (DFSV-ICRO) to lead consistent and evidence-based DFSV policy and practice, and health, housing and community services to address DFSV. A sustainable, inter-agency DFSV policy lead unit should be a whole-of-government structure to oversee system performance, policy development and implementation.

The DFSV-ICRO mechanism should continue to produce an annual report to the Minister to be published online, including through a visual report card. This annual report should include relevant DFSV statistics and information about the implementation of these recommendations.

345. I received evidence that the Territory's DFSV sector wants a peak representative body, to coordinate the sector's efforts to achieve meaningful and lasting change. I heard from service providers that the absence of a peak representative organisation adversely affects the sector's ability to be strategic and well organised, and impacts upon the government's ability to consult with and take advice from the sector. I was told that a peak body would also assist in elevating the voices of those with lived experience.

346. After a term as the representative of the Attorney General's Department on the DFSV-ICRO, Penny Drysdale worked with the NT Council of Social Service (NTCOSS) to codesign a model for a peak body for domestic, family and sexual violence services in the NT.

Recommendation 2: *Peak body*

Following consultation about the appropriate model, the NT Government should establish and adequately fund a peak body for DFSV in the NT. This expands on action 4.12 of Action Plan 2.

(e) Workforce planning

347. A consistent theme throughout the Inquests was the chronic skills shortage affecting the provision of services for the victims of DFSV, including in DCF, NT Police, crisis accommodation and outreach services, NT Corrections, NT Health and the interpreter services, which had worsened after Covid.

348. There are challenges in both recruiting and retaining staff.

349. I note the existence of the Territory's DFSV Workforce and Sector Development Plan; however, there is an urgent need for the NT Government to develop an improved effective short, medium and long-term Workforce Strategy, targeting the workforce needed to address domestic and family violence. This strategy should involve the local university and communities.

350. The chronic housing shortages in the NT also impact upon the capacity of service providers to attract and retain qualified staff, and should be considered in the course of workforce planning.

Recommendation 3: *Workforce planning*

> The NT Government should consider amending the DFSV Workforce and Sector Development Plan to make explicit reference to engagement of the local university and local communities, so that a) the strategy attracts Aboriginal workers, b) local Territorians can be attracted, trained and retained in the areas of need and c) interstate and international workers with the requisite expertise can be attracted, trained and retained in the areas of need.
>
> Noting the existence of the DFSV Workforce and Sector Development Plan (and particularly Focus Area 2, Action 8), the NT Government should produce a short report at least annually, to be published online, in relation

to workforce recruitment and retention strategies addressing the needs of the DFSV workforce.

(f) Interpreters

351. I accept the evidence before me that language barriers and the failure to use qualified interpreters has a significant impact on the capacity of Aboriginal women experiencing violence to seek help, and of Aboriginal offenders to engage in the criminal justice system, as well as their capacity to address the underlying causes of their offending in both the community and in prison.

352. I also accept that there is a chronic shortage of Aboriginal language interpreters throughout the NT. For example, Commissioner Varley gave evidence that NT Corrections are not able to deliver their important programs in language due to the lack of interpreters.

353. I heard that interpreter shortages are experienced across the services and create a real barrier for the victims of violence. The shortage of available interpreters was obvious even for the purpose of these Inquests, which were conducted in a way that endeavoured to be as inclusive of Aboriginal witnesses, family and community members as possible. We experienced shortages and uncertainty about the availability of appropriate interpreters throughout these Inquests.

354. When considering the need for adequate workforce planning in the NT, a significant consideration must be the lack of Aboriginal language interpreters. There must be a greater investment in the Aboriginal Interpreter Service to assist with recruiting, training and retaining staff.

Recommendation 4: *Aboriginal Interpreter Service (AIS)*

The NT Government should increase investment in the AIS (funding, training and support) and devise a short, medium and long term plan to attract, train, and retain interpreters.

(h) The need for community led solutions

> ***"If the solutions are not made in our communities, they will not work in our communities."***
>
> Family of Ngeygo Ragurrk, family statement at [103]

355. I heard evidence about the need for community led solutions to the domestic and family violence crisis in the Territory. This evidence included:

    a. A former Senior Sergeant, who had been the Officer in Charge at Nhulunbuy Police Station, reflected on the FSF agencies' response to Miss Yunupiŋu and told me:

        > "When I look at Miss Yunupiŋu's case in particular, we were so down in the weeds in it. I forgot to take a breath at one point and step back and actually look at it in its totality. And what stands out to me now is, is I missed the cultural connection. I missed the opportunity to actually have a chat to some of those senior members saying "Well this is, these are the circumstances. How would you deal with it from a cultural perspective?" Or, "How would you deal with it from a law perspective?" I think we became so, so stuck in the operation of doing the things that we know how to do, is that we forgot to take into consideration the things that we didn't know as well."[122]

[122] Evidence on 16 August 2023 at T151.

b. Another member of the Nhulunbuy FSF at that time told me that, while there were Yolŋu voices on the FSF,

> "there is still a learning gap, and there is still a gap in terms of Yolngu knowledge and Balanda knowledge coming together."[123]

c. Ngeygo Ragurrk's family told me:

> "As a Warddeken Ranger under the KKT; Ngeygo was listened to, supported, and funded to find solutions for the loss of our culture, land, and waterways. As victims and survivors; our women and communities should be listen[ed] to, supported, and funded to find on-country, in-language solutions to family violence…When our communities are listened to about caring for women, our communities can have meetings, make plans, start projects, and work together."[124]

d. Arrernte man and NT Police Senior Constable Brad Wallace gave evidence that:

> "…part of the solution for any issue [in] Aboriginal communities is to look within – within their own cultural structure and system that's already established, and utilise that to address issues. But I think that's part of the reason why communities are so disengaged at the moment and why there's some turmoil in the community is because the elders have been disempowered."[125]

356. The NT needs to better support and cultivate Aboriginal leadership and community development that is specifically targeted at reducing violence at the local level. Local people need to be actively involved in shaping local solutions to prevent violence and to respond assertively when it occurs. This requires a level of additional investment (in terms of paid positions at a community level) that is not currently supported in the NT.

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[123] Evidence on 17 August 2023, at T229.
[124] Family of Ngeygo Ragurrk, family statement at (Ragurrk brief: 3-13A) at [103].
[125] Senior Constable Brad Wallace, evidence on 7 November 2023 at T472.

(i) Alcohol

357. When Mr Abbott was arrested shortly after murdering Kumarn Rubuntja, he was detected to have an alcohol reading of 0.181. Kumanjayi Dixon, Mr Marika and Mr Nawirridj had all been drinking and were all observed to be significantly intoxicated at the time they killed their partners. From the records available concerning their prior offending, it is clear to me that these men were usually, although not always, significantly intoxicated when they used violence upon their partners.

358. I received evidence of the following post mortem toxicology results:

   (a) Miss Yunupiŋu: 0.10% alcohol,

   (b) Ngeygo Raggurk: 0.18% alcohol,

   (c) Kumarn Rubuntja: 0.21 % alcohol,

   (d) Kumanjayi Haywood: 0.12% alcohol.

359. That evidence is not, of course, suggested as a means of blaming these women or suggesting that they could or should have done anything differently. Over-use and/or addiction to alcohol are recognised as a response to trauma in many circumstances and a way of temporarily numbing the mental and physical pain of violence.

360. We must accept though that alcohol intoxication does make victims more vulnerable, less able to resist the force being applied, with a loss of defensive reflexes and a hindered ability to run away.

361. I accept that, while alcohol doesn’t cause domestic and family violence, it is a major enabler of it and increases the probability, frequency and severity of violence.

362. Professor Marcia Langton was unequivocal about the association between alcohol and family violence that is obvious to her after decades of research. She gave evidence that:[126]

> "[a]lcohol consumption is a risk factor in the extent of family violence experienced by indigenous Australians, especially long periods of dangerous levels of alcohol consumption in Indigenous communities. There is some evidence that shows alcohol use by offenders and victims can be a trigger that exacerbates both the risk and severity of assaults. We certainly found that in our research".

363. As Dr Richard Johnson explained, alcohol is an enabler of violence because:

> "Alcohol lowers the threshold through which a human needs to pass in order to provoke that violent confrontation that leads to assault. So that lowering of threshold may turn somebody who wouldn't get to that point of violence, into somebody who is violent but the actual background of the cause of the violence are the social determinants - essentially the social determinants of health, it's poverty, it's overcrowding, it's disenfranchisement, it's generational trauma, it's generational lack of access to education and resources and it's the long term and intergenerationally part of colonialism in this population."[127]

364. The NT's ten year Framework document recognises that:

> "Alcohol is not sufficient in itself to predict violence, but alcohol abuse increases the probability, frequency and severity of violence. Women consistently report that coercive and controlling violence occurs whether their partners are drunk or sober. However, in the context of power imbalances and attitudes that normalise violence, the harmful use of alcohol and/or drugs increases the risk of DFSV".[128]

365. I received specific evidence of the correlation between alcohol consumption and domestic and family violence, including:

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[126] Evidence of Professor Marcia Langton, 31 October 2023 at T90.
[127] Evidence of Dr Richard Johnson, 23 June 2023 at T424.
[128] NT Domestic,-Family-and-Sexual-Violence-Reduction-Framework (Common brief: 7-76).

a. Bernadette Wombo, of the Gunbalanya Safe House told me that in the dry season, there is more outside alcohol being brought into the community, particularly spirits and heavy beer. She said that having alcohol in the community always made domestic and family violence worse for women and children and more ladies come to the safe house when there is grog in the community,

b. the Alice Springs Hospital based constable told me of her observations of a "spike" in assaults as a result of increased accessibility to alcohol,

c. two Aboriginal witnesses of fact in relation to the death of Kumanjayi Haywood told me that having "grog" in the house leads to worse fighting,

d. an NT Police Senior Constable told me of his experience policing in Alyangula, which is a dry community. He said that there would generally be an escalation in domestic violence if alcohol was smuggled into the community, and

e. Dr Richard Johnson gave evidence of a 77% increase in average monthly domestic violence assaults in Alice Springs after alcohol restrictions were lifted. By contrast, following the reintroduction of alcohol restrictions, average monthly domestic violence assaults reduced by 37%.

366. Dr Johnson told me about what he and Alice Springs Hospital staff saw and experienced when alcohol restrictions were lifted:

> "I think it was like a light switch being flicked…the level of both numerical and the ferocity of the effect of the assaults that we saw as Emergency clinicians…was devastating. I think – having worked in Alice Springs for 12 years, I think that's the first and only time I have questioned what we do or what we can do - what we are capable of. I think the impact that it had on staff was dramatic. The morale and the ability of staff to cope with what

they were seeing on a day to day basis was eroded significantly and it was a difficult period."[129]

367. I accept the submission made on behalf of NT Police that "the statistics and the lived experience of the Northern Territory require as a component of efforts to counter DFSV that there be tailored and robust measures to control access to alcohol and to address the effects of alcohol dependency and abuse."[130]

Recommendation 5: *Evidence-based alcohol intervention strategy*

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

368. I accept the expert evidence I received from Dr Chay Brown that it is important that services be provided to support people with alcohol and other addictions. I accept that there is a significant need for these services to be appropriately funded and sufficiently available, rather than there be a sole focus on alcohol prohibition.

369. I have been urged to make a recommendation concerning increased investment in alcohol and other drug rehabilitation services. Given the evidence I have received about the significance of alcohol in relation to the epidemic of domestic and family violence, and the unmet need for services to address alcohol and other drug addiction, there is a clear need for me to make a recommendation of this type.

[129] Evidence of Dr Richard Johnson 23 June 2023 at T421.
[130] Closing submissions on behalf of NT Police Force, dated 11 October 2024 at [11].

370. I am grateful for the helpful NT Health submissions in relation to this issue and the recommendation I make will be consistent with the recommendation proposed on behalf of NT Health.

Recommendation 6: *Specialist alcohol and other drugs rehabilitation*

The NT Government should increase investment in specialist alcohol and other drugs rehabilitation services, including ambulatory care (medical services performed on an outpatient basis, without admission to hospital or another facility), respite and behavioural change services.

2. Relationship themes

(a) Exposure to DFV in relationships from a young age

371. Miss Yunupiŋu was in a relationship with Mr Marika from when she was about 15 and he was 21. Kumanjayi Haywood started a relationship with Kumanjayi Dixon when she was 13 and he was 16.

372. I received evidence that there are serious repercussions for the victims of domestic and family violence when they are in those relationships from such a young age. They are more vulnerable because of their age, they may not have the skills or knowledge to know how to leave the relationship and exposure to intimate partner violence in their first relationships has a traumatic impact upon these victims. For example, it seems to me that the violence and control that Kumanjayi Dixon perpetrated towards Kumanjayi Haywood while she was a teenager and young adult had a traumatic impact on her and contributed to her own use of violence.

373. This is another reason why it is important that DFSV education and community awareness programs specifically target children and young people.

(b) Coercive control and "jealousing"

374. Coercive control is defined as "a range of strategies used to manipulate, dominate and control the actions of another with the aim of achieving and maintaining personal power, particularly over an intimate partner."[131]

375. For Aboriginal women, coercive control can include family stalking, humiliation, isolation, stopping a woman seeing her children, "jealousing", destroying or threatening to destroy property, threats of witchcraft, threats of suicide, using culture to pressure her to stay in the relationship, control of finances (including withholding Basics card), humbugging from gaol and forcing a woman to stay with a man's family while he is in gaol.

376. In relation to threats of suicide, I heard evidence that women in DFV relationships become worried about the possibility that their perpetrator will self harm or suicide, not just because they care for him, but also because they may get the blame if he dies, particularly from his family.[132] Bernadette Wombo from the Gunbalanya Safe House gave evidence that in her experience,

> "…it is common for men to threaten self harm to get their partners to return. It's a form of abusive power and control."[133]
>
> "…if he successfully suicides, takes his own life, then…the blame is going to go automatically to her from his side of the family."[134]

377. "Jealousy" or "jealousing" is a term used in some Aboriginal cultures to describe a type of behaviour that is seen to provoke a jealous response,

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[131] Northern Territory's "Domestic-Sexual-Violence Reduction Framework (2018-2028) (Common brief: 7-76).
[132] Transcript of Inquest, 23 August 2023, at T116; Record of interview of Maree Corbo and Carmel Simpson dated 30 September 2021, at p13 (Rubuntja brief: 3-14).
[133] Statement of Bernadette Wombo dated 22 June 2023, at [16] (Ragurrk brief: 3-32A).
[134] Evidence of Bernadette Wombo on 26 June 2023 at T50.

which might be violent or controlling.[135] The feeling of jealousy may cause behaviours that drive patterns of coercive control and might be used to justify controlling or violent behaviour. Examples include:

a. if a woman dresses up, a man might accuse her of trying to look good for other men, and

b. a man might "jealous" his partner for spending time with her family and not his, and then isolate her from her family.[136]

378. The complex nature of 'jealousy' or 'jealousing' was evident in this relationship, with Kumanjayi Haywood having assaulted Kumanjayi Dixon on an occasion after she accused him of jealousing her, and then Kumanjayi Dixon committing savage assaults on Kumanjayi Haywood, using jealousy as an excuse for his rage. Their relationship was often unhealthy, with both parties expressing unhealthy jealous emotions, but the expression of jealous feelings by Kumanjayi Dixon was far more brutal and ultimately deadly.

379. Various aspects of Mr Nawirridj's behaviour toward Ngeygo can be categorised as coercive control:

a. on 11 January 2018 he attempted suicide in the cage of a police vehicle while Ngeygo stood a short distance away speaking with police,

b. in August 2018 he attempted suicide after Ngeygo told him she no longer wanted to be with him,

c. in or around early December 2019 he climbed a light pole and threatened to hang himself,

[135] Tangentyere Women's Family Safety Group Submission into the Review of Legislation and the Justice Response to DFV in the NT (Common brief: 10-13).

[136] Tangentyere Women's Family Safety Group Submission into the Review of Legislation and the Justice Response to DFV in the NT, at p8 (Common brief: 10-13).

d. in the days before he killed her, Mr Nawirridj threatened to hang himself if Ngeygo didn't leave the safety of her sister's home to go with him,

e. while looking for Ngeygo on the morning of 23 December, he threatened to set himself on fire using a petrol bowser at the Fannie Bay Puma service station,

f. Ngeygo's sister had seen Mr Nawirridj burn Ngeygo's clothing during their relationship, and

g. Mr Nawirridj set fire to Ngeygo's car the night before he killed her.

380. I note the evidence of Detective Superintendent Engels that self harm can be used by DFV offenders at the time of police attendances to distract from the original report that Police are responding to. This can put the focus on the health and wellbeing of the offender, at the expense of consideration of the safety of the victim.[137]

(c) Why do women stay in or return to violent relationships?

381. Bernadette Wombo from the Gunbalanya Women's Safe House expressed what must be a common frustration for frontline workers when she said that:

> "There are times when I have experienced frustration with ladies knowing they do have a violent partner but no matter what I / we do at the Safe House, they continue to go back. It's hard to watch. I've tried working outside of work to help couples, to help make them understand the right way. It's not a good look for family, them and for the children. I see the children going through the trauma and having to live with it; it's not good and needs to stop. I get frustrated because why is it so hard for them to see the

[137] Evidence of Detective Superintendent Kirsten Engels 3 July 2023 at T403-404.

damage, trauma and pain it's causing to their loved ones and the community." [138]

382. There can be many reasons why women stay in violent relationships, or go back to their partners, knowing that they are violent. These include:[139]

    a. threats of self harm (see above),

    b. external family pressure: "when mother and father fight, it's not just about them. It's spread to the rest of the families. Both their families".[140] There is a lot of family pressure for the couple to stay together,

    c. fear of retaliation and/or retribution,

    d. fear of losing their children,

    e. fear of the consequences of making a report to police, and

    f. a belief that if they left their relationship, it would only get worse for them and create bigger problems.

383. A clear example of these complexities was when Ngeygo told Mr Nawirridj she wanted to leave the relationship in late August 2018. On 27 August he attempted suicide and was airlifted to Royal Darwin Hospital. Ngeygo was back with him when he returned to Jabiru on 31 August.

384. I heard extensive evidence about the enormous pressure placed upon Miss Yunupiŋu by members of Mr Marika's family, in relation to staying in or returning to the relationship, as well as about not speaking to Police or giving evidence at Court about his violence. I heard evidence that Mr Marika's family were known to physically return her to the relationship when she left the area to escape it.

[138] Statement of Bernadette Wombo dated 22 June 2023, at [29] (Ragurrk brief: 3-32A).
[139] Statement of Bernadette Wombo dated 22 June 2023, at [17] (Ragurrk brief: 3-32A).
[140] Evidence of Bernadette Wombo 26 June 2023 at T51-52.

385. I also heard about cultural pressure being placed upon one of the four women, in relation to her child:

> "I heard a number of times where [the Offender]'s family and particularly the matriarch would place a lot of pressure on [the woman] to remain in a relationship with [him] because, you know, she is culturally connected to him through her child and - and, you know, using [the child] I think has excused sort of like if he doesn't have his father here, what status in his clan does he have and what, you know, what cultural status does that mean for [the child] and what does that mean for her, [the woman], and so I think the [sic] really weights [sic] heavily, sorry, on [the woman], that -that, you know, she wanted to make sure that her son was brought up the right way but also with the complexities of culture but at the same time I feel like it was a manipulation from that side of the family to - where it is like negative pull back line links for her to be - would be pulled back into the hold of being with [the offender] and no empowerment for [the woman] to be able to - to be able to live free and take care of her son in a way that was free of violence."[141]

3. Why don't women report DFSV or seek help?

(a) Why don't women report DFSV to Police or refuse to give statements or give evidence?

386. I received evidence that there can be many reasons why women may not report DFSV to Police or other agencies, or give statements to Police, or give evidence in Court, including:

  a. fear of repercussions from the offender or his family. For example, when Kumanjayi Dixon assaulted Kumanjayi Haywood inside Alice Springs Correctional Centre on 18 November 2011, he said to her words to the effect "you should have dropped the charges for me",

[141] Evidence on 17 August 2023, at T223-224.

b. fear or distrust of Police or other service providers,

c. many women may fear their children being removed from their care if they report domestic violence,

d. fear of being involved in the criminal justice system, or she may otherwise not want to go to Court,

e. there may be cultural reasons why a woman may find it difficult to talk about personal matters in front of other family members, particularly males,

f. many women still love their partners and don't want them to go to gaol,

g. in small communities, it is hard to remain anonymous when reporting violence,

h. lack of interpreters can make communication very difficult,

i. geographical remoteness can mean that help is too far away for women living in remote communities,

j. women don't want to leave their communities to escape the violence,

k. there can be a high risk of homelessness, due to chronic housing shortages,

l. there are feelings of shame surrounding those impacted by violence and abuse, and

m. many women may be unaware of what services exist.[142]

387. On 11 January 2018, Mr Nawirridj assaulted Ngeygo and a security guard who tried to protect her. After Police arrived, Ngeygo started talking to

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[142] TWFSG Diagram – Reporting FDV - what barriers do Aboriginal Women in the NT face (Common brief: 9-4).

them: she gave her name and Mr Nawirridj's name, and she told the officers that there was a DVO in place for her protection. That conversation was interrupted by Mr Nawirridj attempting suicide in the back of the caged Police vehicle, which was about two metres from where they were standing (within hearing distance). His attempted suicide at that time contributed to Ngeygo deciding not to tell Police anything more.

388. Despite making an initial report of violence to Police, many women may not want to confirm the complaint or make a statement when Police arrive. They may refuse to go to Court to give evidence. The reasons for these responses are the same as those listed above.

389. In relation to the experience of women not confirming an initial report to police when they attend, I heard evidence that sometimes this is because she has sought police help to deal with an immediate DFV crisis, but the arrival of police and/or removal of the offender from the scene diffuses the immediate situation. For example, there were a number of occasions where attending Police removed Mr Abbott from Kumarn's location, and she did not want any further police engagement. Removal of the offender or police attendance otherwise resolving the immediate crisis, may be a sufficient response for the woman, which may be why she doesn't tell attending Police what happened, or give a statement.

390. Just because a woman doesn't tell attending Police the same thing that she told 000, for example, doesn't mean that she was lying. It may just mean that the crisis has been dealt with and she doesn't want any further action to be taken, for any number of reasons.

391. I also heard that a woman may use "trigger words" when calling Police for help with domestic and family violence. For example, if a woman is concerned for her safety and wants a domestic and family violence perpetrator removed, she may know that reporting that he has a knife is a way to get a quicker Police response.[143] Once Police arrive, and the

[143] Evidence of Maree Corbo 23 August 2023 at T131.

immediate fear has gone, the victim/survivor may just want Police to remove the offender, but not to charge him.

392. There were numerous examples in the evidence before me of Kumarn Rubuntja, in particular, seeking Police assistance by a 000 call, but then refusing to make a complaint once Police arrived. For example, on 16 September 2019, a very distressed Kumarn called Police to report that Mr Abbott had kicked her in the mouth, and that she was pregnant. When police arrived, she denied both of these things; however, her medical records confirm that she was in fact pregnant at the time.

