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REPORT TO THE LEGISLATIVE ASSEMBLY

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

In the matter of the Coroner's Findings regarding the deaths of Master W, Miss B and Master JK

Pursuant to section 46B of the *Coroners Act 1993*, I provide this Report on the findings in the report of Local Court Judge Greg Cavanagh, Territory Coroner, dated 15 December 2020, regarding the deaths of Master W, Miss B and Master JK (the Deceased) (Attachment A refers).

The Report includes the responses from the Chief Executive Officers (CEOs) of the Department of Territory Families, Housing and Communities (DTFHC) (Attachment B refers), and of the Department of Health (DoH) (Attachment C refers).

The Deceased were:

- Master W, a 12 year old Aboriginal boy, who died at some time on 21 May 2018, at Gapuwiyak Community in the Northern Territory. The cause of death was inhalation of petroleum vapour.
- Miss B, a 17 year old Aboriginal girl, who died at some time on 10 August 2018, at Yirrkala in the Northern Territory. The cause of death was self-inflicted hanging.
- Master JK, a 13 year old Aboriginal boy, who died at some time on 3 November 2019, at Maningrida in the Northern Territory. The cause of death was solvent inhalation (butane, propane).

Comments of the Territory Coroner

The Territory Coroner made the following recommendations in regards to the deaths of the Deceased:

> '209. I **recommend** the Top End Health Service provide such training and supervision such as may be necessary to ensure their processes and procedures are in accordance the *Volatile Substance Abuse Prevention Act*.

210. I **recommend** that government give consideration to funding a rehabilitation service in a regional centre in the top end of the Northern Territory.

211. I **recommend** that government implement recommendation 238 of the Royal Commission into Aboriginal Deaths in Custody.'

The Territory Coroner also made extensive comments with respect to the deaths of the Deceased at paragraphs 171 to 208.

Response to Territory Coroner's comments

A copy of the Coronial Findings was provided to the CEOs of DTFHC and DoH on 27 January 2021 in accordance with section 46A(1) of the *Coroners Act 1993*.

A written response was received from the CEO of DTFHC dated 17 March 2021 (Attachment B refers), as required by section 46B(1) of the *Coroners Act 1993*, advising that:

- DTFHC is participating in intergovernmental approaches to youth engagement identified in recommendation 236 (Programs for Aboriginal Youth at Risk) of the Royal Commission into Aboriginal Deaths in Custody (RCADIC) which sits alongside recommendation 238. While positive progress has been achieved, there is more that government can do. Over the last four years, DTFHC has committed to investment in improved youth services.

Sexual harm

- DTFHC has undertaken reforms to improve staff capacity to identify and respond to sexual harm concerns. The Sexual Harm and Exploitation Project aims to improve staff training when responding to child sexual harm, and is updating policy and procedures to address effective responses to sexual harm and exploitation. Phases 1 to 3 of the Project are complete, including delivery of staff training in conjunction with the Sexual Assault Referral Centre in major population centres throughout the Territory.

- The Signs of Safety practice framework has been adopted, which centres on family safety assessments and support, moving away from an incident and risk focussed approach. This encourages working to develop engagement skills, and meeting needs in a more transparent and responsive way.

- DTFHC, NT Police, DoH, and the Department of Education are revising the Memorandum of Understanding to develop a multi-agency child abuse taskforce protocol for screening and investigating allegations of child sexual abuse and exploitation.

Domestic violence

- DTFHC has undertaken reforms to specifically improve staff capacity to identify and respond to domestic violence concerns. The Domestic, Family and Sexual Violence Reduction Framework is a multi-agency approach to prevent, reduce and respond to domestic violence.

- Training in the Safe and Together Model has been underway since 2019, and provides a suite of tools and interventions designed to help staff become informed about domestic violence.

Volatile substance abuse

- DTFHC has undertaken reforms to improve the capacity of staff to holistically consider circumstances in the context of volatile substance abuse (VSA) concerns, which may be an indicator that other harm is occurring.

- DTFHC has improved its response to VSA notifications in East Arnhem through closer work with Miwatj Health to provide information to primary caregivers and family.

- Multi-Agency Community and Child Safety (MACCS) Teams will continue to engage with Aboriginal community controlled health services to deliver community-wide responses to VSA among children and young people.

- The induction program for Departmental Case Managers is being revised to include specific examples on VSA intervention and referral pathways.

Collaborative practices

- DTFHC has established the MACCS Framework to respond to the coronial findings. MACCS Teams in remote communities are using a place-based intervention model to deliver a coordinated response to children and families with comparatively greater needs, and by addressing thematic social issues in the local community.

A written response was received from the Acting CEO of DoH dated 1 April 2021 (Attachment C refers), as required by section 46B(1) of the *Coroners Act 1993*, advising as follows:

In response to the recommendation at paragraph 209:

- The Top End Health Service (TEHS) reviewed its care model for Alcohol and Other Drugs in November 2020, to implement new forms and procedures to guide assessors. This will be formalised as a training package for relevant staff to understand the requirements of working under the *Volatile Substance Abuse Prevention Act 2005* and processes required to provide VSA assessment services.

- Weekly multi-disciplinary team meetings are being held to provide for the review and supervision of VSA cases by team leaders and medical staff.

In response to the recommendation at paragraph 210:

- Regional treatment services are being investigated in East Arnhem, with a series of stakeholder meetings on 23 and 24 February, and 3 March 2021 in Nhulunbuy and Galiwinku. DoH is working closely with the Department of the Chief Minister and Cabinet to provide strong community input into the service design.

- TEHS has also undertaken a review of the Mental Health and Alcohol and Other Drugs service model, with recommendations from this review being progressively implemented. In particular, improving early treatment interventions for young people, with clearer service coordination and support.

I am satisfied that the Department of Territory Families, Housing and Communities and the Department of Health have considered the recommendations and comments of the Territory Coroner and are taking the necessary steps with respect to those recommendations and comments.

DATE: 10 MAY 2021

Selena Uibo

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