(b) Effect of being met with an inadequate Police response

393. Kumanjayi Haywood and her mother called 000 for help a total of seven times between 12:32am and 2:13am on 28 September 2021. Kumanjayi was terrified that Kumanjayi Dixon was about to find her and continue his brutal attack upon her, which had started earlier in the night.

394. Despite the desperate calls from Kumanjayi Haywood and her mother, Police did not come looking for her until twelve hours after her initial phone call.

395. On 28 October 2021, the day before she refused to sign a police statement about Kumanjayi Dixon's most recent violence towards her, Kumanjayi Haywood told the Alice Springs Hospital based Constable that there was a full non contact DVO in place and that:

> "That order is still in place now but [Kumanjayi Dixon] doesn't listen to that order he keeps coming looking for me and ringing me up and verbally abusing and threatening me. If I don't go with him he gets cranky at me and hurts me."[144]

396. It is unsurprising that Kumanjayi Haywood did not think that the DVO would keep her safe, or that giving a statement to Police was worth the

[144] Unsigned statement of Kumanjayi Haywood at [4], annexure LG-01 to the statutory declaration of Senior Constable Lenora Giles dated 12 June 2023 (Haywood brief: 2-9A).

risk of repercussions. For most of their relationship, there was a DVO in place to protect Kumanjayi Haywood from Kumanjayi Dixon and on numerous occasions, Kumanjayi Haywood and/or her mother told Police that Kumanjayi Dixon had breached the non contact DVO. Sometimes, like on 15 September 2021, Police did nothing. No one arrived to help her. On other occasions, he was arrested and charged, and often bailed almost immediately. For example, on 2 November 2021 he was arrested for breaching the full non contact DVO, but he was granted bail and by the very next day was back at her home.

397. Kumanjayi Haywood also experienced occasions when she called Police for help but then was detained herself:

   a. on 17 December 2015 she was taken into protective custody due to her intoxication (and made subject to a non intoxication DVO for Kumanjayi Dixon's protection),

   b. on 25 December 2015 she again called Police because Kumanjayi Dixon had seriously assaulted her, and she was again taken into protective custody and, additionally, was charged herself with breaching the non intoxication DVO. She was convicted and charged for that offence, and

   c. on 28 September 2021 she was arrested pursuant to a warrant.

398. Experiences such as these likely deterred Kumanjayi Haywood from seeking Police help, in particular, by way of giving a statement (as she refused to do on 29 October 2021).

399. I also note that short police attendances on scene may deter DFV victims from making a complaint or giving a statement, as they are not likely to be sufficient for adequate rapport to be built to allow a DFV victim to trust the attending officers enough to tell her story. For example, on 7 July 2019, Police responding to Kumarn's call for help were on scene for just five minutes.

400. In noting the potential problem with short Police attendances, I also note the reality of the huge demands that are placed on frontline officers and their limited resources, which mean that Police may be simply unable to stay any longer before having to attend another priority callout. When reviewing the ICAD logs contained in this brief, the Court saw over and over again the notation "NTPOL NO UNITS AVAILABLE", presumably because the units were already responding to other callouts.

(c) Effect of being met with scepticism: "Not as reported" or "may make false allegations"

401. As I set out above, the fact that a woman who makes a 000 report then fails to confirm that account to attending Police, does not mean that she was lying. There were many examples in the evidence of Police responding to a report of domestic violence, finding that the woman who had called 000 to make that report was not willing to adhere to that complaint, and then the officers marking the incident as "not as reported". This reflects a lack of understanding of the diverse reasons for this response, rather than it simply being that the woman did not report the truth to 000.

402. I received evidence of the "may make false allegation" alert that was added to Kumarn Rubuntja's profile on 7 July 2019 after attending Police decided she had lied to get a family member into trouble. I am satisfied that other police who subsequently responded to Kumarn Rubuntja's reports were aware of that alert, and that there is a real risk that an alert of this type may lead Police to a prejudgment (that the complaint is not credible) before they arrive at an incident.

403. To remedy this risk, NT Police have removed the "may make false complaint" as an option for an alert.

(d) Agencies not understanding the risk: the need for a DFV-lens for all frontline staff

> ***"…you just think: But this was something waiting to happen for the last 20 years. This could have happened last year or last month or last week. It's not a surprise that this happened, it was expected. And…you just think: But how could you not have stopped this? Anybody can see this coming."***
>
> Dr Marianne Tiemensma, Forensic Pathologist,
>
> Evidence 14 August 2023, at T40

404. The Nhulunbuy agencies supporting Miss Yunupiŋu understood how much danger she was in from Mr Marika. That is why they worked so intensively and consistently to try to protect her.

405. With that exception, it seems to me that the agencies and services engaged with these four women in the end failed to appreciate the level of risk that their partners posed to them.

406. For Kumarn Rubuntja, Police received nearly fifty calls for help in the twenty months before Mr Abbott murdered her. Mr Marika had nearly killed Miss Yunupiŋu when she was 16, and had continued to seriously assault her in the years that followed. Kumanjayi Haywood suffered twenty years of violence from Kumanjayi Dixon.

407. Domestic and family violence is often complex and nuanced. It can take a concerted effort to understand and respond to it. I heard much evidence about the extensive efforts of highly skilled and hardworking professionals working to identify, intervene and support women experiencing domestic and family violence; however, I also heard evidence of frontline workers who missed opportunities to intervene to prevent violence. I accept that many of the failures to act were the result of a lack of understanding of the complexity and seriousness of domestic and family violence. During the Inquests, the ideal approach was described as having a "DFV-lens". I accept that if frontline staff were

better able to identify the risks associated with domestic and family violence and were resourced to manage these risks in a coordinated way, this will lead to the prevention of violence.

(e) "The relationship has ended"

408. A review of the various reports prepared during Mr Marika's times in custody shows that, while in custody, Mr Marika would report that his relationship with Miss Yunupiŋu had ended, but upon release, the relationship would resume and there would be further violence. It is important that in assessing risk and treatment needs, declarations that a relationship has ended should be carefully considered, in case they are inaccurate.

4. Coordinated agency responses

409. A whole of government response to domestic and family violence must include specific coordinated agency responses. Some of these already exist, but I recommend that they be strengthened.

(a) Family Safety Framework

410. The Family Safety Framework was introduced in 2012, in an effort to coordinate a response to the scourge of family violence in the NT. It is designed to provide an action-based integrated service response to individuals and families who experience domestic and family violence and who are at high risk of serious injury or death. The FSF is led by NT Police in partnership with other front line government and non government agencies, including DCF, Correctional Services, NT Health, Women's Shelters and health and AOD services. It operates in Darwin,

Katherine, Alice Springs, Yuendumu, Nhulunbuy, Wadeye and Tennant Creek.

411. A Risk Assessment Form (RAF) was formerly used as a referral to the FSF, if the person scored high enough to indicate that they were a high risk of serious injury or death.

412. The Risk Assessment and Management Framework (RAMF) was introduced in 2020. This is a consistent and evidence based approach to identify, assess, respond to and manage domestic and family violence risk in the Territory. It provides a Common Risk Assessment Tool (CRAT) for assessing the risk of domestic and family violence. If a risk assessment determines that there is a high risk of imminent death or serious harm, a couple will be referred to the Family Safety Framework.

413. Referrals to the FSF are made via email to a generic address that is monitored and managed by the NT Police in each region. In Darwin, this is the Domestic and Personal Violence Unit. Once received by NT Police, a referral is reviewed by the FSF Chair, which in Darwin is the Officer in Charge of the Domestic and Personal Violence Unit.

414. Fortnightly stakeholder meetings of the FSF in each location allow for information sharing between key agencies and services and the possibility to have wrap around services for a woman. The task of the meetings is to identify the immediate threats and needs of the woman and to construct a plan of action that will, hopefully, reduce risk and enhance safety of the party/s. The plan is then actioned and monitored over subsequent meetings until the risk is at a low enough level for the couple to be removed from the FSF.

415. One of the aims of the FSF is to avoid victims having to separately engage with each service, and repeatedly becoming revictimised by having to retell their story.

416. Senior Sergeant Erica Gibson, who had previously chaired the Nhulunbuy FSF, gave evidence that the FSF had a significant impact on

behaviour change for many perpetrators because it "made them aware that people were essentially watching out...it made them more accountable."[145]

417. I received evidence that none of the four women were on the Family Safety Framework at the time of their deaths. I heard that:

   a. Miss Yunupiŋu and Mr Marika had been on the FSF, but were removed in April 2018 when he was in custody. There was a re-referral to the Nhulunbuy FSF in July 2018, and then a referral to the Darwin FSF on 13 September, but the Darwin FSF chair "deferred" or, in effect, declined that referral,

   b. Ngeygo Ragurrk and Mr Nawirridj were never referred to the FSF and a risk assessment was never conducted,

   c. Kumarn Rubuntja and Mr Abbott had both previously been on the Framework, in relation to different partners, but they were never referred to the FSF during their relationship and no risk assessment was ever conducted, and

   d. Kumanjayi Dixon and Kumanjayi Haywood were never referred to the FSF, and there is no evidence that a risk assessment was ever conducted.

418. The circumstances concerning Miss Yunupiŋu and Mr Marika reveal room for improvement with the FSF in a number of key aspects. First, one of the most dangerous times for a woman experiencing domestic and family violence is the period just after the perpetrator is released from custody. This is because perpetrators often blame victims for their incarceration. Despite this, when a perpetrator is released from custody, there is no automatic re-referral to the FSF for a couple who had previously been on the Framework. This should be reviewed.

[145] Evidence of Senior Sergeant Erica Gibson 15 August 2023, at T108.

419. Secondly, when a FSF referral is received, it should be provided to all FSF members for a collaborative assessment of whether the referral should be accepted, rather than it being determined solely by the FSF chair. I have been told that this change has now been made.

420. Thirdly, there should be an effective process of transferring a couple from one FSF to another. The referral from the Nhulunbuy FSF should have been automatically accepted by the Darwin FSF.

421. Fourthly, FSF status and historical information should be easily accessible by FSF members. The CAG staff should have been easily able to access the FSF information for Miss Yunupiŋu and Mr Marika, and the Darwin FSF Chair should also have been able to access this information.

422. A FSF "Portal" would address these last two concerns. One was proposed through the DFSV-ICRO to facilitate access to information and information exchange between FSF agencies and FSF locations. This would ensure that work undertaken while a person is on the FSF (such as safety planning) is not lost over time, and would also assist in the transfer of information from one region's FSF to another. A portal as proposed would likely have been of real benefit to the Darwin FSF chair when considering the 13 September referral for Miss Yunupiŋu.

423. Fifthly, there should be consideration of the implementation of a mechanism for FSF consideration when Police become aware of new relationships for men who have previously been convicted of significant domestic, family and/or sexual violence (for example, offenders like Mr Abbott),

424. Sixthly, there also needs to be a tiered response for risk that is less than "high", or is not imminent, as all levels of risk require a response and risk management. There needs to be a process for these victims and offenders to receive the intervention they require to avoid them progressing to a more acute stage. Therefore, an appropriate range of

responses should be developed, with a pathway for an escalated response.

425. Finally, it appears that the FSF agencies are so burdened with the number of people on the FSF, that they are not able to keep all high risk offenders, and sometimes those most at risk of harm, in view. This is another example of an important response to serious domestic and family violence that is severely stretched, and in need of additional resourcing.

426. I received evidence that a number of important changes have been made to the operation of the FSF. These include:

a. improved FSF training,

b. regular FSF chair workshops to ensure consistency of approach and improved communication,

c. a new option to "suspend" involvement on the FSF where a perpetrated is in custody, and a requirement that an updated risk assessment be conducted prior to their release so that the FSF can be resumed if appropriate,

d. a requirement that all FSF referrals be tabled at Family Safety Meetings, rather than decisions about referrals being made by the FSF Chair alone, and

e. significantly enhanced administrative support, including assistance with minute-taking.

427. I commend these improvements, but note that there is still work to do, particularly in relation to funding.

(b) Co-responder model

> ***"I think it's not a job [for police] alone to do. I think we are attending to the critical crisis points when an event is occurring or just occurred and it is for all of us in the whole…to be able to wrap around the services of the victim to get them as much support as possible to make them safe and to give them the ability to separate themselves from a situation so they can then make informed decisions to further and protect themselves with the support of - whether it's a DV specialist, a counselling services, women's shelter, those sorts of things."***
>
> Acting Deputy Commissioner Michael White, evidence 3 July 2023 at T378

428. An effective response to the complexities of domestic and family violence can't fall solely to Police.

429. For this reason, at the heart of NT Police's aspirations for a fundamental rethinking of its response to domestic and family violence is the development of a co-responder model. This will involve an initial front line response from General Duties Police officers, promptly followed up by a team that consists of a specialist domestic violence worker (social worker and/or psychologist) and Police. It will involve a co-response directed toward both the person alleged to have been the victim of violence, and the alleged offender.

430. The development of a co-responder model recognises that Police do not have the time, resources, or expertise to undertake all of the substantial follow up that is required for direct victims of domestic violence. Carmel Simpson from Tangentyere Council explained that:

> "…having services such as [Tangentyere] that are outside of police are going to have probably a better way of engaging and talking to people; …we're going to have a better response. And

that includes us talking to the men…We know how to do that work. That's our expertise."[146]

431. It is anticipated that this response will facilitate:

a. improved rapport building with women experiencing violence, including by improving police interpersonal skills,

b. better identification of women who are in need of intervention and support,

c. more effective identification of the escalation of risk,

d. a more immediate response than just the FSF and

e. a more equal response to both victim-survivors and users of violence to identify and manage risk.

432. The NT already has co-responder models of policing in relation to mental health services in Darwin, and the Child Abuse Task Force.

433. One Police witness told me that she thought the co-responder model was

> "…a great idea. I think there's a lot that has to happen in a domestic violence situation before police can actually really intervene with any sort of law enforcement and if there's a third party there that the victim feels like she can build rapport and have a trusted relationship with, I can only see that that will benefit the situation."[147]

434. Commonwealth DFSV Commissioner Micaela Cronin gave evidence that a co-responder model is consistent with the first "action" to achieve the objectives of the "Response domain" of the National Plan, which is to "ensure frontline services provided by states and territories are coordinated, integrated and appropriately resourced with a skilled and qualified workforce to support all victim-survivors".[148] This is a good

[146] Evidence of Carmel Simpson, 23 August 2023 at T130.
[147] Evidence of NT Police Senior Constable on 23 August 2023, at T198-199.
[148] Statement of Commissioner Michaela Cronin dated 5 November 2023 (Common brief: 1-2D).

example of how the National Plan can (and should) support real action in the Northern Territory that would make a difference to real families on the ground.

435. Queensland Assistant Commissioner Christopher Jory gave evidence about that state's trials of co-responder models, which were evaluated and found to deliver improved outcomes in cases of domestic and family violence. Assistant Commissioner Jory also told me that the funding allocated to Queensland Police Services and specialist domestic violence services has been $229 million over four years.

436. The Queensland models include:

   a. a "crisis and early intervention approach" where DFV specialist services respond at the same time as Queensland Police intervention,

   b. an embedding of DFV specialists in police stations, which brought benefits including emotional support, information sharing, communication, efficiency, education, access to networks and improved police legitimacy,

   c. an embedding of police officers within DFV service providers, in recognition that some victim survivors of DFV do not feel safe attending police stations,

   d. an area-specific model in the Logan area, which has one of the highest callout rates in the State, and

   e. a coordinated response between Queensland Police High Risk Teams and the Department of Justice and Attorney General.

437. A small scale pilot program for a co-responder model has been designed for implementation in Alice Springs; however, I am told that once fully implemented, demand for the service will immediately surpass the pilot's capacity in Alice Springs and it is apparent that, from the outset, the funding for this pilot is inadequate to allow it to succeed.

438. Seranie Gamble, the Executive Director of DCF's DFSV Reduction Division gave evidence that cost-modelling indicated roughly $1million would be needed to fund each co-responder location; however, less than $300,000 has been allocated to fund the Alice Springs pilot.

439. Commissioner Murphy has committed to expanding the Alice Springs co-responder pilot to Darwin, in concert with DCF; however, sufficient funding will be essential in any and all locations where a co-response model is implemented. Any pilot or wider implementation of co-responder programs must be appropriately funded and evaluated.

440. It may be that different models will be more effective in different areas. Appropriate time and resources should be devoted to developing and implementing different models, where appropriate.

441. I strongly encourage the development and implementation of appropriate co-responder models across the Territory. I note the submissions on behalf of the Ragurrk and Yunupiŋu families, which were endorsed by the NTPF, that for a co-responder model to work in remote communities, it must involve partnership and collaboration with Aboriginal Community Controlled Organisations to develop a community-led model.

442. I accept that there are substantial cultural competency benefits of Police partnering with Aboriginal Community Controlled Organisations ("ACCOs"). I recommend that, where possible, co-responder models be developed in partnership with ACCOs.

Recommendation 7: *Co-responder model*

As a matter of urgency, the NT Government should provide further and sufficient funding to the current Alice Springs co-responder pilot (NT Police and the Department of Children and Families (DCF) DFSV Co-responder model) to guarantee its full implementation and independent evaluation. The model must involve victim survivors (including children) as well as perpetrators. Adequate funding (inclusive of independent evaluation) should

be provided so that this model can be evaluated, replicated and implemented in other regions. This expands on action 3.6 of Action Plan 2.

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

i. consideration of models based on the success of the Queensland models, and

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

(c) Information sharing and Supportlink

443. Supportlink provides a centralised referral management and early intervention management service to refer victims and offenders to social support agencies to reduce the risk of repeat victimisation and repeat offending.

444. Despite the number of times that Police were called in relation to Mr Nawirridj, Mr Abbott or Mr Dixon, no Supportlink referrals were made for Ngeygo Ragurrk, Kumarn Rubuntja or Kumanjayi Haywood. Police records indicate that Ngeygo and Kumanjayi each specifically declined to consent on one occasion each, and Kumarn twice.

445. Police made four Supportlink referrals for Miss Yunupingu, who was engaged with support services to a far greater extent than any of the other women.

446. Supportlink referrals require consent; however, following amendments to the *Domestic and Family Violence Act 2007* in 2018, certain information can be shared without consent, in specific circumstances:

Section s124E Sharing information for assessing or preventing domestic violence threat

(1) An information sharing entity may give information to another information sharing entity if the entity that holds that information believes on reasonable grounds that:

(a) a person fears or is experiencing domestic violence; and

(b) the information may help the entity receiving the information to:

(i) assess whether there is a serious threat to a person's life, health, safety or welfare because of domestic violence; or

(ii) lessen or prevent a serious threat to a person's life, health, safety or welfare because of domestic violence, including by providing or arranging a domestic violence related service to or for a person.

447. I accept that the legislative regime may cause confusion in relation to when information can be shared without consent, and that misunderstandings about the law and restrictions on information sharing may have contributed to Police failures to make Supportlink referrals in these matters.

448. I accept the submission made on behalf of Kumarn Rubuntja's family that it is important that Police properly understand the Supportlink regime and, in particular, when information may be shared without consent. For this reason, I recommend that they receive enhanced training in relation to Supportlink and information sharing.

Recommendation 8: *information sharing through Supportlink*

NT Police should:

i. conduct a review of Supportlink's operational protocols in the context of the legal allowances for information sharing under the DFSV framework, and

ii. review and enhance NT Police training in the use of Supportlink, including when a referral should be made and the information to include in a referral.

449. I have been told that the NTPF and NT Health have commenced working together to formalise the information sharing process between hospital based constables and social workers.

450. I have also been told that a new information sharing arrangement has been established between NT Corrections and NT Police, to notify Police of prisoners who are not recommended for parole, or who are released after completing their full term of imprisonment and who have a history of DFSV. NT Police have also assigned a Field Intelligence Officer who operates within the Darwin Correctional Centre Professional Standards Unit, but also communicates with the Alice Springs Correctional Centre Intelligence Team when necessary.

451. I commend productive efforts such as these to improve appropriate information sharing between the agencies, where it is done to improve victim safety.

(d) MAPS: Multi-Agency Protection Service

452. In its closing submissions, NT Police ask me to make a recommendation that the NT Government consider establishing a Multi-Agency Protection Service (MAPS), modelled on the South Australian Initiative. I

understand that this Initiative would formalise a partnership between Police and other relevant government departments in their response to domestic violence and child protection. The South Australian initiative allows for co-location of agencies, which enables integration of information from diverse sources and facilitates the development of shared knowledge. Referrals about domestic violence and child protection can come from South Australian Police or any other agency, enabling earlier and better intervention to reduce risk and harm.

453. I agree that the NT Government should consider an initiative like this, and, accordingly, I make this recommendation.

Recommendation 9: Multi-Agency Protection Service (MAPS)

The Northern Territory Government should consider establishing a Multi-Agency Protection Service (MAPS), modelled on the South Australian initiative so as to formalise a partnership between the NTPF and other relevant government departments.

5. Police responses

454. Clearly, it is not for Police alone to respond to the epidemic of domestic and family violence; however, the role that Police plays is absolutely vital to the whole of government response that is needed.

455. I have no doubt that policing in the Northern Territory is extremely challenging and that the work of police in responding to domestic and family violence even more so. I accept that this work can be traumatic, complex, and, given the rates of domestic and family violence in the Territory, must at times seem overwhelming. I accept that cultural nuances, language barriers, distance and under-resourcing across the sector, make this work even harder for NT Police.

456. I also accept the evidence I received of the significant personal toll and vicarious trauma that policing in the Territory can have on our dedicated officers, and, in particular, the effect of trying to respond to the flood of domestic and family violence incidents. I witnessed the emotional responses that many police witnesses had when giving evidence about their work, and I also observed the pressure and ugency of the work undertaken by the Joint Emergency Services Communication Centre (JESCC) during a view.

457. Every day in the Territory there would be countless examples of excellent policing responses to DFSV; of generous-spirited, committed, patient and kind efforts to assist people experiencing domestic and family violence.

458. Having said that, we must confront the failings of the Police response to date. In these Inquests, I have received evidence of specific and systemic Policing failings and I will now turn to consider these failings.

459. I note from the outset, though, that the NT Police Force has engaged in a bona fide attempt throughout these Inquests to make significant practical and systemic reforms to improve its ability to respond to domestic and family violence. The agency, and its members who gave evidence before me, demonstrated a preparedness for honest self-reflection and a refreshed determination for improvement. I commend the NT Police Force for this approach.

(a) Police resourcing

> ***"I think the reality is that we don't have enough people to attend all jobs in a timely manner and why we have to prioritise where we go first and if an incident comes in that is of a more serious nature we have to go to that before going to other jobs."***

Acting Deputy Commissioner Michael White, evidence on 3 July 2023 at T378

460. I received evidence of specific delayed or inadequate Police responses, including:

a. Miss Yunupiŋu's called JESCC at 2:51am on 30 June 2016, begging for help, and Mr Marika could be heard yelling in the background. Police did not attend until after 7am,

b. Kumanjayi Haywood's mother called 000 on 14 July 2021 to report that Kumanjayi was in Haasts Bluff and feared that Kumanjayi Dixon was going to stab her (as he had before). Police did not make enquiries in the community until two days later, and finalised the job when they couldn't locate Kumanjayi Haywood on Kumanjayi Dixon,

c. On 15 September 2021, Kumanjayi Haywood called 000 again out of concern for her daughter. Police effectively did nothing in response to this call,

d. After Kumanjayi Dixon brutally beat her during the evening of 27 September 2021, Kumanjayi Haywood called 000 five times between 12:32and 2:13am, and her mother called twice during that time. Police did not attend until 12:45pm that day, some twelve hours after her first distressed call was received by JESCC.

461. These delays can be devastating:

a. life saving help may not arrive, or may arrive too late,

b. other serious harm may be inflicted during the time it takes Police to respond to calls for help,

c. long delays can erode trust and confidence in Police; members of the public may think that there is no point calling Police, because

they know that the chances are they will arrive too late or not at all,

d. a delay in Police arriving may influence a victim's attitude to telling police her story. As Detective Superintendent Engels told me in the Inquest into the Death of Ngeygo Ragurrk:

> "the longer the delay probably the less chance we've got with an already reluctant victim for them to provide us with any detail of what occurred."[149]

e. for NT Police officers who are genuinely trying to "serve and protect" the community, I accept that the delays they experience in being able to respond to those needing their help may make it seem an impossible task.[150] This can contribute to feeling demoralised, burnt out, disillusioned and hopeless, the development of post-traumatic stress disorder (PTSD), long term sick leave and, for some, a decision to leave the force.

462. I also heard evidence about the huge demand that responding to domestic and family violence incidents places on Police resources, and, in particular, about whether the NT Police Force has enough resources to deal with the current rates of this crisis. I am satisfied that it does not.

463. This finding is based on evidence that includes:

a. in 2021-2022, 31,594 domestic violence incidents were reported to NT Police, and this increased to 37,621 in 2022-2023.

b. 712,649 hours of police time in 2022 were spent responding to domestic and family violence incidents. This is the equivalent of 387 full time police working solely on responding to domestic violence incidents for the entire year,

[149] Evidence of Detective Superintendent Kirsten Engels 3 July 2023 at T402.
[150] Submissions on behalf of a former NT Police Constable, dated 18 October 2024 at [7].

c. the demand on Police is increasing, with 882,000 policing hours spent responding to domestic and family violence incidents in 2023,

d. Police response times have more than doubled in most parts of the Territory over the past five years,

e. Priority one callouts (for which I was told a unit should be dispatched within ten minutes) are now taking an average of 43 minutes for police to respond to, which is an increase of 96% in the main centres over the five years to 2023,

f. No unit responded at all to approximately 15% of priority 1 callouts, 35% of priority 2 callouts, and 57% of priority 3 callouts in 2022-23. This represents a response rate of 59% overall, and

g. approximately 14,000 calls a month were received by JESCC ten years ago, but this had increased to 35,000 calls a month by 2023, with no corresponding increase in the numbers of General Duties police officers to respond.

464. When Acting Deputy Commissioner White gave evidence in November 2023, approximately one in five of the 1640 NT Police Officers were unavailable for duties, due to various types of leave. Commissioner Murphy gave evidence that, as at May 2024, the staffing of the NTPF was "sitting around 2019 levels", with 120 officers on long term (unlimited) sick leave and only a quarter of those expected to return to work.[151]

465. Deputy Commissioner White gave evidence that:

> "Without urgent and significant provision by government of additional funding…the prospect for any meaningful improvement in the ability of the NTPF to respond to reports of domestic

[151] Evidence of Commissioner Murphy, 20 May 2024 at T15.

violence is unlikely and more probably than not, the already unacceptable delays will become worse."[152]

466. I have been told that the NT Government have accepted a NT Police Review recommendation that an additional 200 officers and 71 staff be employed over the next four years and, clearly, such an increase is welcomed; however, there is no indication that any of these additional positions will be allocated to frontline DFSV policing.

467. The rates of domestic and family violence in the Territory must be curbed, if for no other reason than that our Police simply cannot keep up.

(b) JESCC

468. The effective operation of the Joint Emergency Services Communication Centre (JESCC) is vital to effective policing in the NT. Some of the reasons that it is so important are:

    a. accurate and detailed information needs to be obtained from 000 callers in an efficient way, to allow for appropriate prioritisation in the dispatching of police resources,

    b. the more accurate and detailed the information obtained from 000 callers and from NT Police intelligence holdings, the better prepared attending Police will be on arrival and during any investigation, and

    c. members of the public (including domestic and family violence victims and witnesses) may be deterred from calling 000 in the future if they have negative experiences during calls to JESCC, or if prioritisation of their call means that Police take too long to respond, or don't respond at all.

[152] Affidavit of Acting Deputy Commissioner Michael White, dated 20 October 2023 (Common brief: 2-5), at [25].

469. There is no doubt that JESCC call takers and their supervisors work under significant pressure and real urgency. There are often language and cultural barriers. They know that the longer they take with one caller usually means that another person in distress will have to wait longer for their call for help to be answered. It is often the case that JESCC operators are not afforded the opportunity for calm reflection, and that the more pressure they are under, the harder it is for them to do their jobs effectively.

470. I received very important evidence from a JESCC supervising Sergeant about the incredible pressure faced by JESCC staff on a daily basis. The evidence included that:

   a. there are on average about 300 to 900 calls to JESCC during a nightshift (7pm to 7am), sometimes more,

   b. there is a minimum of six JESCC call takers on each shift; two enquiry officers (or call checkers), who perform checks such as on criminal history and orders; up to five dispatchers; and also CCTV operators. When JESCC is short staffed, they do not have enquiry officers,

   c. there are national standards for the time in which 000 calls should be answered: 90% should be answered within ten seconds and 80% of the 131 444 assistance line calls to be answered within thirty seconds. He said that JESCC fell below the national standard most of the time because of under-staffing. He gave evidence that in 2016/2017 NT Police answered 95.6% of 000 calls within ten seconds, but this had dropped to 80.5% by 2021/2022,

   d. there are five priority levels: priority 1 requires dispatch within ten minutes, 2 is for dispatch within thirty minutes, 3 is for dispatch, 4 is not for dispatch but to be dealt with by a triage unit with phone follow ups and 5 is information only,

e. a lack of available police units often means that JESCC is unable to dispatch officers in accordance with the grading requirements. This results in the dispatchers having to carefully prioritise which jobs to send police to resulting in "all we do for 12 hours is prioritise",[153]

f. despite the lack of available police units, JESCC members felt that they risked disciplinary action for not dispatching within the required times, and I heard evidence of one instance where a JESCC member had been reprimanded for this,

g. jobs that are not attended to during night shift are handed over to the incoming day shift and, in his recent experience, this meant sometimes 40-50 jobs being handed over to an incoming day shift,

h. all domestic violence incidents, whether verbal or physical, are always automatically a priority 1 grading (requiring dispatch within ten minutes), but in his recent experience, domestic violence incidents can be waiting for two to three days for police to be dispatched,

i. he estimated that 70% of the calls to JESCC were hard to understand, because the caller did not speak English as a first language, was distressed, had mental health issues, was a child, or because of intoxication,

j. the length of time that call takers spend on calls is monitored and if they are taking longer than expected, the call taker will get a call audit and it will be recommended that they keep the calls shorter, and

k. an effect of understaffing in JESCC was that enquiry officers were not available to undertake checks of police records, so general duties staff had to do their own checks on their mobile devices.

[153] Evidence on 27 June 2023, at T102.

471. I was extremely impressed with the candour and dedication of this JESCC supervisor. He presented as an officer with an excellent commitment to the NT Police Force and to the people of the Territory. I found his evidence to be a very important contribution to the Inquests.

472. Following on from that officer's evidence about the difficulties that JESCC call takers experience due to language or cultural barriers, I was able to hear 000 calls that had been made by these four ladies, and others on their behalf and I heard many examples of these difficulties. For example:

    a. on three separate occasions, JESCC call takers misheard Kumanjayi Haywood's mother when she said that her daughter was in "Haasts Bluff". Each time, the call taker recorded it as "ice block", and

    b. on the one occasion that Ngeygo Ragurrk called 000 in relation to Mr Nawirridj's violence towards her (on 13 July 2019), due to communication difficulties between Ngeygo and the call taker, the first six minutes or so of the call were taken up by the call taker trying to ascertain where she was.

473. I have received evidence about efforts being made to improve JESCC responses.

474. The first of this is the development of a "Triple Zero" communication campaign to promote the correct use of 000 and 131444, both in relation to when to use which number, but also in relation to how to provide location and incident details to call takers. Cultural adaptations are being made and it is proposed that the campaign material will be translated into Aboriginal dialects.

475. Secondly, I received evidence of two trials undertaken to improve JESCC accessibility for Aboriginal language speakers. I was told that more than 31 per cent of Territorians are Aboriginal and there are up to 140 Aboriginal languages spoken. Six key Aboriginal languages account for

over 65 per cent of all emergency calls to JESCC. About 76 per cent of Aboriginal Territorians live in a remote or very remote areas and the more remote the community, the less likely that Aboriginal people speak English. The language barrier is exacerbated in an emergency call, as callers are frustrated and scared, and tend to speak faster. They also may revert to an Aboriginal language, rather than speak English.

476. The first interpreter trial involved Aboriginal language interpreters being placed in the JESCC call centre to assist call takers with triaging police emergency calls and the second involved interpreters being available by a telephone link up. Overall, the first trial demonstrated that providing access to an interpreter can improve caller engagement and assist emergency call operators to accurately identify the key details to inform an effective police response. The second trial had a problematically low uptake rate, with significantly less interaction with interpreters.

477. The helpful JESCC supervising sergeant gave evidence about the first interpreter trial. He said that, in practice, a call taker would put their hand up if they wanted assistance from the interpreter, and the interpreter would have a second headphone to listen to the call. If they could speak the caller’s language, the interpreter could take over the call and the call taker would listen to what the interpreter said. The interpreter could give advice. In his view, the interpreters were great and quickly established a rapport with the callers.

478. I accept that embedding interpreters and/or Aboriginal Liaison Officers within JESCC will assist not only with language, but also with cultural guidance and I strongly encourage that this recommendation be implemented.

Recommendation 10: *Embedding of Interpreters and/or Aboriginal Liaison Officers (ALOs) in JESCC*

The NT Police should:

i. employ interpreters and/or ALOs in JESCC to provide language and/or cultural skills to assist callers to communicate more effectively,

ii. embed the role of Aboriginal language speakers within JESCC's operating procedures, and

iii. improve training for JESCC call takers to know when to ask if a caller would like the assistance of an interpreter.

(c) Training

479. Deficits in Police DFSV training were identified throughout these Inquests, particularly in relation to understanding the complexities of domestic and family violence.

480. Some of these deficits were in relation to:

a. the detection, response, investigation and prosecution of DFV incidents, including in trauma-informed approaches,

b. failures to check or reflect on the perpetrator's history of serious violence,

c. evidence gathering, including the use of body worn video to take statements and ensuring that attending Police engage with relevant witnesses to identify evidence that may allow them to proceed with charges in the absence of a victim statement,

d. ensuring that DFV incidents are not seen in isolation, so that a more accurate picture of risk can be obtained and Police decisions will be better informed, and

e. in relation to member's understanding of the FSF.

481. I received evidence of major changes made by NT Police over the last two years to enhance training provided to recruits, frontline officers, supervisors and specialist officers. In particular:

a. A specific DFV training package has been developed and delivered for recruit Police Auxiliaries, including for JESCC call takers,

b. DFV specific training has been provided to existing JESCC staff members as part of Command Training, and

c. PARt training[154] has been delivered to recruits with the assistance of Dr Chay Brown. Commissioner Murphy has committed to the rollout of the program to all of the NTPF. Although the implementation of this training has already commenced, I believe that it is of such critical importance, that I make a recommendation that it be provided to all NT Police officers and auxiliaries.

482. So far, the PARt training has been very well received; however, the implementation and evaluation of PARt has been costed at approximately $1.8 million over five years but there is no long term funding strategy for it.

Recommendation 11: *PARt training*

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

[154] The "Prevent. Assist. Respond. Training" ("PARt") is a specialist DFSV training package that was designed by external experts for police and healthcare workers in the NT.

483. To assist with effective information sharing between Police and other agencies, it would be helpful if the training for recruits and members on this issue be reviewed and enhanced.

(i) Rapport building

484. Poor rapport building by Police represents a significant barrier for women experiencing domestic and family violence to open up and talk about what they have experienced. If Police can't obtain a complaint, the available DFSV responses are not triggered. In addition, whenever a woman has a poor experience, she may be less likely to make a report in the future.

485. I received evidence of specific examples of poor rapport building efforts by Police. Some of these include:

   a. On 19 July 2019, Ngeygo Ragurrk called Police for the first time seeking their help, because Mr Nawirridj had thrown hot sand from the fire at her head. Four police officers attended that call and spent about three minutes gathering information before finalising the job as "not as reported". Those officers did not attempt to speak with Ngeygo away from the group of people she was sitting in. They examined her head under torchlight in front of this group of people, which likely shamed her. She said she wanted to be taken to family in Palmerston and the officers treated that as proof that she had called Police for a lift. They clearly did not take her complaint seriously, despite her hair being singed. These officers did not take the time, or try to make any arrangements, to make Ngeygo feel comfortable to tell them what had happened. She did not call Police again.

   b. In some of the 000 calls that Kumarn Rubuntja made seeking Police help, the call takers spoke with her in an overly frustrated and, at times, inappropriate manner. For example, on 7 November

2019, Kumarn reported to 000 that Mr Abbott was suicidal, before reporting that he was trying to hit her. The call taker responded "ma'am, are you lying about the suicide?" This response was inappropriate, disrespectful and destructive of efforts to obtain further information from Kumarn.

c. When Police attended upon Kumarn on 7 November, the first words that one officer said to her were "why'd you call us, [Kumarn]? Now you're going to lose all your grog, just cause you called us and made silly story." Not only did this officer make no attempt to build rapport with Kumarn or to obtain a version of events from her, but from his very first words, he made it clear to her that he thought she was a liar.

d. Some of the 000 calls that Kumanjayi Haywood made to Police in the early hours of 28 September 2021 were met with inappropriate responses from call takers, which did not assist with rapport building. For example, despite Kumanjayi having experienced a savage beating from Kumanjayi Dixon in the preceding hours, a JESCC supervisor told her that it was "not likely" that Kumanjayi Dixon would come to find her to continue his assault, and questioned why she remained in the relationship.

e. When Police attended upon Kumanjayi Haywood at a home in Haasts Bluff on 28 September 2021, they did not attempt to speak with her alone, away from the family members who were also present in the house. One of the officers stood over her as she lay on a mattress and addressed her with a blunt tone, lacking in compassion. She was not forthcoming with a complaint, despite having made one to 000 the night before, and to a health worker earlier that day.

486. The significance of these individual examples is that, taken together, they reflect a systemic failing by NT Police to adequately train its officers in rapport building skills, which are necessary for officers to

effectively communicate with women experiencing domestic and family violence. Effective communication is far more likely to result in a complaint being made. In addition, efforts should be made every time to speak with the woman away from other people at the scene.

(ii) Prejudgment and collusion

487. On occasion, attending officers were seen to exhibit sympathy and prejudgment in favour of the man accused of domestic violence, and they were disarmed or distracted by a perpetrator who was downplaying his violence or blaming the victim.

488. The clearest example of this was the Police attendance upon Kumarn Rubuntja and Mr Abbott on 7 November 2019. On that occasion, almost the first words spoken by Police to Mr Abbott were "Is she being annoying, eh?" and the first words spoken to Kumarn were to ask her why she had told a "silly story". As I set out above, these comments clearly demonstrate that the officer had prejudged the situation he was attending, he believed that Kumarn was making a false complaint about Mr Abbott, and he did not make any effort to obtain Kumarn's version of events.

489. This attendance is also an example of collusion: upon Police arrival, Mr Abbott was calm and cooperative, and almost immediately, he was successful in shifting Police attention away from investigating Kumarn's complaint to investigating Kumarn herself by saying that she was drinking and had alcohol in her house. This was a form of manipulative and controlling behaviour that disempowered Kumarn and helped Mr Abbott to avoid scrutiny and accountability for his actions. Police did not bring an index of suspicion to what Mr Abbott was telling them; despite not finding the bottle of rum he told them was inside the house. Police need to guard against colluding behaviour such as this; however, at that time NT Police had not provided its officers with the necessary

training to recognise Mr Abbott's manipulative behaviour, or to understand how their response was collusive.

(iii) Failures that demonstrate the need for a "DV lens"

490. There were examples of Police failing to identify that domestic violence had occurred, of Police failing to recognise the DFSV significance of the situation they were faced with, or of Police misidentifying the victim as a perpetrator of domestic violence.

491. Some examples from the evidence were:

   a. When the Chair of the Darwin FSF received a referral for Miss Yunupiŋu, he failed to identify that Miss Yunupiŋu was at significant risk by being in Darwin and "possibly" back with Mr Marika, who had just been released from custody.

   b. When Police attended the car fire on 23 December 2019 Mr Nawirridj told them at least six times that he and Ngeygo had been arguing and he burned the car. He also repeatedly told them that Ngeygo had run away and was hiding from him in the bushes. This should have been recognised as a serious incident of domestic violence. Police should have tried to find Ngeygo to check on her welfare. They should have been concerned for her, given the account that Mr Nawirridj had given them.

   c. On 2 November 2021 when Police decided to grant bail to Kumanjayi Dixon, the officers involved did not understand the level of risk to Kumanjayi Haywood, if bail was granted. For example, one of the arresting officers did not understand how to read a criminal history in relation to domestic violence, and relevant past DFV offending was not properly considered, if at all. Recent reports of violence and threatening behaviour by Kumanjayi Dixon toward Kumanjayi Haywood were not

considered, but should have been and they were of very serious concern.

d. On 3 November a JESCC call taker failed to appreciate the DFV significance of the following: Kumanjayi Haywood called 000 to report that her partner was not meant to be at her location because of a DVO. A male voice could then be heard in the background saying "you're a liar" and "you called Police". The call was terminated. Police tried to call back and the phone was answered by a female who identified herself as "Rebecca". She said it was "all good", and that she did not call Police. As Police were unable to confirm the people involved or the existence of a DVO, the priority was downgraded, meaning that no police response was required. This was despite the particularly menacing nature of the male voice in the background of the original call. This call should have resulted in the urgent dispatch of Police.

e. Police misidentified Kumanjayi Haywood as a perpetrator of violence when they attended Wycliffe Well Roadhouse on 17 December 2015, in response to a report that Kumanjayi Dixon had assaulted her. Despite no allegation against Kumanjayi Haywood, Police sought reciprocal DVOs against them both.

492. The officers in these examples did not properly consider the domestic and family violence aspects of these incidents.

493. In addition, there were failures to coordinate or "piece together" multiple incidents, to properly consider relevant histories in accurately assessing the DFV risk in these relationships, or to act upon the information that Police had. For example:

a. when Police first became aware of the relationship between Kumarn Rubuntja and Mr Abbott, the attending officers, and two supervising sergeants all recognised the significant risk of domestic violence between them, but nothing was done about it, and

b. on 23 December 2019, Police were called to four separate incidents involving Mr Nawirridj within just four hours: an allegation that he was fighting near the Fannie Bay monument, the car fire in Banyan St, assaults upon people including an older lady, and an attempt to set a fuel bowser on fire. He had told Police that he had argued with Ngeygo and she was hiding from him; yet the significance of these events was not appreciated, and Police failed to recognise that Mr Nawirridj posed a significant threat to Ngeygo.

494. Their failures are a reflection of a significant failing in the training of NT Police at that time, both of recruits and serving members.

495. I have received evidence of the enhanced guidance that the new NT Police General Order provides to officers in responding appropriately to domestic and family violence, as well as the education and training that have been provided to officers.

(iv) Coercive control

496. More specifically, I received evidence of Police failures to identify more subtle domestic violence in the form of coercive control. These examples included reports of property damage, or threats to damage property:

a. the report that Mr Marika had burned Miss Yunupiŋu's keycard, ID card, Centrelink card and Medicare card on 19 June 2017,

b. the report that Mr Abbott had smashed Kumarn Rubuntja's powerbox with a stick on 16 May 2019 (which he admitted), and subsequent reports that he had damaged other property including her mobile phone and car windscreen, and threats that he had made to do other damage, and

c. Mr Nawirridj's admission to Police on 23 December 2019 that he had burned the vehicle that Ngeygo Ragurrk had bought.

497. The examples also included episodes of self harm, or threats of self harm:

a. on 11 January 2018, Mr Nawirridj attempted suicide in the cage of a police vehicle while Ngeygo stood a short distance away speaking with police about an assault he had just committed upon her,

b. while looking for Ngeygo on the morning of 23 December, Mr Nawirridj threatened to set himself on fire using a petrol bowser, and

c. Kumarn made numerous reports to Police that Mr Abbott was threatening self harm. I am satisfied that Police did not appreciate the significance of any of these reports.

498. Police failed to consider that these incidents were examples of coercive control.

499. The new General Order explains what coercive control is and identifies the signs that members should look for in determining whether a person is exercising coercive control.

<u>(v) Failures to follow NT Police policies and procedures</u>

500. There were numerous examples of officers failing to follow NT Police policies and procedures. These include:

a. Incorrectly downgrading or changing the categorisation of domestic incidents. A JESCC supervisor told me that he had done this on one particular occasion because:

i. doing so reduced the administrative workload on overstretched front line officers, and

ii. he was unable to dispatch a unit in the time that the automatic Priority 1 categorisation requires, due to a shortage of available units.

b. A failure to meet minimum standards of investigation. For example:

   i. when police received a report from Kumarn's family member that Mr Abbott had smashed her powerbox with a stick, the attending officers neither inspected the powerbox, nor did they speak with the reporting family member or other witness who was present, and

   ii. when Police responded to a report that Mr Nawirridj had tried to set a petrol bowser alight, they failed to speak with witnesses at the scene, or to view the CCTV from the petrol station.

c. A failure to lay charges where there was sufficient evidence to do so. For example:

   i. when Mr Marika assaulted Miss Yunupiŋu in the back of the Night Patrol vehicle, in front of independent witnesses who attended the Police station, Police did not charge him with that assault,

   ii. when Mr Nawirridj assaulted Ngeygo at the Palmerston bus exchange, there were independent witnesses and CCTV available, yet Police did not charge him with assaulting her, and

   iii. when Mr Abbott admitted to hitting Kumarn's power box with a stick, Police did not charge him.

d. A failure to initiate DVOs where there was a sufficient basis to do so. For example:

i. A DVO was not sought for the protection of Kumanjayi Haywood following his assault upon her on 7 November 2009, when he repeatedly punched her to the head and hit her with a broken chair. He was arrested and remanded in custody for some six months, but no DVO was sought, and

ii. No DVO was ever sought against Mr Abbott for the protection of Kumarn Rubuntja. There was, for example, a failure for Police to seek a DVO against Mr Abbott in relation to Kumarn's report that he had kicked her in the chest on 9 June 2020. She sought medical treatment at Alice Springs Hospital for her injury, and Police should have initiated a DVO. The failure to do so was in breach of the General Order.

e. A failure to offer Supportlink referrals where appropriate. For example:

i. In relation to the incident on 9 June 2020 when Kumarn reported that Mr Abbott had kicked her to the chest, Police should have offered her a Supportlink Referral, but there is no indication that they did.

501. I have been told that Police have taken steps to address these failings. For example:

a. a new DV Response Senior Sergeant is now located in JESCC 24/7 to provide support to frontline responses to DFV-related incidents Territory-wide. In particular, this role aims to provide enhanced assessment and prioritisation of DFV related computer aided dispatch ("CAD") events that are awaiting dispatch, infield guidance to frontline members responding to DFV callouts and early detection and notification for DFV-related trends and issues,

b. the new General Order provides enhanced guidance to Officers in determining who is the person most in need of protection, with reference to the known history between each of the parties, and

c. the new General Order also provides a direction that when admissible and sufficient evidence exists to support charging an offender, members are obliged to submit a prosecution file, even in the absence of a statement from the alleged victim.

(d) Changes to Police systems

(i) The need to respect, support and elevate senior police in charge of domestic family violence

> ***"I am actually terrified, and I – that – that seems like really strong language, but I'm really scared that [Superintendent Engels]'ll go, and then we have to start again. And it's so much about doing good work in the space is about relationships. Relationships between services. Relationships with the community that we're all working for. So I think it's really important that we have that stability within the police, that we know who to talk to. We know that they're absolutely equally engaged as we are."***
>
> Maree Corbo, evidence 23 August 2023 at T119

502. Since the commencement of these Inquests, NT Police have appointed an Assistant Commissioner in charge of Domestic Violence and Youth, and Commanders have been appointed to be in charge of the police response to domestic violence in both the Top End and in the Southern Region. I accept that the establishment of these positions is a significant step forward and reflects NT Police's serious prioritisation of the domestic and family violence problem that exists in the Northern Territory.

503. Given the amount of Police time and resourcing that DFV accounts for, the positions of Assistant Commissioner, Commander and

Superintendent, should be filled by the most experienced officers, who should be incentivised to stay in those roles. That is vital, in order to secure and build on a relationship of trust between NT Police and the DV sector. In particular, the Assistant Commissioner is the NTPF's representative on several key committees, so continuity in this role is extremely important in developing and maintaining critical partnerships.

504. The position of Assistant Commissioner in Charge of DFV and Youth is currently Assistant Commissioner Michael White, who received widespread thanks and recognition through the Inquest, for his assistance to the sector. I also heard evidence of the significant trust that the non government DFSV sector also has in Commander Sachin Sharma and Superintendent Kirsten Engels. I found the contributions of all three of these officers to these Inquests to be thoughtful and very helpful.

505. I received evidence that the existing Domestic and Family Violence Units ("DFVUs") (located in Darwin and Alice Springs) consist of some 64 personnel (out of which five constables are part time domestic violence officers), and there are also 11 members in the Strike Force Lyra unit, which works in conjunction with the DV and Crime Divisions to investigate and respond to reported DFSV.

506. I accept that NTPF anticipates that, when resources permit, the DFVUs will expand and I recommend that the DFVUs be sufficiently resourced to be able to appropriately respond to the domestic and family violence demands upon NT Police.

Recommendation 12: *A permanent NT Police DFSV Command*

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

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

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

(ii) Development of new NT Police policy documents

507. I heard evidence of the development of important new Police documents, including:

a. a Northern Territory Domestic, Family and Sexual Violence Doctrine, which will articulate the NTPF's responsibilities, goals and commitment in relation to responding to DFSV,

b. a Northern Territory Police Charter of Victim-Survivor Rights, which will prioritise the safety and welfare of victim-survivors, their families and their property. I am told that it incorporates rights to courtesy, compassion and respect, and

c. a new DFV General Order, which commenced in November 2023 and, amongst other changes, educates police on coercive control, updates issues in relation to risk assessment and imposes auditing obligations on an expanded Domestic and Family Violence Unit (DFVU). It includes a "tiered response" model to provide specific guidance on responding to DFV incidents.

508. I received evidence about the development of a police risk screening tool ("the PRST"), which provides a moment in time assessment of risk posed by an offender to a victim. The PRST is aligned with the Common Risk Assessment Tool (CRAT), which in turn is part of the NT Government's Risk Assessment and Management Framework (RAMF).

509. The development of these documents is to be commended; however, they must be implemented through effective training and resourcing, driven by specialist senior police who will require support and significant human resources.

510. I also note the submission that I received on behalf of the family of Kumarn Rubuntja, which asked me to make a recommendation that the Northern Territory adopt some of the elements of the Queensland Police Service's domestic and family violence reform, modified for this jurisdiction. Some of these elements are:

   a. implementing the Domestic and Family Violence Doctrine, which is a foundational document signed by the Commissioner and Deputy Commissioners that outlines the responsibilities, goals and shared commitment with respect to the prevention, disruption and response to DFSV,

   b. Establishing the First Nations Advisory Group whose role is to provide advice on reshaping the cultural capability of the organisation to address racisms as well as more culturally appropriate responses to DFSV,

   c. Training sessions with the Queensland Indigenous Family Violence Legal Services, addressing "what makes First Nations people a vulnerable group, understanding the impacts of government colonization policies and how they connect to intergenerational trauma and DFV, discussions around health, wellbeing, social and economic challenges intergenerational trauma create and the link to DFV, culture including

family/kinship relationships/language, understanding barriers to reporting by First Nations people, unconscious bias”,

d. establishing the DFV Advisory group that consists of Women’s Legal Services, DV Connect, Multicultural Australia, the Queensland Family and Children Commission and academia, which provides advice directly to the Commissioner,

e. developing compressive community specific cultural competency induction packages,

f. tasking the Deputy Commissioner with the role of ensuring the delivery of recommendations from the various Queensland reviews, and

g. establishing the DFV Transformation Board which advises on reform with intra and cross agency perspectives.

511. It may be that some of these would largely duplicate measures that are already being implemented or recommended; for the remaining elements, I encourage NT Police to continue to look at other jurisdictions, such as Queensland, that have implemented effective DFSV reforms to see if they can be appropriately and effectively adapted to this jurisdiction.

(iii) DV audits and the Family Harm coordination Project pilot

512. From the evidence before me, I am satisfied that there is a need for a renewed vigour in supervisory oversight at all levels of the Police response to domestic and family violence. This is relevant to all levels, including the JESCC response, and DV audits following Police attendance. This is important to ensure that the first response was appropriate, the investigation was thorough, the correct charges were laid, and consideration has been given to DVO applications and/or Supportlink referrals.

513. In particular, DV audits need to be more than "tick a box". I received evidence of examples of inadequate auditing that failed to identify obvious police failings. For example, the DV audit concerning the incident where Mr Abbott was alleged to have smashed Kumarn Rubuntja's power box on 16 May 2019 failed to identify the deficiencies in the police response. These included failures to inspect the power box or speak to witnesses and a failure to charge Mr Abbott, despite his admission at the scene to having committed an offence.

514. In November 2021, Police introduced a pilot project in Alice Springs and the Central Desert to review Police responses to domestic and family violence incidents, aiming to reduce the rates of domestic and family violence in the NT. This is the Family Harm Coordination Project (FHCP), and it involves Police officers and a civilian analyst undertaking a daily audit of intimate partner domestic violence incidents, to ensure that all administrative functions have been completed correctly, and then a holistic assessment that considers involved parties and their DV histories. A risk assessment is conducted that considers past and current behaviours. The FHCP provides a conduit member to share information with the Central Australia Women's Legal Service (CAWLS) and the Women's Safety Services of Central Australia (WoSSCA).

515. As of 1 September 2023, of the 3215 reported incidents of intimate partner violence, 1424 incidents had been reviewed by the FHCP. Of these, 100 had been tasked to frontline officers for follow up.

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

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

(iv) Protective custody

516. I have been told that NT Police is currently formulating a new alcohol policing strategy, which will focus on the key priorities of Prevention, Enforcement and Partnership. The Custody & Transport General Order has already been reviewed and proposed changes include permitting apprehending members to transport an intoxicated person and transfer custody of them to a suitable sober adult at a safe place other than a police watch house.

(v) specific changes to Police systems

SerPro

517. A new police computer communications and recording system ("SerPro") went live on 27 November 2023. It is designed to provide Police with better accessibility to relevant information about domestic and family violence histories. There is scope for building tailored reports to make the system content more relevant to assessments of DFV circumstances. At the time that the evidence was concluded in these Inquests, it was too early for an assessment of the effectiveness of this new system.

"May make false allegations" alert

518. In the leadup to these Inquests, NT Police identified the potentially problematic nature of the "may make false allegations" PROMIS alert that had been placed on Kumarn Rubuntja's person profile. It was identified that this type of alert has the potential to lead to allegations not receiving the appropriate level of investigation, because it can encourage prejudgment of credibility and the making of inappropriate assumptions. From an assessment of all of the relevant evidence before me, I think it was likely that this alert on Kumarn's profile did adversely affect the attitude of Police officers who were responding to her calls.

519. As of May 2023, NT Police deactivated all alerts of this type and prevented new such alerts being created in SerPro. Members were told that all allegations need to be properly investigated, despite the existence of an inactive alert of this type.

Misleading bail presumption flow chart

520. In deciding to grant bail to Kumanjayi Dixon on 2 November 2021, the arresting officers and their supervisor relied on a "Presumption of Bail Flowchart for Adults" that was misleading in relation to whether there was a presumption for or a presumption against bail.

521. I am satisfied that during the course of these Inquests, that misleading Flowchart has been replaced with a corrected document, and members have been notified accordingly.

Classification of domestic violence calls by JESCC

522. I received evidence of many examples of domestic and family violence calls being miscategorised by JESCC. I have been told that a number of measures have been adopted to enhance the performance of JESCC in responding to DFSV, including changes to the JESCC Standard Operating Procedures ("SOPs") and the new Domestic Violence General Order as it relates to Computer Aided Dispatch ("CAD") events.

Changes to JESCC SOPs in relation to delays

523. When Miss Yunupiŋu called 000 for help just before 3am on 30 June 2016 she was distressed and scared. She begged for Police to come and help her, but they did not arrive until after 7am and she had not been told that there would be a delay. At that time, there was no JESCC Policy that required her to be notified of the delay; however I have been told that this has changed. JESCC Standard Operating Procedures now dictate

that "if there are any delays in contacting the members to attend, the complainant must be called back to advise and obtain any update or changes in circumstances."

524. I commend each of these changes.

6. The role of child protection agencies

525. I am in no doubt that child protection workers in DCF and other agencies are motivated by a genuine desire to help and protect children at risk. I also have no doubt that their jobs are incredibly challenging, and that they work hard to deliver timely, consistent and well documented support, which is focused on maintaining the safety of the children they work with.

526. The work undertaken by child protection practitioners is critical in keeping our children safe.

527. I accept that these workers are under enormous pressure due to high workloads. During these Inquests I heard that an alarming 39.8% of DCF's child protection positions across the Territory are vacant. That is, 100% of the work is being undertaken by only 60% of the workers required. It is shocking to think that this situation can have been allowed to develop and to continue.

528. It is in this context that I consider the evidence I received of DCF failings in relation to some of these women and their children.

529. I note that not all of these four women had children, but DCF had dealings with each of the women who did. So as not to identify the children I will anonymise the examples below, but they all come from the evidence that I heard in these Inquests.

(a) The experience of mothers in contact with child protection agencies

530. I accept that there is often a reluctance for women to want child protection agencies to know when they experience domestic and family violence, because they are worried about the power that these agencies have to take their children into care.

531. I accept that this reluctance comes from a complex and traumatic history of child removal practices, which have particularly affected Aboriginal communities. The legacy of the Stolen Generation continues to impact the lives of Aboriginal families.

532. More recent child protection (and removal) practices also contribute to this reluctance; they are part of the lived experience of many in our community who have witnessed and experienced their children being removed. The reality is that Aboriginal children are 10.5 times more likely than non-Indigenous children to be in out of home care.[155]

533. There is reason, though, to be hopeful that progress is being made in child protection in the Territory, toward a more positive and constructive approach. I have been told that we are in the midst of the implementation of a fundamental shift in thinking in this area, the effects of which may take years to feel. This shift was explained to me as follows:

> "In August 2015, a special issue of the Child Abuse Review (vol 24, issue 4) was published, Domestic Abuse and Safeguarding Children, with a compilation of articles demonstrating how DFV (when following the dominant gendered pattern) should be viewed as an attack on the mother-child relationship...Within this context, contemporaneous policies and practices in child protection agencies across the world began to be identified as actively harming adult and child survivors of domestic violence and/or making it harder for them to access support or assistance. Such practices commonly included: constructing mothers who parent in the context of domestic violence as failing to protect their children, rendering invisible men who use violence by ignoring

[155] Office of the Children's Commissioner Northern Territory, *Our most vulnerable children bearing the consequences of a failed system: A thematic analysis of the needs of children aged 10 to 13 held in Northern Territory youth detention 2022/23*, (2024) at p20.

their perpetration patterns and fathering practices, and de-contextualising survivors' mental distress and/or problematic substance misuse. These constructs are reflected in the language commonly recorded in child protection assessments and broader documentation, such as, "The mother is failing to protect her children from her partner's violence", "The couple has a history of domestic violence", and, "She picks him over her children."

"Referred to now as **'DFV destructive' practice**, the approach blames survivors for the violence, listing them as alleged perpetrators of child abuse/neglect, and sees them as having power to stop the violence by making better choices. Child protection responses consistent with this approach dictate women to apply for a Domestic Violence Order (DVO), or leave the relationship. Failing to do so can result in their children being brought into care. Consequently, survivors are placed at an increased risk of violence, facing pressure to comply regardless of the consequences, and they are less likely to reach out to authorities for help. Perpetrators are able to exert more control over partners and children, and children face unnecessary removal. Furthermore, there are no connections made between issues, such as substance abuse and trauma caused by perpetrators, and no recognition of the role of coercion. Women's mental health issues and/or substance misuse arising out of the experiences of living with chronic trauma are often not well contextualised in practice and documentation, further stigmatising women as 'mad, bad or sad' thus relegating them to the ranks of the 'unfit mother' (Weare, 2017, in De Simone & Heward-Belle, 2020)."[156] (emphasis added)

534. I was told that these four deaths occurred during a period in which the NT DCF was transitioning to a new approach to child protection, away from an approach that was at times founded on "DFV destructive" practices, and towards a new **"DFV informed"** approach in the "Safe and Together Framework".

535. I accept that the old DFV destructive approach informed the agency's approach to some of these women and their children and that, at times, DCF child protection practitioners did in fact take a DFV destructive approach to these women and their children. I accept that for more than one woman, child protection practitioners viewed her as having the

[156] DCF Practice Review Report dated 6 June 2023, at [7] (Brief: 7-1A).

power to stop the perpetrator's use of violence and focused on her response to the violence, rather than focusing on the behaviour of the man using violence. DCF effectively held these women accountable for their children being exposed to violence, rather than holding the men who were using the violence accountable.

536. This DFV destructive approach resulted in DCF being unaware of the significant risk that more than one of these men posed to their partner.

537. The following examples demonstrate this DFV destructive approach:

a. one of these women was viciously assaulted by her partner, despite the existence of a DVO. In responding to a notification of this serious assault, the child protection practitioner determined that a child protection investigation was required due to that woman "allowing" her violent partner to "access" herself and her children,

b. DCF child protection practitioners removed one woman's children because they believed she posed a risk to them. They did this without considering how her behaviour was being affected by the many years of violence and control that her partner had subjected her to, and

c. child protection practitioners determined that one of these men was the Person Believed Responsible (PBR) for causing harm to his children, due to the violence he used towards their mother. This violence was one of the predominant factors in the Department's decision to apply for Protection Orders in relation to the children; however, DCF never spoke with this man about its concerns in relation to his behaviour. Instead, the Department's sole focus was on the mother and the risk *she* posed to the children.

538. I accept that taking a DFV destructive approach to child protection tells perpetrators and victim-survivors that perpetrators will not be held accountable for their violence and that, instead, victim-survivors will be

the ones held accountable. It exposes a double standard of expectations for mothers and fathers: a high expectation of the mother, with a focus on her response to his violence, and her efforts to keep herself and the children safe; and a corresponding low expectation of the father and a lack of focus on his behaviour and choice to use violence.

539. In 2019, DCF commenced the five year roll out of the Safe and Together Framework, the Signs of Safety Framework and the Signs of Success Practice Framework. This roll-out is a paradigm shift in DCF's child protection practice, from DFV-destructive practice towards DFV-informed practice. The latter "relies on child protection practitioners partnering with victim survivors and intervening with perpetrators".[157] It is primarily defined by policies and practices that focus on child safety and wellbeing, recognise survivor strengths, hold perpetrators accountable, and see DFV intervention as a core part of child protection practice."[158]

540. I find that each of the four women who had children would have benefitted from DCF child protection practitioners taking a domestic and family violence informed practice approach, consistent with the Safe and Together Framework.

541. I accept that women who have experienced a "DFV destructive" approach from child protection practitioners are unlikely to seek assistance from those same workers in relation to the domestic and family violence they are experiencing. They simply do not trust the Department and its employees to help them.

542. I am hopeful that the implementation of the Safe and Together Framework, and its DFV informed practices will lead to constructive relationships between child protection practitioners and women experiencing domestic violence, and that these relationships will provide a safe environment for women to disclose violence that they are

[157] Closing submissions on behalf of DCF, dated 11 October 2024 at [12].
[158] DCF Practice Review Report dated 6 June 2023, at [11] (Brief: 7-1A).

experiencing. I am hopeful that the implementation of the Framework and DFV informed practices will build trust with families and communities.

543. To ensure that this "fundamental pivot" has been achieved, I recommend DCF conduct an audit of the Safe and Together Framework roll out.

Recommendation 14: *Continued commitment to Safe and Together Framework*

DCF should demonstrate its continued commitment to the Safe and Together Framework by conducting an audit into the implementation of the Framework, to ensure that the roll out has been effective and complete.

(b) The needs of young people affected by DFSV

544. I received evidence that there are limited services that support DFSV victims who are young. For example, many women's shelters do not accept victims who are under 18 years of age.

545. There are also few support services for young people who are perpetrators of violence. If a young person is referred to diversion programs under the pre-court diversion process, there are no specific programs that cater for DV perpetrators who are minors.

546. DCF accepts that there are not enough services in remote communities, including services for young people. I have been told about Programs that are available; however, DCF accepts that there are not enough primary prevention and early intervention services.

Recommendation 15: *Young people engaged in violence*

The NT Government should fund, and DCF should develop and implement, timely and intensive early interventions for young people who are reported

as being involved in DFSV (as victims or perpetrators), consistent with the Safe and Together Framework and in an attempt to prevent further DFSV.

These should be in addition to existing programs. This expands on an existing action 3.10 of Action Plan 2.

(c) Community based approaches to child welfare

547. On behalf of the Rubuntja, Ragurrk and Yunupiŋu families it was submitted that there have been major failings by DCF in relation to:

   a. a "breakdown of trust" between DCF and the Aboriginal community due to the Department's previous "DFV destructive practices",

   b. a failure to deliver or fund sufficient DFSV programs for young people in remote communities, and

   c. "justified difficulties" that Aboriginal people have in being able to trust child protection agencies.

548. DCF are working to address the first of these failings by the rollout of the Safe and Together Framework, the importance of which is discussed above.

549. DCF resists the second criticism on the basis that the lack of services in remote communities is due to funding constraints outside the Department's control. It submits that under Action Plan 2 the Department is taking steps to strengthen and expand its prevention and early intervention initiatives. My recommendations in relation to funding aim to strengthen the services across the Territory and a specific recommendation is directed to the delivery of DFSV programs to young people.

550. DCF submits that the final criticism ignores the policies and structures that the Department already has in place, such as Aboriginal Practice Advisors, who provide high level advice on the delivery of effective and culturally appropriate Aboriginal child and family services, and the Signs of Safety and Child Wellbeing and Safety Partnership (CWSP) Frameworks" which focus on community-based approaches to child protection and safety. I was told that these Frameworks operate across the Northern Territory and invite place-based cultural advice and leadership regarding the safety and wellbeing of children and families, and aim to empower families and their networks to plan together to achieve safety.

551. On behalf of the Rubuntja family it is submitted that more needs to be done by DCF to effect the meaningful change that is needed in the relationship between DCF and the Aboriginal community and that this change needs to be "wholly devised on the views of Aboriginal people".[159]

552. DCF submits that these Inquests do not provide a suitable context to examine the adequacy of the Signs of Safety and CWSP Frameworks or their implementation and I do not propose to examine these Frameworks; however, I do not accept that the existence of these Frameworks and other DCF policies and practices fully answer the criticism advanced on behalf of the families. I accept that DCF still have work to do in building trust with the Aboriginal community.

553. On behalf of the Ragurrk and Yunupiŋu families, it is submitted that DCF should partner with Aboriginal Community Controlled Organisations to develop community-based responses to child welfare notifications involving domestic and family violence. The Mikan Child Protection Reference Group was provided as an example of a successful community controlled, community led approach to keeping children safe

[159] Closing submissions on behalf of the family of Kumarn Rubuntja, dated 27 September 2024 at [81].

and families together. It is a "grass roots" Yolŋu program. Gabrielle Brown, on behalf of DCF, gave evidence that she

> "...would consider Mikan to be one of those ones where local people got together with the local staff and found a very proactive, very impressive solution for making shared decision-making for the children. And...for the children who come to the attention of the Mikan group, around making solutions and ideas, that actually...has made a huge benefit to those children."[160]

554. An evaluation of the Mikan program found that:

> "The model formally embeds local decision making into child and family matters and signals a fundamental change to the landscape for child protection in East Arnhem. The support offered through Mikan is invaluable to ensuring decisions that are premised on Yolŋu cultural values and sensibilities, ensure that children retain their connection with family, clan, community and country."[161]

555. I received evidence that, despite receiving an excellent evaluation, no efforts have been made to roll out similar programs in other parts of the Territory. I accept the submission made on behalf of the Ragurrk and Yunupiŋu families that effective grass roots initiatives, such as Mikan, should be supported and expanded, and I recommend that DCF do this.

Recommendation 16: *Community-based approaches to child welfare*

The NT Government should provide additional funding for existing and developing community-based approaches to child welfare (such as the Mikan Child Protection Reference Group in East Arnhem) and for research into how community models may be expanded to increase the safety and wellbeing of children in remote NT communities.

556. Finally, on behalf of the Rubuntja family, I am reminded that DFSV-ICRO established the Aboriginal Advisory Board on Domestic, Family and Sexual Violence to provide advice to the Minister for Prevention of

[160] Evidence of Gabrielle Brown on 31 October 2023, at T136.
[161] Mikan Reference Group Evaluation Report (Common brief: 7-73).

Domestic, Family and Sexual Violence in relation to improving the prevention and response to DFSV as it impacts upon Aboriginal people, communities and services". It is submitted that this Board, or a similarly constituted board, could advise DCF on how it should reform itself to rebuild trust with the Aboriginal community.

557. This submission has merit and I encourage DCF to consider how it could seek advice from this Board or a similarly constituted board in relation to this important issue.

(d) Systems failings

558. I received evidence of a number of specific failings by the Department of Children and Families. These included:

a. when DCF received a notification that a child had been exposed to the violence that one of these women was experiencing from the man who ultimately killed her, the Intake officer prepared but did not send a request to NT Police for that man's criminal record. Then the notification was closed without having received that vital information. Had DCF received that criminal history (which was significant), the notification would not have been finalised. The DCF child protection practitioner could be expected to have acted, such as by preparing a safety plan with the woman, and/or to have assisted her in applying for a DVO,

b. DCF referred one woman and her child to an Intensive Family Preservation Service ("IFPS") in relation to that child's poor school attendance. At the time of the referral, DCF was aware that the woman was experiencing domestic and family violence, but it did not task that support service to deliver services for DFSV. In fact, the information accompanying the referral made only a minimal reference to it, and that reference was framed in the context of the woman's jealousy, that is, it was in DFV-destructive

language. The IFPS did not identify the significance of the DFSV reference in the referral,

c. one of the women agreed to a referral to the Stronger Families Program for support with alcohol and drug use, housing and other issues, to work towards reunification with her children, DCF failed to send the referral and then effectively criticised that woman for "not engaging with supports to change her behaviour",

d. final orders had been made for the children of one of the women, granting parental responsibility to the CEO of DCF until the children turned 18. Those children were in a kinship placement when they were removed by a family member. DCF were subsequently notified that they were living with their mother and the man who had subjected her to significant domestic and family violence. DCF failed to take any action: no risk assessment was undertaken and DCF did not make any effort to speak with the mother or the children. This failure meant that DCF was not aware of the level of risk that this woman was in at that time. Tragically, she was killed just four months later.

559. Had DCF not taken steps to address these failing, I would have recommended that they do so; however, I have been told that they have, including:

a. partnering with NT Police to co-locate a police officer within DCF's Central Intake Team two days per week,

b. negotiation of a new data access agreement with NT Police,

c. transitioning to a new client information management system (CARE), which has a work tray specifically for notifications "awaiting information",

d. implementation of Safe and Together practice has influenced DFV-informed practice in the Central Intake Team,

e. CIT requests for police involvement histories and criminal histories are now submitted through a single email account, to permit better monitoring, and

f. integration workshops have been delivered to IFPS providers to build staff competencies around DFSV and improve cross-system collaboration.

7. Responses of the justice system

(a) DV Specialist Court

560. In July 2020 a trial commenced of a specialist court approach to domestic and family violence-related crime at Alice Springs Local Court. The specialist approach uses a trauma-informed approach to court proceedings and was developed in consultation with local service providers with aims to:

a. improving safety, and reducing re-traumatisation for persons who have experienced domestic or family violence, including children, by prioritising the safety of victims through a range of practical mechanisms; and

b. encouraging offenders to take responsibility for their actions and increase opportunities for them to change their behaviour, by imposing additional levels of accountability upon offenders, compared to traditional sentencing regimes.

561. The Registrar of the Specialist Domestic and Family Violence list in Alice Springs, Maria Le Breton, gave evidence of particular aspects of this specialist approach, including the accountability mechanism that involves men returning to Court regularly to report upon the status of their rehabilitation through attending a Men’s Behavioural Change Program.

562. I accept that "very few men voluntarily approach a men's behaviour change program to seek help"[162] and that the specialist approach provides a legal mechanism to require men to undertake such a program.

563. Registrar Le Breton also gave evidence of the significant resourcing constraints that affect the operation of the Specialist Approach, such as the limited resourcing of the Tangentyere Men's Behavioural Change Program that participants are referred to.

564. An initial evaluation of the specialist approach showed significant positive results. Of the thirteen domestic violence offenders who were placed on the Specialist List during the trial of the Specialist Approach and who successfully completed the Tangentyere Men's Behavioural Change Program, *none* had committed any further domestic violence offences by the time of the evaluation.

565. I strongly recommend that the specialist approach be expanded to increase its capacity in Alice Springs, and adapted and implemented in other courts across the Territory, and that adequate funding be provided for this.

Recommendation 17: *Specialist DFSV Court*

The NT Government should provide increased funding to allow for an expansion of the specialist court approach in Alice Springs to other courts (prioritising Darwin and Katherine) and to adapt the model for bush courts. This expands on existing AP2 actions 2.2(a-e). The increased funding should be sufficient to enable:

i. Funding of the suite of services required to support the work of the court, including victim support and risk assessment, offender support and risk assessment and behaviour change programs (including partner contact services), and legal advice and representation for both parties.

[162] Statement of Michael Brandenburg dated 6 October 2023, at [9] (Common Brief 1-1).

ii. Following the commencement of the *Sentencing Legislation Amendment Act 2023*, adaptation of the current specialist court model, particularly in relation to the introduction of new community based orders and the requirement of the court to consider whether there is unacceptable risk of DFSV in sentencing.

iii. A trial to determine the extent to which restorative justice practices can be safely incorporated into the model.

(b) ADR - Mediation/peacekeeping

> ***"We need to go back to the old ways, where we have a mediation within our communities where the elders would be back in that circle".***
>
> Tangentyere Women's Family Safety Group Submission,
> Review of Legislation and the Justice Response to DFV in the NT

566. From the evidence before me, I am satisfied that there is a need for highly qualified, highly skilled, trauma informed and culturally appropriate mediation services in the response to domestic and family violence.

567. For example, a manager from Anglicare Nhulunbuy told me that, while a lot of Balanda service providers were trying to help Miss Yunupiŋu, there was no real engagement with Yolŋu, except for Mr Marika's family. She expressed her strong support for engagement of a mediation service that would involve family in future cases like Miss Yunupiŋu's.

568. I accept that skilled mediation and peacemaking services would likely be enormously beneficial at the following points:

   a. to assist parties to resolve conflict in a way that might limit a victim/survivor being put back in a position of risk. For example,

instances like when Miss Yunupiŋu returned to live with Mr Marika's family,

b. to assist parties to resolve conflict that arises out of jealousy issues, or a major past upset or perceived wrong, that can linger for months,

c. to help reduce tensions that flare up immediately after someone is seriously injured or killed. For example, the families and communities of Kumarn Rubuntja and Mr Abbott would have been greatly assisted by highly skilled and culturally safe mediation services to help with significant the tensions that built between them when some family members did not accept the overwhelming evidence that Mr Abbott was responsible for Kumarn's death, and

d. to help reduce tensions that can lead to more serious violence, when court proceedings related to a death come up many months, or even years after the death. For example, the criminal and later coronial court processes related to the death of Kumarn Rubuntja.

569. Justine Davis gave evidence about traditional peacemaking, which many remote communities throughout the NT continue to practice, but this is mostly unpaid and without resources. Peacemaking groups include:

a. Mawul Rom Mediators (Arnhem Land),

b. Pongki Mediators (Tiwi Islands),

c. ARDS Napuŋguwuy team (ARDS supports and facilitates peacemakers, in Nhulunbuy (and the greater Miwatj area), Galiwin'ku, Miliŋimbi, Ramingining, Gapuwiyak and surrounding homelands),

d. Groote Eylandt peacemakers (Groote Eylandt),

e. Kurdiji Mediators (Lajamanu),

f. Southern Tanami Kurdiji Indigenous Corporation peacemakers (Yuendumu and Willowra),

g. Watjarr group (Ngukurr),

h. Pekpek Marda group (Wadeye), and

i. Ali Curung mediators.

570. Training for the groups has been provided by a number of organisations, primarily the Community Justice Centre (CJC), NAAJA, and Mawul Rom, and some consultancy groups. The training is based on best practice guidelines of being community led and driven, with a focus on capacity building, two way learning and sustainability.

571. I am mindful of the evidence of Professor Marcia Langton that:[163]

> "We will not see any improvement in the reduction of violence without Aboriginal leadership and the creation of programs at the very local level by local Aboriginal leaders. It is a vital part of what is necessary to tackle the rising rates of violence."

572. I find that there is an important role for skilled mediators and peacemakers as part of the broad response to domestic and family violence, and that this is a good example of empowering Aboriginal leaders.

Recommendation 18: *Culturally appropriate, trauma informed, mediation/peacekeeping for family and community violence*

The NT Government should fund and ensure trained (including some PARt and RAMF trained) mediators are available to work in conflict resolution processes relating to family and domestic disputes. Adequate funding should include provision for remuneration, training, coordination and exchange of information, and the investigation of opportunities to fund law and justice groups to support, participate in or lead mediations. Peacekeeping groups should include both cultural and DFSV expertise.

[163] Evidence of Professor Marcia Langton, 31 October 2023, T108.

573. In addition, I accept the submission made on behalf of the Ragurrk and Yunupiŋu families that the NT Government should recognise the skill and expertise of community-led mediation and peacemaker groups that are already operating in Remote Communities, by recognising, regulating and funding them as Alternative Dispute Resolution (ADR) service providers, where those groups consent to this model.

Recommendation 19: *ADR recognition for Community-led mediation and peacemaker groups*

Community-led mediation and peacemaker groups operating in remote NT communities should be recognised, regulated, and funded by the NT Government as Alternative Dispute Resolution (ADR) service providers, with their consent.

574. The families of Ms Yunupiŋu and Ngeygo Ragurrk make a "radical" proposal that DVO applications should be able to be referred for alternative dispute resolution (ADR), with the consent of the person in need of protection, when it is appropriate and safe to do so. I have considered the submissions made in support of this proposal, which are founded on the idea that ADR is a restorative justice practice that could be safely incorporated into the specialist DFSV Court model.

575. These submissions drew on Recommendation 122 from the Final Report of the Victorian Royal Commission into Family Violence:

> "Recommendation 122: The Department of Justice and Regulation, in consultation with victims' representatives and experts in restorative justice, develop a framework and pilot program for the delivery of restorative justice options for victims of family violence. The framework and pilot program should have victims at their centre, incorporate strong safeguards, be based on international best practice, and be delivered by appropriately skilled and qualified facilitators [within two years]."

576. Reference was also made to the evidence of Ms Jeanette Kerr in the Inquest into the Deaths of Wendy Murphy and Natalie McCormack [2016] NTLC 24 that:

> "A more community based model may provide an option that would also not lead to the victimisation to which these women might be subjected using the current system. Such models need to be appropriately considered and any trials properly resourced."

577. I think it is appropriate that the NT Government consider whether the Local Court should have the power to refer DVO Applications for alternative dispute resolution, with the consent of the person in need of protection, if it is appropriate and safe to do so. The Government should also consider whether Law & Justice Groups and Community Courts operating in remote NT communities should be empowered and enabled to consider the operative period and terms of DVOs, if those groups and Courts are working well.

(d) Commitment to enhancing alternatives to custody for perpetrators of domestic and family violence in the Northern Territory

578. The Northern Territory has the highest rate of imprisonment in Australia, by far. The Territory's rate of 1026.6 inmates per 100,000 adults eclipses the nearest state, which is Western Australia with 293 inmates per 100,000. Around 1380 inmates are in custody for domestic and family violence related offences.

579. The only restorative justice project currently operative in the Territory is the Alternative to Custody program in Alice Springs for women over 16 who are at risk of reoffending. This is a 26 week program that incorporates painting-based therapies, storytelling and sharing of personal stories. It has a ten bed capacity and, at the time of the Inquests, 33 women had participated with a markedly low rate of reoffending.

580. I accept that there is a real need for culturally based programs to address deep-seated issues of trauma, loss and grief.[164]

581. I received evidence that the development of Alternatives to Custody (ATCs) are a central component of the NT Aboriginal Justice Agreement. These programs are generally intended to:

   a. be located on country,

   b. be available for self-referral, orders, or through a Community Court proceeding or a judge's sentence,

   c. use interpreters for many programs and counselling sessions,

   d. have a needs assessment on intake,

   e. offer psychological support and counselling through individual and group sessions,

   f. include behaviour change programs such as DFV specialist programs,

   g. incorporate exercise and occupational therapy, library visits, arts and crafts programs,

   h. include life-skills courses, including family support, financial and legal literacy;

   i. provide general preparation of participants for return to home community or access to safe housing elsewhere; and reintegration back into communities, and

   j. have a strong robust governance framework that includes participation across government, non-government and specialist service providers.

[164] Report of Professor Harry Blag "Rehabilitation and Diversionary Programs delivered to Aboriginal Men and Women in Prison in the Northern Territory", Final report August 2022, at p10.

582. I was told that the Aboriginal Justice Unit aims to have five ATCs operational across the NT by the end of 2025. These will include specialist DFV services for men and for women and children and families.

583. I have also been told that NT Corrections have established two bail supported accommodation programs, as an alternative to custody, in partnership with the Salvation Army.

584. I commend and encourage these efforts to develop and implement alternatives to custody for perpetrators of domestic and family violence, noting that the safety of victims of domestic and family violence must remain the paramount concern.

Recommendation 20: *alternatives to custody for perpetrators of domestic and family violence*

The NT Government should commit to enhancing, developing and funding alternatives to custody for perpetrators of domestic and family violence within the NT.

(e) The CVSU, NT Charter of Victims Rights & NT Victims Register

585. The Crimes Victims Services Unit (CVSU) was established under the *Victims of Crime Rights and Services Act 2006* and its main functions include:

a. administering the financial assistance scheme and counselling scheme established under the *Victims of Crime Assistance Act 2006*,

b. operating the Victims of Crime Register, and

c. overseeing the operation of the Charter of Victims' Rights.

586. The financial assistance scheme established under the Victims of Crime Assistance Act 2006 pays financial assistance of up to $40,000 to victims of crime who have suffered financial loss or injury as a result of a violent act. This may be paid to a primary victim, a secondary victim such as an eyewitness or close family member who suffered an injury as a result of becoming aware of a violent act, or family victims of someone who has died as a result of a violent act. Up to $5000 immediate financial assistance can be paid to victims of violent crime who are experiencing financial hardship and have urgent out of pocket expenses, such as relocation expenses, dental or counselling expenses.

587. Victims of violent or sexual offences are able to apply to become a "Registered Victim", and those persons are then added to a “Victims Register”. As part of operating the Victims Register, CVSU will inform NT Corrections when a person is registered as a Registered Victim, and this initiates information sharing between Corrections and the CVSU. Having received the relevant information from NT Corrections and other stakeholders, the CVSU are tasked with informing Registered Victims of the progress of an offender through the correctional system, including any consideration of release on parole.

588. I accept the evidence I received that the demands upon the CVSU exceed its capacity. This is reflected in enormous wait times for the processing of applications for Victims of Crime Compensation, which take on average four years but can take up to nine years to determine. I received evidence that Kumanjayi Haywood had made one of these applications on 19 May 2017, which had not been finalised by the time of her death on 7 November 2021. Another eighteen applicants passed away in 2022-2023, before their applications were finalised.

589. I received evidence of the deficiencies associated with engaging a victim of domestic and family violence in the parole decision making process. This engagement is through the Crimes Victims Services Unit when the victim is registered on the Victims Register; however, for this system to operate effectively, victims are required to formally sign up to the CVSU

Victims Register. For a number of reasons, many people do not complete this process, and as a result, are not registered and do not receive engagement from CVSU. This means that they are neither engaged in the parole decision making process, nor are they notified when their perpetrator is to be released from custody.

590. NAAFLS, on behalf of the Ragurrk and Yunupiŋu families, urge me to make three recommendations to improve the processes for DFV victims to be engaged in the parole decision making process, and for them to know when the perpetrators of violence against them are being released. I find that the proposed recommendations are well considered and designed to enhance the safety of DFV victims.

591. First, it is proposed that the Victims Register be an opt out system. This appears to have merit. I agree with Professor Langton that it is "disturbing" that the "laxity of the system" allows "offenders back into the community without any notification of the victims or the victim's families."[165] I accept that the Victims Register enables victims to engage services, such as Aboriginal Community Controlled Organisations operating in remote communities, to safety plan for the inevitable return of the perpetrator. Every effort should be made to have as many DFV victims as possible on the Victims Register, and implementing an "opt out" system would be an effective way to achieve this.

592. In addition, submissions on behalf of the CVSU suggest that consideration should be given to how the Victims Register can be used to share information with victims in relation to:

   a. inmates released to sentences of "time served", and

   b. persons found unfit to plead and dealt with under the provisions of Schedule IIA of the *Criminal Code.*

[165] Evidence of Professor Marcia Langton on 31 October 2023, at T109.

593. I agree that it is important that efforts be made to share this information with victims, in an effort to improve victim safety.

594. I accept that implementation of this recommendation will require adequate resourcing. I find that the value in implementing these recommendations would be an appropriate use of resources in the response to the epidemic of domestic and family violence.

Recommendation 21: *The NT Victims Register to be an opt-out system*

The operation of the NT Victims Register should be reviewed to consider whether it should be as opt-out system of registration. Such a review should consider how the Register can be used to notify victims of the release of inmates to "time served" and those inmates dealt with under the provisions of Schedule IIA of the *Criminal Code*. If those changes are made, the NT Government should provide CVSU with a corresponding increase in funding.

595. Secondly, the submissions on behalf of the Ragurrk and Yunupiŋu families propose that the NT Charter of Victims' Rights be updated, expanded and embedded in the *Victims of Crime Rights and Services Act 2006*. I accept that the rights contained in the Charter of Victims' Rights should be better supported by all areas of government and that embedding the Charter in legislation would provide the primacy of a legislative enactment. I also accept the submission on behalf of the CVSU that a full and frank consultation process is required to consider whether embedding the Charter in legislation may have any unintended consequences.

Recommendation 22: *Update to NT Charter of Victims' Rights*

> The NT Government should consider whether the Charter of Victims' Rights should be embedded as a new Part 5A of the *Victims of Crime Rights and Services Act 2006* (NT).

596. Thirdly, the Ragurrk and Yunupiŋu families urge me to recommend that the Charter be expanded to include the rights of interested persons in s40(3) of the *Coroners Act 1993,* and that the means to exercise these rights should be included in the information to be given to persons on the NT Register.

597. The CVSU submits that consideration of this expansion to the Victims Register should include an appropriate consultation process, and that, if it is so expanded, persons on the Register would be given information about their rights as interested persons pursuant to s40(3) of the *Coroners Act*. I acknowledge that consultation would be appropriate.

8. The role of the Department of Corrections

598. The role of the Department of Corrections in implementing sentencing and bail orders of our courts is twofold:

   a. to secure prisoners for the safety of the wider community and victims of violent offences, and

   b. to equip prisoners with tools and skills to rejoin society and lead a productive and law abiding life, including by providing clinical intervention aimed at changing criminogenic behaviours.

599. The Department of Corrections has an important opportunity to deliver evidence-based practices to change the attitudes and entrenched behaviours of DFV offenders, who treat women as inferior.

600. Like all agencies involved in the response to the epidemic of domestic and family violence in the NT, this Department is under-resourced to be able to fulfil these core functions. Specifically, there has been a chronic lack of investment in funding for and evaluation of programs in custody to assist in the rehabilitation of men who commit domestic and family violence. The effect of this is that opportunities are missed on a daily basis, to intervene in the cycle of domestic and family violence in the Territory.

(a) Mr Marika, Mr Nawirridj, Mr Abbott and Kumanjayi Dixon

601. I received evidence of the custodial histories for Mr Marika, Mr Nawirridj, Mr Abbott and Kumanjayi Dixon. In particular:

a. Mr Marika undertook the Indigenous Family Violence Offender Program (three times – but withdrew before completing the third), the Alcohol Treatment Program, the Alcohol and Other Drugs Program, the Drink and Drug Driver Education Program, the Safe Sober Strong Program (twice). He had never met the "minimum period to serve" eligibility requirements for Offence Specific Programs. In the community, he completed the Family Violence Offender Program (twice) and attempted residential rehabilitation unsuccessfully once. He completed the RAGE program in June 2024,

b. Mr Nawirridj completed the Family Violence Program, the Alcohol and Other Drugs Program and a number of Safe Sober Strong sessions. He never met the "minimum period to serve" requirement to be eligible for Offence Specific Programs. In the community he attempted the CAAPS and FORWAARD residential rehabilitation programs, but did not complete them. He is currently waitlisted for the RAGE program,

c. Mr Abbott completed the Family Violence Program, Alcohol Awareness Program and the Brief Intervention Anger Management Program. He commenced but did not complete the Violent Offender Treatment Program (VOTP), due to aggressive behaviour toward a program facilitator and lack of engagement. He declined to participate in an Offence Specific Program, residential treatment programs and the Tangentyere Council Men's Behaviour Change Program. He was reluctant to complete programs to address his offending behaviour and alcohol abuse. He is waitlisted for the RAGE program, and

d. Kumanjayi Dixon undertook the Family Violence Program (FVP) and the Alcohol Treatment Program, but was never eligible for Offence Specific Programs because of the "minimum period to serve" requirement. In the community, he completed the FVP again, as well as the CAAAPU and Venndale residential rehabilitation programs.

602. I am satisfied that:

a. each of these men had been sentenced to full time imprisonment many times, including for very serious violence against women. Often they were released without any supervision or other conditions upon them, because they had served short sentences or they had served their entire sentence in gaol because parole was refused,

b. each of these men had undertaken programs in custody in relation to alcohol and other drug abuse, and family violence. Sometimes those programs were undertaken numerous times, but were clearly inadequate to curb their drunken and violent offending against women, and

c. only one of the men had been eligible to undertake Offence Specific Programs, due to the "minimum time to serve"

requirement (they were on remand or their minimum period to serve was too short).

603. I heard numerous examples of these Offenders refusing to accept responsibility for their violent offending, instead blaming their victims. Their attitudes towards their partners and their own use of violence are unacceptable and demonstrate that more needs to be done to intervene when these attitudes exist. Periods in custody are an excellent opportunity for intervention to occur, so part of our response to the shocking rates of domestic and family violence must be to enhance and expand the DFSV related programs that are available to inmates.

604. I also note the practical effects of failed parole attempts, which can be seen in the case of Mr Marika, who was repeatedly refused parole in 2011-12 and ultimately served his complete sentence. An unfortunate consequence of his multiple failed parole applications during that time was that, if it had been known from the outset that Mr Marika would serve his full sentence, NT Corrections would likely have assessed him for participation in an offence specific program.

605. In addition, the multiple failed parole attempts appear to have resulted in the change of attitude demonstrated by Mr Marika: his motivation to change and participate in rehabilitation and other programs early in that sentence, disappeared as his parole applications were refused.

(b) Availability of programs in custody

606. I had the benefit of receiving evidence from Commissioner Matthew Varley and psychologist Dr Natalie Walker, who is the Director Offender Services and Programs at Corrections. I found that they are both thoughtful and committed professionals, who are clearly troubled by working in an environment with such a deficit for programs.

607. The programs delivered by NT Corrections fall into four categories: psychoeducational programs, offence related programs, offence specific programs and individual treatment.

608. *Psychoeducational programs* are relatively short in nature (typically two weeks or less) and designed to provide participants with information, motivation and skills to assist them in addressing their offending behaviour. Both remand and sentenced inmates are eligible for these programs, which include:

a. the Family Violence Program (FVP), which is a group-based, gazetted perpetrator program that was developed by Aboriginal women. It challenges attitudes and behaviour and aims to assist participants to develop capacity to accept responsibility for the violence they have committed. This program is run in custody and in the community, as a five day program,

b. the Safe Sober Strong (SSS) program consists of 15 stand alone modules over 37.5 hours, and aims to provide an intervention opportunity for all inmates, whether they are on remand or serving a sentence. It uses a Cognitive Behaviour Therapy approach to increase a prisoner's awareness of offending behaviour, and to provide strategies that enhance pro-social thinking and goal setting,

c. the Addictive Behaviours Program (ABP) is delivered over eight sessions of two hours' duration, and is designed to increase participants' understanding and self-awareness of factors that contribute to alcohol or drug use, and other addictions such as gambling or solvent abuse and the relationship to offending behaviour.

609. *Offence Related Programs* are programs designed to address factors related to offending behaviour, but not specific to a type of offending. Sentenced inmates with more than 24 months to serve, and all sexual

offenders, are eligible for these programs, but have to undergo a specialised assessment before participating. They include:

a. the Intensive Alcohol and Drugs Program (IADP), which is designed for inmates with a chronic alcohol or illicit drug problem and is delivered by two, three hour sessions a week over three months.

610. *Offence Specific Programs* are designed to address criminogenic needs for particular types of offending. The intensity (length and duration) of the program is designed to reflect the offender's risk of recidivism. They are longer than psychoeducational programs and involve significantly more face-to-face time with the offender. Moderate intensity programs suitable for offenders at moderate risk of re-offending are typically three months in duration, whereas high intensity programs suitable for offenders at moderate to high risk of reoffending are typically six months in duration. Sentenced inmates with more than 24 months to serve, and all sexual offenders, are eligible for these programs but have to undergo a specialised assessment before participating. These programs include:

a. Recognising Anger & Gaining Empowerment (RAGE), a six month program developed for Aboriginal people in the Northern Territory to treat people who have engaged in DFV. It is delivered across two, three hour sessions per week that are designed to address the dynamic risk factors that underpin domestic violence. It was implemented in 2017 and is the only technically offence specific DFSV program available in the NT,

b. the Violent Offender Treatment Program (VOTP), a six month group-based program, which is delivered in two, three hour sessions per week. It identifies and treats the underlying attitudes of a person who commits serious acts of physical violence, exhibits a willingness to inflict harm on others and has feelings of justification and an attitude of entitlement related to doing so,

c. the Violent Offender Treatment Program-Moderate (VOTP-Mod), a low to moderate intensity program designed to meet the intervention needs of low to moderate risk violent offenders. It is delivered by two, three hour sessions per week over four months, and

d. the Sexual Offender Treatment Program (SOTP), which treats offenders with a high or moderate-high risk of sexual recidivism.

611. Individual treatment programs are usually modified forms of the offence specific or related programs, delivered one on one to inmates who are unable to undertake the programs delivered in a group, because of, for example, language barriers or cognitive impairment.

612. There are other programs, which are delivered by other government and non government organisations, including NT Health's Prison in-reach Alcohol and Other Drugs program, the Alternatives to Violence Programs; Jalia Wanti (Central Australian Aboriginal Congress); Cross Borders Indigenous Family Violence Program (NT, SA, WA); DASA Safe and Smart; Lutheran Community Care; Narcotics Anonymous; NAAJA Throughcare; and Anglicare pre- and post-release support.

613. Three other services are of note:

a. Venndale Residential Rehabilitation Centre is a 12-week residential rehabilitation program delivered by Kalano Community Association Aboriginal Corporation about 35 km from Katherine. This program is designed to address alcohol and drug use,

b. FORWAARD AOD is an Aboriginal Corporation based in Darwin that provides a range of Alcohol and Other drugs programs, and

c. the Central Australian Aboriginal Alcohol Programs Unit (CAAAPU) is an Aboriginal controlled provider of alcohol counselling and residential treatment services, on the rural outskirts of Alice Springs.

614. I accept that NT Corrections policy concerning eligibility based on "minimum sentence left to serve" requirements is founded upon research into recidivism, which suggests that while offenders who complete treatment programs reoffend at lower rates than those that don't, offenders who commence but do not complete a treatment program reoffend at a higher rate than those who do not commence treatment.

(c) Risk-Needs-Responsivity model of offender assessment

615. Offender Services & Programs adhere to the Risk-Needs-Responsivity (RNR) model of offender assessment and rehabilitation:

    a. Risk refers to the importance of using appropriate assessment tools to determine an inmate's risk of recidivism: *who* to treat. The Violence Risk Scale (VRS) and Spousal Assault Risk Appraisal guide, version 3 (SARA V3) is used for suitability assessments for offenders convicted of domestic and family violence offences,

    b. Needs refers to ensuring that interventions address the dynamic criminogenic needs for that individual (these are the factors that are empirically linked to offending): *what* to treat, and

    c. Responsivity refers to providing treatment or intervention to offenders in a way that meets their unique characteristics and maximises learning: *how* to treat. For example, treatment programs should deliver interventions that are culturally appropriate and suit an offender's cognitive ability, learning style, and motivation.

616. While the Risk-Needs-Responsivity Model's risk assessment tools have not been validated for Aboriginal or Torres Strait Islander people, NT Corrections have urged me to be cautious in any criticism of this model. It is submitted that, in the absence of risk assessment scales that have

specifically been validated for Aboriginal or Torres Strait Islander people, "not using risk assessment scales is likely to be even more harmful to Indigenous peoples than using scales with differential accuracy".[166]

617. To address the deficiencies of using assessments that are not validated for Aboriginal people, NT Corrections have made efforts to ensure that use of existing assessment tools is underpinned by a culturally informed understanding of personal, situational and contextual factors that are relevant to conceptualising an individual's risk. In particular:

   a. staff working within the Offender Programs, Throughcare and Custodial space have received cultural competency training from Dr Tracy Westerman AM,

   b. there will be trauma informed practice training to be delivered in early 2025 specifically for Offender Programs staff (Community Corrections already provides this training),

   c. recruitment is continuing for Aboriginal Program Facilitator and Senior Cultural Practice Advisor positions, to ensure that assessments and program delivery is being conducted in an accessible and culturally safe and responsive manner, and

   d. a practice manual is currently being developed by Corrections to outline the standards for accurately addressing the limitations of assessing Aboriginal offenders using existing tools.

618. Until a locally or nationally developed, empirically validated assessment tool is available, I accept that NT Corrections are doing all that is reasonably possible to ensure that the current assessment tools are being used in an appropriately culturally informed way.

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[166] References cited in closing submissions on behalf of NT Corrections, dated 11 October 2024 at [195].

(d) 2022 Professor Harry Blagg review

619. Professor Harry Blagg conducted a review into the NT Prison programs in 2022, which was commissioned by the Aboriginal Justice Unit. The report found that:

    a. existing programs offered by Corrections are neither diverting nor rehabilitating Aboriginal people in custody for DFSV offending. There needs to be a fresh, multi-agency strategy to increase the rate of diversion and develop community-based alternatives to prevent enmeshment in the justice system,

    b. programs for prisoners on remand and serving sentences of less than six months should be introduced. Programs should link them with support services in the community as part of any throughcare plan,

    c. there is a pressing need for programs acknowledging the role violent victimisation has played in Aboriginal women's offending behaviour. I pause to note here my earlier references to this effect in relation to Kumanjayi Haywood,

    d. theories of "criminogenic need" do not adequately capture the cultural and situational factors of Aboriginal family life, or the role cognitive disabilities, mental illness, homelessness, alcohol and drug use, traumatic rage and long term victimisation, play in triggering violent episodes,

    e. high rates of DFV are largely traceable back to trauma, loss and grief in communities and families,

    f. prisoners want to see more use of work camps,

    g. there is a need for more Aboriginal people to be engaged in delivering treatment programs – to work in partnership with clinicians, and

h. Aboriginal Cultural Workers would have a vital role in shaping strategies for addressing trauma, loss, and grief in partnership with clinicians and therapists.

(e) Reforms underway

620. Fifteen additional positions have been created in the Offender Programs & Services Team, including nine Aboriginal Program Facilitators, who will work alongside clinicians to deliver offence specific and related programs. I commend NT Corrections for funding these positions at the same level as a professional stream position, in recognition of cultural expertise being equivalent to professional expertise.

621. In 2018, the eligibility for Offence Specific Programs was reduced from 30 months to 24 months. During the course of these Inquests, NT Corrections committed to reducing the minimum sentence requirement for the RAGE program to twelve months and I have been told that since January 2024 the Program has been delivered to inmates with 12-24 months to serve, in addition to those with more than 24 months. To accommodate this, the program is being delivered across three sessions per week over four months, rather than two per week over six months.

622. The RAGE program is now being delivered by a co-facilitation model, involving one clinician and one Aboriginal program facilitator.

623. Corrections intend to commence delivery of the RAGE program to Alice Springs Correctional Centre from late 2024 or early 2025, following necessary recruitment.

624. I am told that, despite these changes, the ability of NT Corrections to increase and sustain its delivery of the RAGE program remains dependent upon funding, recruitment and retention of program staff, and, importantly, the availability of custodial staff to facilitate prisoner attendance.

625. During these Inquests, NT Corrections committed to offering DFSV programs to remand (unsentenced) inmates and in May 2024 delivery of the "remand Family Violence program (FVP)" was commenced. In addition, since April 2024, Mr Charlie King has been delivering the "Pride in Your Tribe" program of yarning circles to promote the "No More" to DFSV message. Intensive DFSV programs remain unavailable for remand inmates.

626. In September 2024, NT Corrections commissioned Relationships Australia to co-design and deliver counselling services for female inmates who are victims of DFSV, and local Aboriginal business Intarct is also piloting a women's yarning circle at Darwin Correctional Centre, centred around sharing knowledge and establishing rules around respectful behaviours.

627. An offence related, culturally appropriate General Offending Program has been developed over the last twelve months, primarily designed to be delivered in community based settings by Aboriginal Community Controlled Organisations or non government organisations. I heard that this may be adapted for delivery within correctional centres. NT Corrections has to date committed some $2.7 million to the rollout of this program, which is to be delivered in:

   a. Yuendumu, by the Southern Tanami Kurdiji (since September 2024),

   b. Alice Springs, by the King's Narrative (since October 2024),

   c. Katherine, by Venndale (since September 2024),

   d. Tiwi Islands, by CatholicCare (intended to commence before the end of 2024), and

   e. Darwin, by FORWAARD (intended to commence before the end of 2024).

628. NT Corrections is committed to an evaluation of its program delivery, which will assess the effectiveness of the programs currently being delivered, and identify gaps within service delivery and areas for enhancement of programs. The preparatory work for this evaluation is well advanced.

629. NT Corrections is currently establishing a National Disability Insurance Scheme (NDIS) Offender Services Team, which will be responsible for supporting offenders who are eligible to apply, or are currently on, the NDIS, providing a single point of contact between NT Corrections and the NDIS.

630. As noted above, I have also been told that, in partnership with the Salvation Army, NT Corrections has established two bail supported accommodation programs, known as "Open House". These operate in Darwin (capacity of 50 beds) and Alice Springs (capacity of 32 beds) and are funded until June 2026. An Open House regional outreach service is currently being trialled in the Big Rivers Region.

631. A new Throughcare model is currently being developed, to increase successful rehabilitation and reintegration of prisoners into the community after their release from custody. The model is underpinned by the need to connect individuals with appropriate services in their communities. It is being developed in consultation with community members across the Territory, to better understand and address the needs of individual communities, and the situational and cultural factors that influence offending behaviour and reintegration needs.

632. A new information sharing arrangement has been established with NT Police, to notify Police of prisoners who are not recommended for parole, or who are released after completing their full term of imprisonment and who have a history of DFSV. NT Police have also assigned a Field Intelligence Officer who operates within the Darwin Correctional Centre Professional Standards Unit, but also communicates with the Alice Springs Correctional Centre Intelligence Team when necessary.

633. I also note the evidence of Dr Walker that there has been an improvement in communication between the Parole Board and NT Corrections in recent years, in that if the Parole Board considers that an inmate is unlikely to be released to parole, it will advise NTCS of this, which allows further consideration of offending behaviour programs for that inmate.

634. I commend the efforts being undertaken by NT Corrections to take real and substantial action to improve the Correctives response to domestic and family violence. I commend the response of NT Corrections to these Inquests and find that they have provided valuable assistance and a sincere commitment to the process. I accept that it is an agency that is determined to play its part in enhancing the safety of women experiencing or at risk of DFSV across the Territory.

635. I accept the evidence of Commissioner Varley that the demand for rehabilitation programs in the Territory's Correctional centres greatly outstrips supply. Dr Walker gave evidence that the programs available to Corrections to rehabilitate inmates like Mr Marika, for example, were "woefully inadequate"[167] making it "extremely challenging for [Corrective Services] to provide adequate rehabilitation to prisoners."[168]

636. The opportunity to meaningfully intervene at the point of contact with a prisoner is too important to miss, so I recommend that the Department of Corrections receives an urgent and significant increase to its funding for prisoner programs.

Recommendation 23: *Funding for men's prison-based behaviour programs and counselling*

The NT Government should ensure increased and long term funding is allocated for behavioural change programs and counselling in prisons, inclusive of independent evaluation of the effectiveness of those programs.

[167] Evidence of Dr Natalie Walker on 18 August 2023 at T7.
[168] Evidence of Dr Natalie Walker on 18 August 2023 at T4.

This *should not* be done at the expense of funding for offence specific programs, such as the RAGE program. This expands on Action Plan 2 action 2.1c.

Recommendation 24: *criteria for men's prison-based behaviour programs and counselling*

The criteria for entry into men's prison-based programs and counselling should be revised to improve accessibility, particularly for the large cohort of inmates on remand and those with disabilities.

637. Given the persistent attitude of denial among many DFSV offenders, in my view it is essential that a men's prison-based behaviour program be developed and implemented for deniers. A failure to admit responsibility for their conduct should not disentitle inmates from participation in appropriate rehabilitative programs.

Recommendation 25: *Men's prison-based behaviour programs for deniers*

The NT Government should urgently fund the development and implementation of a program for 'preparatory' counselling and/or programs to target men who are reluctant to accept responsibility for violent behaviour.

638. As noted above, NT Corrections are already working to develop a Throughcare model. Throughcare is important to facilitate the effective engagement of men exiting custody with appropriate services in their communities, thereby supporting the safety of women in those communities.

639. Submissions on behalf of the family of Kumarn Rubuntja suggest that throughcare programs need to occur on-country. I accept this, except where it conflicts with the safety of women.

Recommendation 26: *DFSV specific throughcare and reintegration*

The NT Government should provide long term funding to establish specific Throughcare and reintegration programs for men leaving prison and returning to community, and support for their partners. The programs should be centred around the Risk Assessment and Management Framework (RAMF) so that the safety of women is paramount. If it is safe to do so, these programs should occur on country.

9. Health Services

640. In these Inquests, NT Health acknowledged that "the prevalence of domestic violence within families and communities in the Northern Territory is inseparable from the complex structural disadvantage experienced by many, including the poor health and health outcomes experienced by many Aboriginal people."[169]

(a) Work underway to improve NT Health responses to DFSV

641. I accept that NT Health is implementing a range of reform initiatives directed at improving service delivery to people experiencing domestic violence, and a process of evaluation of these initiatives. Prior to these Inquests, it developed the "Culturally Safe Responses to Domestic, Family and Sexual Violence Clinical Guideline" ("the Guideline"), which was updated in August 2024.

642. The implementation of the Guideline commenced in August 2024 and I have been told that it will be integrated into the Territory hospital system

[169] Closing submissions on behalf of NT Health, dated 11 October 2024 at [8].

through structured teaching and training processes, as well as through experiential teaching to clinical staff across each NT Hospital.

643. In addition, the Guideline has been distributed to non government organisations and networks, including the Northern Territory Council of Social Services (NTCOSS), Aboriginal Medical Services Alliance Northern Territory (AMSANT), the NT Primary Health Network, Melaleuca Australia and the National Centre Against Child Abuse (NCACA). It is anticipated that the Guideline will be publicly available on the NT Government website sometime this month.

644. Importantly, the implementation of the DFSV Clinical Guideline includes a plan to co-locate specialist domestic violence workers within each NT Hospital. The aim of this initiative is to provide practice mentoring for staff, and to strengthen patient transition and referral pathways. I am told that the process of commissioning the participating non government organisations and recruitment is underway.

645. In addition, in response to the evidence heard in these Inquests, the Top End Regional Health Service has established the Top End Region DFSV Taskforce, which is responsible for implementing several Top End location-specific and NT-wide changes.

646. NT Health has also developed and implemented a Domestic and Family Violence Royal Darwin and Palmerston Hospital Emergency Department Procedure to enhance the response of Emergency Department doctors and nurses in those hospitals to signs and disclosures of domestic, family and sexual violence. Efforts are being made to roll out the Procedure to Gove District Hospital.

647. I was told about other initiatives that have been implemented by NT Health to strengthen services to people experiencing domestic and family violence, including DFSV victim-survivor specific bed configuration at Royal Darwin Hospital, and access to funds, mobile phone, clothing and feminine hygiene products.

648. NT Health is also working to improve healthcare system responses to adults who cause or use domestic violence. These efforts include developing training tools to support staff to identify and find appropriate ways to work with users of violence and conducting a clinical audit to assess the feasibility of a screening and support program for men who use violence – in the context of the Royal Darwin Hospital emergency department and hand clinic.

649. Other relevant initiatives include the development of an Aboriginal Led Sexual Assault Service.

(b) Hospital based social worker services

650. One issue that arose on the evidence before me was the importance of timely social worker attendances on women presenting to hospital as a result of domestic and family violence. During Kumanjayi Haywood's admissions to Alice Springs Hospital between 28 September to 4 October, and 23 October to 30 October 2021, she was not offered a social worker referral, despite her admission being due to an injury sustained as a result of domestic violence. This was a failing of the Hospital's provision of services to Kumanjayi during a period of high risk to her, but also suggests a failure in the Hospital's DFSV screening processes more generally.

651. I have been told that NT Health is undertaking further work to improve DFSV screening, including patients presenting to drug and alcohol services. I encourage this work.

652. In addition, I heard evidence about the lack of DFSV specific after hours services, specifically, at Alice Springs Hospital. For example, Kumarn Rubuntja was taken to that Hospital by Police during the night of 9 June 2020. This was in relation to her report that Mr Abbott had kicked her to the chest. She was admitted overnight on and discharged at 6:30am. She told the Police and Hospital staff that her injury was the result of

domestic violence, but the records indicate that she declined a social worker referral. A social worker was not available during the hours she was at the hospital anyway, as they only worked 8am to 4:21pm.

653. In January 2024, NT Health established the DFSV Afterhours Response Clinical Design Working Group, which in turn developed an initial proposed DFSV afterhours service model for each hospital in the Territory. These proposed models are yet to be finalised and implemented, but I understand include having on-call social workers rostered on afterhours.

654. I am of the view that every effort should be made for every hospital to have an appropriate number of social workers available on site at all hours. Social work responses must be timely, before a patient is discharged. In addition, delays in speaking with victims of domestic, family and sexual violence can make the difference between a complaint being made, triggering appropriate DFSV responses, or no complaint being made at all.

655. Given the prevalence of domestic, family and sexual violence in the Territory, Counsel Assisting urged me to recommend that NT Health employ hospital based DFSV (specific) social workers. NT Health submitted that a recommendation to this effect would result in a narrowing of service provision, particularly in regional hospitals.

656. Having considered both submissions, I decline to recommend that DFSV specific hospital based social workers be employed; however, I do recommend that hospital based social workers receive DFSV specific training, as well as cultural competency training, anti-racism training and training in using AIS interpreters (as suggested by NAAJA).

(c) Reports to Police

657. I accept that NT Health staff understand that they have mandatory reporting obligations and that they generally do report incidents of

domestic and family violence to Police. Counsel Assisting submitted that I should recommend that NT Health develop policies that require (or at least encourage) its staff to report a suspected case of DFSV to Police, even where a patient claims to have already reported it. NT Health oppose the making of this recommendation.

658. Two examples from the evidence are apt. First, when Kumanjayi Haywood attended at the Ikuntji Community Health Centre in Haasts Bluff on 28 September 2021, she told the nurse there that her partner had assaulted her the night before. The nurse observed injuries consistent with the assault that was alleged; however, as Kumanjayi Haywood told her that she had already made a report to Police, the nurse did not make a report herself. I am not suggesting that the nurse was in breach of her mandatory reporting obligations and I do accept the nurse's evidence that if she thought making a report would have assisted Kumanjayi, she would have done so.

659. After Kumanjayi attended the Health Centre, Police spoke with her at a family member's house in Haasts Bluff. One of the officers stood over her as she lay on a mattress on the floor and lacked compassion in the way he spoke with her. In those circumstances, Kumanjayi was not forthcoming with a complaint. As the nurse had not contacted Police, the attending officers did not have information about the complaint Kumanjayi had already made at the Health Centre, or the injuries that she had, which were consistent with the alleged assault. I have no doubt that this additional information would have been of significant assistance to the Police when they spoke with Kumanjayi.

660. The second example is that when Kumanjayi Haywood presented to Alice Springs Hospital the next day for treatment of the injuries sustained in the same assault, she told the hospital staff that the assault had already been reported and, despite not being obliged to, the nurse contacted NT Police and obtained the PROMIS number for that report. I find that this is an ideal response by a mandatory reporter, as not only did this nurse

ensure that she was compliant with her obligations, but it ensured that the incident of domestic violence would not fall through the cracks.

661. While I will not recommend that NT Health require its staff to report a suspected case of DFSV to Police where a patient claims to have already reported it, I do recommend that NT Health encourage its staff to do this, and to provide related training as to why this is important, not just in terms of the fact of a mandatory report but also its potential significance for Police evidence gathering. I understand that frontline health staff are already overburdened; however, I also understand the rates of underreporting of domestic and family violence, and the difficulties faced by Police in obtaining evidence in support of DFSV complaints. I find that in the frontline response to domestic and family violence, the value in Health staff reporting DFSV to Police, even when a patient claims to have already reported it, outweighs the concerns raised on behalf of NT Health, which generally relate to resourcing concerns.

(d) PARt Training

662. The Prevent. Assist. Respond. Training ("PARt") is a specialist DFSV training package that was designed by external experts for police and healthcare workers in the NT. The package consists of one week of in-person training and ten online modules. It has four central aims:

a. to ensure the voices of victim-survivors, particularly Aboriginal women, inform the training materials and package for police and healthcare workers,

b. to increase collaboration and strengthen relationships between the domestic, family, and sexual violence (DFSV) sector, health and police,

c. to increase knowledge and understanding of DFSV, its drivers, emerging forms (such as technology facilitated abuse), myths and misconceptions, CRAT/RAMF, key challenges (such as

misidentification), trauma-informed culturally-safe and non-collusive practice, and vicarious trauma among stakeholders and community members through the development of the training package, and

d. to support healthcare workers and police with targeted ongoing specialist training materials and packages, which are online, accessible, and modular with attached competencies.

663. As indicated above, NT Police have already commenced the roll out of this important training to its recruits and members and, so far, it has been extremely well received.

664. Counsel Assisting asks me to recommend that NT Health should engage in and fund the PARt Consortium to pilot DFSV (PARt and RAMF) training for NT Health workers, including ALOs. NT Health oppose this recommendation.

665. In considering the competing submissions, I note that NT Health are already developing and implementing their own initiatives and associated training to improve NT Health responses to DFSV. I also note that NT Health engaged in the PARt project, including providing in principle support for the consortium's funding application and attending Steering Committee meetings from 2022 to 2024. I consider NT Health's role on the Steering Committee to be significant in my consideration of this proposed recommendation.

666. I understand that in May 2024, with the PARt modules complete and the consortium moving towards implementation, NT Health advised the consortium that it would be "taking a step back to focus on delivering its own commitments under Action Plan 2."[170]

[170] Closing submissions on behalf of NT Health, dated 11 October 2024 at [151].

667. I understand that NT Health is not specifically funded to implement PARt, but that it "remains committed to promoting the availability of PARt resources to staff, as appropriate".[171]

668. I have outlined above the importance of a coordinated and whole of government response to the domestic and family violence crisis in the Territory. The evidence before me has demonstrated a "siloing"[172] of efforts between agencies and a consequent fragmented set of responses. This needs to change and part of an integrated response must be a shared understanding of what domestic and family violence is, with all of its complexities, and of how to identify it. Put another way, there must be a common language for the agencies to be able to work together to respond to the crisis.

669. For this reason, I do recommend that Health staff receive PARt training.

Recommendation 27: *DFSV screening and assessment of health clients*

NT Health should:

i. continue to improve and increase its screening of clients for DFSV, with priority given to antenatal and emergency service clients, and amend any policy or procedures necessary to embed this change,

ii. implement and enhance training to ensure that this screening is undertaken by employees who have had DFSV training, cultural competency training, anti-racism training and training in using AIS interpreters. It is important that these social workers be trained in DFSV risk assessment and safety planning for clients identified with DFSV through the screening process,

iii. develop policies that encourage its staff to report a suspected case of DFSV to Police, even where a patient claims to have already reported

[171] Closing submissions on behalf of NT Health, dated 11 October 2024 at [153].
[172] Evidence of Penny Drysdale, 30 October 2023 at T40.

it, with related training about the importance and value of these reports, and

iv. raise staff awareness and give staff the tools and structures to assess and manage risk by engaging in and funding the PARt Consortium to pilot DFSV (PARt and RAMF) training for NT Health workers, including Aboriginal Liaison Officers (ALOs).

(e) Aboriginal Liaison Officers

670. Aboriginal Liaison Officers provide an invaluable service to patients in the NT Health system. They bring specialised expertise, knowledge, wisdom and other skills "that NT Health clinicians won't know and couldn't know."[173]

671. The terms of remuneration and supports for ALOs should recognise the important role that they play. I have been told the Office of the Commissioner for Public Employment ("OCPE") is working to better recognise the specialised skills of ALOs across the NT Government, "through appropriate allowances".[174] I encourage the Government's efforts to appropriately recognise these skills.

Recommendation 28: *Aboriginal Liaison Officers in hospitals and clinics*

The NT Government and NT Health should ensure that the terms of remuneration and supports for ALOs in hospitals are increased in recognition of their unique expertise and the crucial cultural role they provide for clients and staff, including support provided to clients with DFSV.

[173] Evidence of Dr Luke Butcher, 7 November 2023 at T536.
[174] Closing submissions on behalf of NT Health, dated 11 October 2024 at [172].

(f) Domestic Violence evidence in chief

672. When the Alice Springs Hospital Based Constable spoke with Kumanjayi Haywood on 28 October, Kumanjayi provided a detailed complaint to her. Unfortunately, the Officer was not permitted by the Hospital to record that complaint on her body worn video in the form of a Domestic Violence Evidence in Chief. The Officer recorded the conversation on her mobile phone, then typed the information into a statement, but by the time she returned the following day, Kumanjayi Haywood refused to sign the statement.

673. I find that NT Health and NT Police should work together to discuss what can be done in the Hospital setting to accommodate Police taking video recorded statements wherever possible. I understand that these discussions have commenced, and I encourage them to continue.

10. Other Services and supports

(a) Women's safety services

674. I heard evidence about the importance of Women's crisis accommodation that included from:

   a. family members of two of the women, who had themselves experienced domestic violence. They told me that they "felt safe" when they went to their local Women's shelter, and that the shelters were an important help for women experiencing violence.

   b. Bernadette Wombo, the Community Safety Manager of the Gunbalanya Women's Safe House. In her experience, generally women attend the Safe House as a "short term preventative measure", while they wait for their partner to settle down and, usually, to sober up.

c. Dr Luke Butcher, from NT Health, who told me that "safe houses are absolutely critical for women and children at that point at crisis, so they can have somewhere safe, somewhere warm, somewhere where people can start to process that trauma and are safe, in a safe manner with their children, after experiencing a horrific incident."

675. I also heard of under-availability of these services, as well as immense funding pressures and under-resourcing. I accept that they are acting beyond capacity to try to meet the increasing unmet need of women seeking crisis accommodation and support. The evidence included that:

a. many parts of the Territory are not serviced by a Women's crisis accommodation service. For example, in Haasts Bluff and Papunya there are no shelters, which is why Police had to transport Kumanjayi Haywood the three hours from Haasts Bluff to Alice Springs when she needed crisis accommodation (28 September 2021),

b. even if a refuge exists in some locations, there will only be one, which can cause additional barriers to access for some women. For example, family members (including in-laws) may work or already be staying at the shelter, or there may be other personal reasons they cannot stay there. I heard that Miss Yunupiŋu found it difficult to go to Crisis Accommodation Gove because her sister had passed away there and she found it deeply upsetting,

c. the overwhelming demand for crisis accommodation cannot be met by existing services, and is increasing:

i. Larissa Ellis, the CEO of the Women's Safety Services of Central Australia (WoSSCA), told me that they have crisis accommodation capacity for 31 women and children, approximately 98% of whom are Indigenous. She told me that they are forced to operate on a deficit budget, and they regularly have to turn away women who are seeking help,

ii. I heard that at Tennant Creek Women's Refuge the demand for the available eight crisis accommodation beds can be huge, to the point that one of the acting CEOs considered buying tents to house more people,

iii. the Darwin Aboriginal & Islander Women's Shelter (DAIWS), an Aboriginal and Torres Strait Islander governed and managed domestic violence service, has two domestic and family violence 24-hour crisis centres, transitional housing units and provides an outreach service; however, due to significant demand, this service is under pressure,

iv. Crisis Accommodation Gove (CAG) has a four bedroom facility, and has regularly had to turn women away because they were at capacity. I was told that CAG could easily double the capacity in an attempt to meet the needs of the area, and

v. YWCA Australia, which has five safe houses and case management outreach in Darwin and Palmerston assisted 155 people between 1 January and 15 May 2024, but were unable to assist a further 250 people who sought their help.

676. I also received evidence of specific failures at a number of Women's Refuges. These were not failures of compassion, but rather, were failures to take the time to undertake risk assessments. For example:

a. when Kumanjayi Haywood attended WoSSCA on 28 September, it was at dinner time. She was fed and settled into her room. The staff working there did not have the capacity to sit with her at that time and undertake a risk assessment, because it is a busy time at the Refuge,

b. when Kumanjayi Haywood and her sister-cousin Ms Duggie arrived at the Tennant Creek Women's Shelter at 8:51pm on 3

November, no risk assessment was conducted. I accept that this was because the case workers on duty were busy with other clients, and

c. when Miss Yunupiŋu attended Crisis Accommodation Gove and asked to be transferred to DAIWS, no risk assessment was undertaken and Family Safety Framework records were not checked. This meant that CAG staff did not appreciate that Mr Marika was in Darwin and that he posed a very serious risk to her safety.

677. I accept that some of these failures may have been due to a lack of skill of the workers at the Refuges; however, it was clear to me that many of these failures could be attributable to a lack of resources.

678. I accept the evidence that I heard of the difficulty that Women's services experience in recruiting and training staff, particularly when the employees of these services are underpaid and over stretched. There is a strong and urgent need to address this through increased funding, and workforce planning.

679. I also note a related issue that was raised in evidence. Apart from the lack of sufficient crisis accommodation in women's refuges, there is generally a lack of accommodation options for people leaving their homes. I accept that there is a real need for medium to longer term transitional housing for women escaping domestic and family violence.

680. In the interests of exploring all options to keep women safe, the NT Government may wish to consider the model known as 'The Orange Door' in Victoria. These hubs could offer a fresh approach for women, children and young people facing DFSV to access co-ordinated support from community, health, and justice services.

(b) Men's Services

> ***"How do we break this cycle? How do we break this vicious cycle?...the only way is you work with everyone, you know? You work with the local men, you work with the service providers…come together in the middle of the table and talk about…these issues. You know, with the men. Because the men need to start talking and – and acknowledging and…they really need to acknowledge what they're doing…their wrongdoing. And how do they improve, how do they fix themselves up?"***
>
> Bernadette Wombo, Gunbalanya Safe House,
> Evidence 26 June 2023 at T47

681. Men must be part of the solution to domestic and family violence. Prevention of violence requires widespread, culturally appropriate programs to change attitudes and behaviours. Supporting men to own their actions and change their behaviours should be understood to be a critical part of the plan to support women, children and the broader community.

682. I received evidence of different forms of programs for supporting men who use domestic and family violence: men's behaviour change programs, like those run by Tangentyere Council and CatholicCare NT, and more informal culturally aligned programs (and programs on country), such as the family violence counselling and education provided to men by the Darwin Indigenous Men's Service (DIMS) and Codes 4 Life (developed by Michael Liddle). It is imperative that more programs and services like these be developed, funded and implemented across the Territory.

683. Men's behaviour change programs serve two important functions. First, they work to change the behaviour and attitudes of men who use violence and, secondly, they protect women and children's safety by keeping men "in view"; that is, by keeping them engaged over a long period of time.

This provides a mechanism for assessing and managing the risks that these men pose to women and children.

684. Maree Corbo from Tangentyere Council is a highly skilled specialist practitioner in the field of men's behaviour change programs. She gave evidence that:

> "I am worried that we are losing the view on men who use violence. I have experienced many times how easy it is for men who use violence to become invisible in the conversation about addressing DFV. The invisibility of men is often insidious as the discussion turns away from holding men accountable and supporting them to change their behaviour and attitudes to placing band-aid solutions on women's safety. During my early career I worked with women and children who were victim/survivors of violence, and I knew then as I know now that the real change for women and children needs to be addressed with men who are using violence."[175]

685. Keeping men who use violence "in view" requires the development of specialist interventions, including men's behaviour change programs.

686. There needs to be more intervention targeted at men who commit violence, including group programs and individual work. These interventions need to encourage men to take responsibility for their actions, giving a clear message that domestic and family violence is never acceptable, but it also needs to support men to heal from their own trauma.

687. This work must be undertaken by highly skilled specialists, working within specialist services, who actively guard against colluding with men who use violence who seek to minimise or excuse their violence, or blame their victim. These programs need to operate in a culturally safe and DFSV informed environment.

688. I received evidence that there is an insufficiency of programs available to men in the Territory. I heard that there are only two Men's behaviour

[175] Statement of Maree Corbo dated 1 November 2023 at p3 [9] (Common brief: 1-2C).

Change Programs: Tangentyere Council's program in Alice Springs, and CatholicCare NT's program in Darwin, Wadeye and Tiwi Islands. I heard that there is an increasing number of men who have applied but remain on a waitlist for the Tangentyere Men's Behavioural Change Program, and that the geographical areas serviced by existing programs are simply insufficient to meet demand (and need) across the Territory.

689. Commissioner Micaela Cronin gave evidence that further funding of men's behaviour change programs would be an *immediate* change that would provide greater access to perpetrators of domestic violence who need these services; it is "a critical part of the change that's needed."[176]

690. Professor Marcia Langton gave evidence that the kind of work done by Michael Liddle is absolutely essential, so that men can play a leadership role in challenging the normalisation of violence in communities.[177]

691. I accept that, in particular, men's behaviour change programs need to be available in the regional centres. For example, Ioanna Gamble from the Katherine Women's Crisis Centre, gave evidence that a Men's Behaviour Change Program in the Katherine Region would be a "significant" measure to achieving accountability of domestic violence offenders in Katherine.[178]

692. I also accept that these programs need to be culturally appropriate and, where possible, facilitated by an Aboriginal Community Controlled Organisation.

Recommendation 29: *Men's community based programs and prevention related activities*

The NT Government should increase funding for existing behavioural change programs and other community-driven DFSV programs for men, to improve their current capacity and to provide for delivery of programs into additional

[176] Evidence of Commissioner Micaela Cronin on 6 November 2023 at T408.
[177] Evidence of Professor Marcia Langton, 31 October 2023 at T107.
[178] Evidence of Ioanna Gamble on 7 November 2023, at T606.

locations (including remote communities according to identified need), and for independent evaluation of all programs. These should include culturally appropriate prevention related activities. Where possible, each of these programs should be developed and delivered by or in partnership with Aboriginal Community Controlled Organisations. This expands on Action Plan 2 action 2.1b.

(c) Other programs in community

693. There are programs already operating that have had some levels of success in challenging community attitudes to violence and inequality, including two that are run by Tangentyere Council. Dr Chay Brown informed the Court that the evaluations of the 'Girls Can Boys Can' project and the 'U Right Sis?' project show that these programs are having some success in shifting underlying attitudes that drive violence.

694. Bernadette Wombo from the Gunbalanya Women's Safe House gave evidence about two effective programs that that service was able to deliver in 2018-2019 in partnership with Relationships Australia. These were the "Straight Talk" and "Healing our Children" programs, which focused on having stronger family structures to deal with issues, and dealing with trauma from a children's perspective, respectively. Ms Wombo said that the programs were effective because they were delivered by Indigenous presenters, who broke the concepts down to community level. For example, the Straight Talk program demonstrated how families could work together on issues rather than fighting. She said that there was good attendance and participation in those programs but then the funding ran out.

695. There should be adequate primary prevention and education programs in community, which address attitudes that may contribute to DFSV, but that also deal with trauma, healing, and empowerment for women and children.

<u>Recommendation 30:</u> *Education*

The NT Government should invest in the development of culturally appropriate prevention and education programs, initially in schools, but also in the wider media, including social media, so that young people have the opportunity to learn about DFSV and interpersonal violence (IPV) and, conversely, respectful relationships. This builds on Action Plan 2 action 1.1.

(d) Licenced premises

696. No serious policy to tackle domestic and family violence can ignore the 'rivers of grog' that have fuelled it. The alcohol and gambling industries in the Northern Territory benefit from the culture of drinking that also contributes to our devastating rates of domestic and family violence. Those industries should be part of the solution that promotes more 'responsible' drinking and make greater contributions to redressing the harms caused by problematic alcohol consumption.

<u>(i) Training</u>

697. I commend the Gillen Club for constructively engaging in the coronial process in relation to the death of Kumarn Rubuntja. The Club accepted that mistakes were made on 7 January and that its employees should have done more to protect its member, Kumarn Rubuntja. As I was invited to do, I found that those mistakes were due to the Club's staff not being "DV Aware".

698. After the completion of the evidence in relation to Kumarn's death, the Club engaged Dr Chay Brown to develop and deliver training to its employees and management to "become DV aware". I commend the Club for this and recommend that all NT licenced venues implement similar training.

Recommendation 31: *DFSV training for clubs and pubs*

The NT Government should retain an independent service provider and fund a training package in 'becoming domestic and family violence aware' (similar to that provided by Dr Chay Brown to the Gillen Club), that is funded by NT licensed clubs and can be rolled out to all clubs and other licenced premises. Such training may be mandated or incentivised as part of the licensing scheme.

699. Despite my assessment that the evidence did not support a finding that the Gillen Club staff's actions were attributable to racial bias, I did find that training in culturally appropriate communication techniques would have assisted them in better understanding and appropriately responding to Mr Abbott's behaviour toward Kumarn in the Club. I commend the Gillen Club for having now implemented training in culturally appropriate communication techniques and anti-discrimination.

700. The NT Government should require licensed venues in the Northern Territory to provide anti-racism and anti-discrimination training to its employees, including training in culturally appropriate communication techniques. Such training may be mandated or incentivised as part of the licensing scheme.

(ii) Banned Drinker Register (BDR)

701. The Banned Drinkers' Register (BDR) commenced on 1 September 2017. Relevantly, Mr Nawirridj was on the BDR at the date of Ngeygo Ragurrk's death. Mr Abbott and Kumanjayi Dixon had both previously been on the register, but not at the time of Kumarn or Kumanjayi Haywood's deaths. I note that an application for Mr Abbott to be added to the BDR in August 2020 was inadvertently made for a different person. Kumarn was on the register at the time of her death.

702. The BDR operates across the Northern Territory and is a tool aimed at reducing harm by identifying people who are on a “banned” list and preventing them from purchasing takeaway alcohol.

703. An issue that arose in relation to the death of Kumarn Rubuntja was how she was able to purchase large quantities of alcohol at the Gillen Club when she was listed on the Banned Drinker Register (and intoxicated).

704. If a person is on the BDR, a licensee or licensee’s employees must refuse to serve them (s138 *Liquor Act*); however, the effect of ss 128 and 129 of the *Liquor Act 2019* and r106 of the *Liquor Regulations 2019* is that only a person who is purchasing takeaway alcohol must have their identification checked prior to purchase to ensure that they are not on the banned drinker register. This is done by way of a BDR identification scanner. There is no such requirement when a person is purchasing alcohol to consume on premises.

705. Licensed premises that sell both takeaway alcohol and alcohol that is consumed on premises, such as the Gillen Club, are provided with BDR scanners, which they use for takeaway sales, but not for patrons who are drinking alcohol on premises. That meant that although Kumarn was on the BDR, because she was drinking on the premises, her identification was not scanned and she was allowed to purchase and consume alcohol.

706. The BDR scanners are provided, free of charge, by the Department of Corporate and Digital Development (DCDD) to prescribed licensees. The Banned Drinker Registrar told me that she is not aware of any restriction that would prevent a licensee from using the BDR scanners for patrons who are consuming alcohol on premises.

707. The legislation proscribing supply of alcohol to a person on the BDR does not differentiate between supply for takeaway or on premises consumption; however, the BDR regime is imposed in this differential manner because of the inconsistency in the requirement to undertake BDR checks for takeaway sales and not on premises sales.

708. I recognise that alcohol abuse and effective policy is complex and I agree and accept that evidence-based alcohol intervention strategies should be imposed. I received evidence of various reviews that have been conducted into the operation of the BDR, as well as academic research papers and viva voce evidence of two specialist researchers in this area. I received evidence that there have been earlier recommendations that BDR scanners be trialled on premises at venues in Alice Springs, Tennant Creek and Katherine where Police Auxiliary Liquor Inspectors are present.

709. I have considered the submissions of NT Health and NAAJA opposing this proposed recommendation, and, in particular, their concerns about:

    a. social exclusion and stigmatisation for people on the BDR who are refused service at licenced premises or events,

    b. an increase in unregulated drinking through secondary supply; that is, that it would lead to people drinking unsupervised, rather than under supervision subject to responsible service of alcohol restrictions, rather than unsupervised,

    c. the possibility of a consequential increase in secondary supply and risk of more prosecutions for secondary supply, which may disproportionately increase the interaction of Aboriginal people with the criminal justice system,

    d. the possibility of consequential increase in offences such as theft and break-ins to obtain alcohol,

    e. the costs of administering this trial, which could otherwise be used elsewhere, and

    f. research considering the efficacy of the impacts of alcohol supply reductions, including the BDR in its existing form.

710. I have considered each of these concerns; however, at its heart, the existing BDR regime is inconsistent in its approach to banned drinkers,

dependent upon whether they are drinking on premises, or taking away. If it has been determined as a matter of policy and having regard to the circumstances of an individual that they should be subject to the restrictions of the Banned Drinker Register, this law should apply equally. The legislation that creates the offence of supplying alcohol to a person who is on the Banned Drinker Register could create an exception for on premises supply, but it does not. I recommend that BDR scanners be trialled in licensed premises and that an independent evaluation be undertaken of this trial.

Recommendation 32: *Banned Drinker Register (BDR) scanners:*

To give effect to s138 *Liquor Act,* the NT Government should impose a mandatory 12-month trial of the use of BDR scanners in licensed venues to screen patrons who intend to consume liquor on the premises, and should evaluate the trial to determine its efficacy. If the trial is evaluated to be ineffective, consideration should be given to amending the terms of s138 of the Liquor Act.

11. The Funding Crisis

"How much does a life cost?"

Commissioner Murphy, evidence 20 May 2024 at T13.

711. It is abundantly clear that the response to the domestic and family violence epidemic in the Northern Territory is in urgent need of a significant funding increase.

712. In particular, there is an urgent increase in baseline funding for frontline DFSV services like crisis accommodation and outreach. Dedicated non government agency representatives repeatedly told me about the challenges they are increasingly facing in delivering their core services,

due to a lack of growth in core funding to meet increasing demand, as well as increasing wages and operational costs.

713. The funding across the DFSV sector should be adequate and needs based. It needs to be available for core service delivery, as well as for the development and implementation of new initiatives.

714. Importantly, the funding needs to be long term: reducing DFSV requires a long term commitment and investment. Two year funding cycles are inefficient and insufficient. Senior police lawyer Penny Drysdale explained that:

> "Two years is not a sufficient length of time to stand up new programs, recruit, attract and induct skilled staff, give programs an opportunity to start doing some good, and properly evaluate the merits of the program. It is widely accepted that for meaningful change to occur – at an individual level, an organisational level and a community level – it takes time."[179]

715. Excellent work has been undertaken in the development of the Territory's DFSV Policy Framework. If there is to be any serious commitment to achieving the outcomes set out in the Territory and national DFSV frameworks, the Action Plan 2 budget proposal must be fully funded and fully implemented. The funding should be allocated in accordance with Action Plan 2.

716. The DFSV-ICRO funding proposal for Action Plan 2 was a sensible and modest plan. Fully funding Action Plan 2 would demonstrate a true commitment to lasting reform, rather than piecemeal stop gaps; however, realistically, this funding would be just the start if we are to adequately respond to the shocking rates of domestic and family violence in the Territory. I accept the evidence of Penny Drysdale that:

> "DFSV is preventable. There is much in the NT Government's current approach to DFSV that is positive and going in the right direction, but what we are doing now is simply nowhere near enough to change the entrenched levels of violence in the NT and

[179] Statement of Penny Drysdale dated 26 October 2023, at [48] (Common brief: 1-3).

revamp and co-ordinate frontline responses. In my view the NT Government should build on the existing DFSV Reduction Framework and Action Plan 2, but increase its effort and its funding allocation exponentially over a generation or longer. The scale of the response needs to be commensurate with the scale of the problem if we are to achieve change."[180]

Recommendation 33: *Full implementation of NT DSFV Action Plan 2*

The NT Government should fully implement Action Plan 2 (to be read with the associated Mapping Report) as developed and costed by the Domestic, Family and Sexual Violence Interagency Coordination and Reform Office (DFSV-ICRO) (that is, at the cost of at least $180 million over five years, and ongoing funding of $36 million per annum, adjusted for inflation to account for the years since the DFSV-ICRO made its submission).

717. I accept the evidence that I heard to the effect that, with no funding increases to correspond with CPI increases, and with the imposition of "efficiency dividends", services like WoSSCA are experiencing a loss in real funding of 10 to 30 percent. This results in these services having to cut back on the frontline services they are already providing, and means that they struggle to provide their core functions. This is unacceptable.

718. I received evidence of the disruptive effects of late or retrospective indexation and the imposition of "efficiency dividends" upon the budgetary planning of community service organisations. For example, Rachael Uerbergang from YWCA Australia explained that:

> "It is essential for budget preparation work in community services organisations to know prior to the commencement of a financial year, what funding is available. Knowing what indexation payment might be forthcoming, including whether indexation is an increase or decrease in funding, is an essential component of this. On 29 December 2022, some of our services were provided with 36 months of indexation funding and informed that the 36 months of

[180] Statement of Penny Drysdale dated 26 October 2023, at [73] (Common brief: 1-3).

indexation funding was to be expended by 30 June 2023. Such a late payment of indexation, with the requirement to expend over a short period of six months, does not facilitate thoughtful, consistent and reliable service delivery."[181]

719. I commend DCF for its decision not to apply the efficiency dividend to frontline specialist DFSV services in 2024-25 and recommend that these services be permanently exempt from budgetary measures like the efficiency dividend.

Recommendation 34: *Increase to core funding*

The NT Government should increase the baseline funding for frontline DFSV crisis services (for example but not limited to safe houses, outreach support for women and children experiencing DFSV; counselling and healing services) by a figure in the order of 10%, to address the quantified lack of core funding which results in unmet need.

Recommendation 35: *Indexation*

With respect to frontline DFSV services, the NT Government guidelines should be amended so that grant funding terms and conditions explicitly include indexation that is commensurate with real cost of living increases, and ensure those services are exempt from (what are referred to by the Government as) "efficiency dividends" and "budget measures".

[181] Statement of Rachael Uebergang dated 18 May 2024 (Common brief: 1-10) at p4.

A note on the involvement of families and communities during these Inquests

720. I was fortunate to have the enormous assistance of a number of people and organisations during the course of these Inquests, in addition to the legal representatives for interested parties.

(a) Engagement and support prior to Inquests

721. In the lead up to the Inquest, an "education document" was prepared to be provided to the families and other interested persons. For example, in relation to the Inquest into the death of Kumarn Rubuntja, Tangentyere Council assisted in circulating the document to community, in particular at Anthepe and Abbotts Camps.

722. This document was prepared by the Counsel Assisting team, in consultation with my Office and the Community Justice Centre, and it provided information about Coronial Inquests generally, and this series of Inquests in particular. It covered the following topics:

    a. What is a Coronial Inquest?

    b. What can and can't a Coroner do at the end of the Inquest? (including the difference between criminal proceedings and a Coronial Inquest),

    c. What is the reason for having a Coronial Inquest?

    d. What kinds of issues will the Coroner look at in this Inquest?

    e. Who is the Coroner?

    f. Where and when will the Inquest be?

    g. What should I do if I want to share my story or want support? (including contact numbers for Counsel and solicitor assisting, and the Coroner's Court counsellor).

723. Prior to the commencement of the Inquest into the Death of Kumarn Rubuntja, NAAJA, the CJC and Tangentyere Council facilitated meetings between services, family and community members with Counsel Assisting, both in person and by video conference.

(b) assistance during the Inquests

724. Members of the families of Miss Yunupiŋu, Ngeygo Ragurrk, Kumarn Rubuntja, Kumanjayi Haywood and Kumanjayi Dixon attended and were engaged in these Inquests.

725. They (and I) were assisted by the Community Justice Centre ("CJC"), and in particular, Family Engagement Officer Valda Napurrula Shannon, Director Melinda Tew and Mediator Gary Childs from the (CJC).

726. The Aboriginal Interpreter Service (AIS) provided enormous assistance with interpreters as required for each of the Inquests.

727. DCF assisted and facilitated the attendance of some family members and the efforts of the DCF caseworkers were particularly helpful.

728. NT Police Community Resilience and Engagement Command (CREC) also assisted the families and community during this process, and the Counsel Assisting team was particularly grateful for the assistance and expertise provided by Senior Constable Brad Wallace in relation to the Inquest into the death of Kumarn Rubuntja.

729. The North Australian Aboriginal Justice Agency (NAAJA) and NAAFLS provided enormous assistance in facilitating family members' involvement in this process.

730. In particular, I wish to note that for Miss Yunupiŋu's family, it was not until they were working with NAAFLS to prepare for this Inquest that they came to know the story of what Mr Nawirridj had done to Ngeygo. In the weeks before the Inquest, a Kunwinjku AIS Interpreter and

workers from NAAFLS sat down in Gunbalanya with them and there, for the first time, they heard the story Justice Blokland had told about what Mr Nawirridj did to Ngeygo. None of the family had known the full story and it was very sad for them to hear. One of Ngeygo's sisters had been in the criminal Court, but there was no interpreter for her so she had not understood what happened.

731. I also wish to note some of the arrangements that were made for the Inquest into the death of Kumarn Rubuntja, which included:

a. remote viewing locations were set up at two separate Tangentyere Council offices, so that Kumarn's family and members of Anthepe Camp could attend one, and Mr Abbott's family and members of Abbotts Camp could attend the other,

b. Tangentyere Council arranged transportation from each camp to the Tangentyere offices and back, multiple times per day, for each day of proceedings, and provided tea, coffee and lunch for those attending Court or the remote viewing locations,

c. Tangentyere Council also provided evening barbecues at Anthepe Camp and Abbotts Camp during the Inquest, on alternating nights. The significant Tangentyere Council efforts were coordinated by Sunaina Pinto, who also cooked the barbecue each night. The barbecues provided the opportunity for community to be told what had happened in Court, and to ask any questions they had. Counsel assisting were invited and attended one of the nightly barbecues at Abbotts Camp, which provided an opportunity for them to engage with Mr Abbott's family and community, to hear their concerns and answer their questions about the Inquest process,

d. the Community Justice Centre did important work on the ground in Alice Springs before, during and after the Inquest, working with both families and both communities, and

e. following extensive consultation with both families, the CJC, CREC, Tangentyere Council, NAAJA and SC Wallace, and with the assistance of all of those groups, my counsel assisting facilitated appropriate members of Mr Abbott's family viewing the CCTV footage of Kumarn's death. This was an important truth telling moment, as it allowed Mr Abbott's family to see the critical evidence for themselves. It helped them understand why he had pleaded guilty to Kumarn's murder and been sentenced to life imprisonment. I have been told that it was of enormous benefit to Mr Abbott's family in understanding what happened and to the communities being able to move forward.

732. I understand that the very significant level of support and assistance that was provided to Kumarn and Mr Abbott's families and communities during the Inquest made a very real difference to the way that these families and communities were able to engage in the process, and to the impact that their communities experienced from the Inquest.

733. Alice Springs and Darwin Local Courts made available dedicated rooms during the Inquests for the family members to use, and for the Darwin sittings of these Inquests, the CJC, NAAFLS and my office coordinated to provide lunch and refreshments to the family members who attended.

(c) Return of belongings

734. During the course of the Inquests, the Court became aware that some personal items belonging to Ngeygo Ragurrk and Kumarn Rubuntja had not been returned to their families and remained in the custody of Police. With the tremendous assistance of NAAFLS and NAAJA, arrangements were made for me to return these to Ngeygo and Kumarn's loved ones.

735. During the Inquest into the death of Kumarn Rubuntja, I was invited and attended Anthepe Camp one evening after Court, along with my Counsel Assisting team, the parties' legal representatives, CJC, Tangentyere

Council, and members of NT Police. During this visit I was able to return Kumarn's belongings to her family.

736. During the Inquest into the death of Ngeygo Ragurrk, Ngeygo's family invited me, the legal representatives, Police, media and other interested persons to a ceremony at Mindil Beach one morning before Court. This allowed Ngeygo's family to visit the place of Ngeygo's sad passing. When they attended, Ngeygo's grandmother called out to her to follow the family on her journey. Her sister and young father did the same. I heard that this was important for Ngeygo's spirit to be able to rest in peace. During this ceremony, I returned Ngeygo's belongings to her family members, which I understand will be returned to her country, to allow for her spirit to pass over. I am told that this was an important ceremony for Ngeygo's family and it was moving for those of us who were present to witness it.

Recommendations

> ***I know that during this inquest I should have a feeling of impending change and hope, however, I am worried. I am worried that this inquest will not bear fruit and that life will go on, sadly we have seen this happen with various reports, inquests recommendations and evaluations.***
>
> Maree Corbo, Manager of the Family Safety Programs,
> Tangentyere Council Aboriginal Corporation
> Statement dated 1 November 2023 at [3]-[4]

737. I make the following recommendations, in the sincere hope that they will be implemented fully and that meaningful, long term change will result, and lives will be saved:

Recommendation 1: *Permanent DFSV-ICRO*

The NT Government should establish a sustainable permanent DFSV whole-of-government coordination mechanism (DFSV-ICRO) to lead consistent and evidence-based DFSV policy and practice, and health, housing and community services to address DFSV. A sustainable, inter-agency DFSV policy lead unit should be a whole-of-government structure to oversee system performance, policy development and implementation.

The DFSV-ICRO mechanism should continue to produce an annual report to the Minister to be published online, including through a visual report card. This annual report should include relevant DFSV statistics and information about the implementation of these recommendations.

Recommendation 2: *Peak body*

Following consultation about the appropriate model, the NT Government should establish and adequately fund a peak body for DFSV in the NT. This expands on action 4.12 of Action Plan 2.

Recommendation 3: *Workforce planning*

The NT Government should consider amending the DFSV Workforce and Sector Development Plan to make explicit reference to engagement of the local university and local communities, so that a) the strategy attracts Aboriginal workers, b) local Territorians can be attracted, trained and retained in the areas of need and c) interstate and international workers with the requisite expertise can be attracted, trained and retained in the areas of need.

Noting the existence of the DFSV Workforce and Sector Development Plan (and particularly Focus Area 2, Action 8), the NT Government should produce a short report at least annually, to be published online, in relation to workforce recruitment and retention strategies addressing the needs of the DFSV workforce.

Recommendation 4: *Aboriginal Interpreter Service (AIS)*

The NT Government should increase investment in the AIS (funding, training and support) and devise a short, medium and long term plan to attract, train, and retain interpreters.

Recommendation 5: *Evidence-based alcohol intervention strategy*

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

Recommendation 6: *Specialist alcohol and other drugs rehabilitation*

The NT Government should increase investment in specialist alcohol and other drugs rehabilitation services, including ambulatory care (medical services performed on an outpatient basis, without admission to hospital or another facility), respite and behavioural change services.

Recommendation 7: *Co-responder model*

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

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

i. consideration of models based on the success of the Queensland models, and

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

Recommendation 8: *information sharing through Supportlink*

NT Police should:

i. conduct a review of Supportlink's operational protocols in the context of the legal allowances for information sharing under the DFSV framework, and

ii. review and enhance NT Police training in the use of Supportlink, including when a referral should be made and the information to include in a referral.

Recommendation 9: Multi-Agency Protection Service (MAPS)

The Northern Territory Government should consider establishing a Multi-Agency Protection Service (MAPS), modelled on the South Australian initiative so as to formalise a partnership between the NTPF and other relevant government departments.

Recommendation 10: *Embedding of Interpreters and/or Aboriginal Liaison Officers (ALOs) in JESCC*

The NT Police should:

i. employ interpreters and/or ALOs in JESCC to provide language and/or cultural skills to assist callers to communicate more effectively,

ii. embed the role of Aboriginal language speakers within JESCC's operating procedures, and

iii. improve training for JESCC call takers to know when to ask if a caller would like the assistance of an interpreter.

Recommendation 11: *PARt training*

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

Recommendation 12: *A permanent NT Police DFSV Command*

The NT Police should:

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

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

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

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

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

Recommendation 14: *Continued commitment to Safe and Together Framework*

DCF should demonstrate its continued commitment to the Safe and Together Framework by conducting an audit into the implementation of the Framework, to ensure that the roll out has been effective and complete.

Recommendation 15: *Young people engaged in violence*

The NT Government should fund, and DCF should develop and implement, timely and intensive early interventions for young people who are reported as being involved in DFSV (as victims or perpetrators), consistent with the Safe and Together Framework and in an attempt to prevent further DFSV.

These should be in addition to existing programs. This expands on an existing action 3.10 of Action Plan 2.

Recommendation 16: *Community-based approaches to child welfare*

The NT Government should provide additional funding for existing and developing community-based approaches to child welfare (such as the Mikan Child Protection Reference Group in East Arnhem) and for research into how community models may be expanded to increase the safety and wellbeing of children in remote NT communities.

Recommendation 17: *Specialist DFSV Court*

The NT Government should provide increased funding to allow for an expansion of the specialist court approach in Alice Springs to other courts (prioritising Darwin and Katherine) and to adapt the model for bush courts. This expands on existing AP2 actions 2.2(a-e). The increased funding should be sufficient to enable:

i. Funding of the suite of services required to support the work of the court, including victim support and risk assessment, offender support and risk assessment and behaviour change programs (including partner contact services), and legal advice and representation for both parties.

ii. Following the commencement of the *Sentencing Legislation Amendment Act 2023*, adaptation of the current specialist court model, particularly in relation to the introduction of new community based

orders and the requirement of the court to consider whether there is unacceptable risk of DFSV in sentencing.

iii. A trial to determine the extent to which restorative justice practices can be safely incorporated into the model.

Recommendation 18: *Culturally appropriate, trauma informed, mediation/peacekeeping for family and community violence*

The NT Government should fund and ensure trained (including some PARt and RAMF trained) mediators are available to work in conflict resolution processes relating to family and domestic disputes. Adequate funding should include provision for remuneration, training, coordination and exchange of information, and the investigation of opportunities to fund law and justice groups to support, participate in or lead mediations. Peacekeeping groups should include both cultural and DFSV expertise.

Recommendation 19: *ADR recognition for Community-led mediation and peacemaker groups*

Community-led mediation and peacemaker groups operating in remote NT communities should be recognised, regulated, and funded by the NT Government as Alternative Dispute Resolution (ADR) service providers, with their consent.

Recommendation 20: *alternatives to custody for perpetrators of domestic and family violence*

The NT Government should commit to enhancing, developing and funding alternatives to custody for perpetrators of domestic and family violence within the NT.

Recommendation 21: *The NT Victims Register to be an opt-out system*

The operation of the NT Victims Register should be reviewed to consider whether it should be as opt-out system of registration. Such a review should consider how the Register can be used to notify victims of the release of

inmates to "time served" and those inmates dealt with under the provisions of Schedule IIA of the *Criminal Code*.

If those changes are made, the NT Government should provide CVSU with a corresponding increase in funding.

Recommendation 22: *Update to NT Charter of Victims' Rights*

The NT Government should consider whether the Charter of Victims' Rights should be embedded as a new Part 5A of the *Victims of Crime Rights and Services Act 2006* (NT).

Recommendation 23: *Funding for men's prison-based behaviour programs and counselling*

The NT Government should ensure increased and long term funding is allocated for behavioural change programs and counselling in prisons, inclusive of independent evaluation of the effectiveness of those programs. This *should not* be done at the expense of funding for offence specific programs, such as the RAGE program. This expands on Action Plan 2 action 2.1c.

Recommendation 24: *criteria for men's prison-based behaviour programs and counselling*

The criteria for entry into men's prison-based programs and counselling should be revised to improve accessibility, particularly for the large cohort of inmates on remand and those with disabilities.

Recommendation 25: *Men's prison-based behaviour programs for deniers*

The NT Government should urgently fund the development and implementation of a program for 'preparatory' counselling and/or programs to target men who are reluctant to accept responsibility for violent behaviour.

Recommendation 26: *DFSV specific throughcare and reintegration*

The NT Government should provide long term funding to establish specific Throughcare and reintegration programs for men leaving prison and returning to community, and support for their partners. The programs should be centred around the Risk Assessment and Management Framework (RAMF) so that the safety of women is paramount. If it is safe to do so, these programs should occur on country.

Recommendation 27: *DFSV screening and assessment of health clients*

NT Health should:

i. continue to improve and increase its screening of clients for DFSV, with priority given to antenatal and emergency service clients, and amend any policy or procedures necessary to embed this change,

ii. implement and enhance training to ensure that this screening is undertaken by employees who have had DFSV training, cultural competency training, anti-racism training and training in using AIS interpreters. It is important that these social workers be trained in DFSV risk assessment and safety planning for clients identified with DFSV through the screening process,

iii. develop policies that encourage its staff to report a suspected case of DFSV to Police, even where a patient claims to have already reported it, with related training about the importance and value of these reports, and

iv. raise staff awareness and give staff the tools and structures to assess and manage risk by engaging in and funding the PARt Consortium to pilot DFSV (PARt and RAMF) training for NT Health workers, including Aboriginal Liaison Officers (ALOs).

Recommendation 28: *Aboriginal Liaison Officers in hospitals and clinics*

The NT Government and NT Health should ensure that the terms of remuneration and supports for ALOs in hospitals are increased in recognition of their unique expertise and the crucial cultural role they provide for clients and staff, including support provided to clients with DFSV.

Recommendation 29: *Men's community based programs and prevention related activities*

The NT Government should increase funding for existing behavioural change programs and other community-driven DFSV programs for men, to improve their current capacity and to provide for delivery of programs into additional locations (including remote communities according to identified need), and for independent evaluation of all programs. These should include culturally appropriate prevention related activities. Where possible, each of these programs should be developed and delivered by or in partnership with Aboriginal Community Controlled Organisations. This expands on Action Plan 2 action 2.1b.

Recommendation 30: *Education*

The NT Government should invest in the development of culturally appropriate prevention and education programs, initially in schools, but also in the wider media, including social media, so that young people have the opportunity to learn about DFSV and interpersonal violence (IPV) and, conversely, respectful relationships. This builds on Action Plan 2 action 1.1.

Recommendation 31: *DFSV training for clubs and pubs*

The NT Government should retain an independent service provider and fund a training package in 'becoming domestic and family violence aware' (similar to that provided by Dr Chay Brown to the Gillen Club), that is funded by NT licensed clubs and can be rolled out to all clubs and other licenced premises.

Such training may be mandated or incentivised as part of the licensing scheme.

<u>Recommendation 32:</u> *Banned Drinker Register (BDR) scanners:*

To give effect to s138 *Liquor Act,* the NT Government should impose a mandatory 12-month trial of the use of BDR scanners in licensed venues to screen patrons who intend to consume liquor on the premises, and should evaluate the trial to determine its efficacy. If the trial is evaluated to be ineffective, consideration should be given to amending the terms of s138 of the Liquor Act.

<u>Recommendation 33:</u> *Full implementation of NT DSFV Action Plan 2*

The NT Government should fully implement Action Plan 2 (to be read with the associated Mapping Report) as developed and costed by the Domestic, Family and Sexual Violence Interagency Coordination and Reform Office (DFSV-ICRO) (that is, at the cost of at least $180 million over five years, and ongoing funding of $36 million per annum, adjusted for inflation to account for the years since the DFSV-ICRO made its submission).

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The NT Government should increase the baseline funding for frontline DFSV crisis services (for example but not limited to safe houses, outreach support for women and children experiencing DFSV; counselling and healing services) by a figure in the order of 10%, to address the quantified lack of core funding which results in unmet need.

<u>Recommendation 35:</u> *Indexation*

With respect to frontline DFSV services, the NT Government guidelines should be amended so that grant funding terms and conditions explicitly include indexation that is commensurate with real cost of living increases,

and ensure those services are exempt from (what are referred to by the Government as) “efficiency dividends” and “budget measures”.

Concluding remarks

> ***“We cannot maintain the status quo. We have to do things completely differently. We have to challenge our thinking…and challenge each other”***
>
> Commissioner Michael Murphy in evidence 20 May 2024 at T9.

738. The plague of domestic violence homicides that relentlessly courses through our community in the Northern Territory is our horror and our national shame.

739. The number of domestic violence deaths in the Northern Territory is truly shocking. My office is aware of at least 86 domestic violence deaths of women, most of them Aboriginal women, over the last 24 years. Shockingly 8 of those deaths have been since June this year and all of these most recent deaths are Aboriginal women. In addition to these 8 recent deaths, a man and a sister girl have also died from domestic violence since July last year. The grief and trauma across our communities flowing from this traumatic loss of life is inexhaustible.

740. Domestic and family violence is present in our homes, on our streets, in our shopping centres and parks, on our beaches and at our bus stops. It is happening right now. Right now 000 calls are being made and first responders, in police cars and ambulances, are being dispatched.

741. Statistics are numbers but the people they count are not. Those people include the four women whose lives and deaths were examined in these inquests. All of these women were daughters and sisters and aunties and some of them were mothers. Each of these deaths was preceded by years,

decades even, of other acts of harassment, control and violence. Together, their stories help us understand the nature of the problem.

742. This is not just an unfolding tragedy for those families most directly affected. It is also an existing tragedy for our community, our agencies and our institutions that work to serve our community. It affects the Northern Territory every single day: women and children are suffering, our young police constables are exhausted, our courts are struggling to cope and our gaols are overflowing. We cannot arrest our way out of this problem.

743. And what is all this doing to our children? The developmental damage being suffered by children exposed to domestic violence is difficult to quantify but cannot be overlooked or underestimated. It is not only a terrible blight on their lives but also directly on ours because we know that 94% of the very youngest children in detention (10-13 year olds) have been exposed to family violence. When children do not feel safe at home they move out into the streets and join forces with other similarly traumatised children. Most children are in detention for repeat and serious property offending committed when in company with other young persons, and the community is reeling from this offending. Sadly, without serious interventions, these children often will likely grow into adults who use violence. We seem very quick to blame kids and parents, but there are currently no pre-court diversion specific programs for children who are exposed to or are perpetrating domestic violence. Who is responsible for that failing? And what are the consequences for those children and for all of us?

744. The response of many individuals working to turn this tide is often heroic and often at the expense of their own wellbeing. As a community we extend our gratitude and thanks to those working tirelessly to respond to this plague. But in spite of those efforts, we must also frankly acknowledge that our agencies, Government and Non-Government, are failing to turn the tide: our combined responses are too narrow, too piecemeal, too small, too ineffective, and they are often culturally ill-

informed and culturally inappropriate. Imagine for a moment calling 000 in an emergency, knowing that the call will be answered by someone who does not speak your language and there is no interpreter. Do you make the call? And if you do, how will you communicate?

745. Early in these Inquests, Acting Deputy Commissioner Michael White said, “we are at an epidemic proportion that I can’t see a way out of unless there is radical change.” When I heard that statement, I very much believed it to be true. But having received all the evidence and considered the detailed submissions, I no longer think radical is the way to describe it. I have made 35 recommendations today and I don’t think any of them are radical. None of them are new. They all build on and are informed by the work that is already being done by our academic experts, the managers and front line staff working every day in the domestic violence sector, the Police, Health, Department of Children and Families and Corrections executives and workers, and by the family of those who have passed and community members with lived experience.

746. If the task seems too big or overwhelming and this all sounds impossible, if anyone is feelings defeated, there is some good news. With all this combined input we know what needs to be done and there is no reason for any further delay before action is taken.

747. To the families of Miss Yunupiŋu, Ngeygo Ragurrk, Kumarn Rubuntja and Kumanjayi Haywood: thank you for entrusting us with their stories. In these Inquests we have talked about sad times and their tragic passings but I know that you remember them when they were smiling and laughing, sharing stories and spending time on country, and in delivering these Findings I am going to remember that way too.

Cover Art by: Esther Bruno Nangala, *"Bush Raisin Dreaming"*
Back Cover Art by: Evelyn Daniels, *"Girls Learning Ceremony after School"*

CORONERS COURT

Northern Territory

2024