**FORM 37**

Rule 60(1)

# FINDING INTO DEATH WITH INQUEST

*Section 67 of the* ***Coroners Act 2008***

**Court Reference: 5166 / 2007**

**Inquest into the Death of Sharkia Handy**

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|---|---|
| Delivered On: | 14th January 2010 |
| Delivered At: | Mildura |
| Hearing Dates: | 18th, 19th and 20th November 2009 ; 14th ,15th December 2009 and 22nd December 2009. |
| | Finding delivered 14th January 2010. |
| Findings of: | William Peter WHITE |
| Representation: | Jim Buchecker - DHS |
| | Thomas Ashton - Famliy |
| | Campbell Thomson - Family |
| Place of death/Suspected death: | Robinvale |
| *SCAU | |
| *Counsel Assisting the Coroner | Senior Constable Stuart Thompsett |

## FORM 37

Rule 60(1)

## FINDING INTO DEATH WITH INQUEST

*Section 67 of the* ***Coroners Act 2008***

**Court Reference: 5166 / 2007**

In the Coroners Court of Victoria at Mildura

I William Peter WHITE , Coroner having investigated the death of:

**Details of deceased:**

| | |
|---|---|
| Surname: | HANDY |
| First name: | Sharkia |
| *Address: | 222 Latje Rd Robinvale VIC |

AND having held an inquest in relation to this death on 18th, 19th and 20th November 2009 ; 14th and15th December 2009 ; 22nd December 2009

at Robinvale, Mildura and Melbourne.

find that the identity of the deceased was Sharkia Handy

and the death occurred on or about 21/12/2007

at Robinvale

from Hanging in the following circumstances:

1. I, William Peter White Coroner, having investigated the death of Sharkia Handy at an inquest held over a total of six days - vis 18, 19 and
2. 20 November 2009 at the Robinvale Magistrates' Court; 14th and 15 December 2009 at the Mildura Magistrates' Court and 22 December at the Melbourne Magistrates' Court. During the course of this inquest viva voce evidence was received from 17 witnesses and statements from two witnesses were tendered. Further, a number of exhibits ranging from notes of various witnesses to official records were tendered.
3. From the evidence presented and the recording in various documents (both official and unofficial) it is clear that the first name of the deceased varies in both spelling and pronunciation, she being referred to variously as Shakir, Sharkya, and Sharkia. There being two documents bearing the heading, "Statement of Identification" - both signed by one David Handy an uncle of the deceased, which state the first name of the deceased as being Sharkya (dated 21 December 2007) and Shakia (identification witness dating the document as

4. 6 July 2008).

5. The police report of death dated 21 December 2007 states the deceased's first name as being Sharkia.

6. The autopsy report dated 22 August 2008 states the deceased's first name as Shakia.

7. The reports of the Department of Human Services submitted to the courts over the years 2005, 2006 and 2007, in applications for extension of custody orders, each refer to the deceased as Sharkia.

8. All relevant reports concerning the deceased's death refer to the same case number 5166 of 2007. All reports of relevance refer to the deceased's date of birth as being the 27th day of July 1993.

9. I find the deceased to be Sharkia Handy (also known as Shakia Handy and Sharkya Handy) who was born on

10. 27 July 1993.

11. I find that the deceased died in the early hours of the morning of 21 December 2007 at Robinvale in the State of Victoria.

12. I find that the cause of the deceased's death was hanging. The deceased being found hanging by a garden hose from a branch of a tree situated in the grounds of the Robinvale Consolidated school at about 7.15 a.m. on 21 December 2007.

13. From the evidence and situation of the deceased when found, there is no reason to suspect that any person or persons other than the deceased herself were involved directly in this act.

14. It is not known how the deceased obtained this garden hose or from whence such hose came; no garden hose has been found to be missing from nearby houses and the hose itself, was not of a type that was used by the school where the deceased was found. I make the comment, that it would appear that only perfunctory inquiries have been made to ascertain from whence the garden hose came or to whom it belonged.

15. I set out, together with various comments, that which I find to be the background circumstances and events surrounding and leading up to the deceased's death. For convenience this will be loosely dealt with under a number of headings.

16. A THE DECEASED'S PERSONAL BACKGROUND AND RELEVANT GENERAL HISTORY

17. The deceased was the third of four children born to Kym Holloway and Dean Handy. This family came under the notice of the Department of Human Services (hereinafter referred to as, "the Department") in about March of 1995.

Custody to Secretary Orders were made in respect of all the children in November of 2000. So far as concerns the deceased such orders were extended each year - the last extension being granted by the Children's Court at Mildura on the 11th day of December 2007. It would appear that most extension applications were made by consent. Certainly the most recent extension application - that of 11 December was made by consent - at such application the deceased was represented by counsel; neither Ms K Holloway nor Mr D Handy were present at that application hearing, although each had been notified of such application.

18. I note that the original application for a Custody to Secretary Order related to protective concerns in relation to ... "The children's exposure to domestic violence, alcohol and substance abuse, and subsequent abandonment/desertion by their mother."

19. I note further that in the report of Ms Lee O'Connor of 5 December 2007 (a protective worker for the Department) prepared to support the Department's application to extend the Custody to Secretary Order, the following observations and comments are made concerning the deceased:-

20. • She is currently displaying behaviours that are testing the boundaries set by (her) grandmother;

21. • She is believed to have participated in some alcohol and drug experimentation, and has engaged with a drug and alcohol counsellor to address these issues;

22. • She has at times displayed problematic behaviours;

23. • She continues to be angry, resentful and disappointed in her mother's treatment of her. She is regularly offered counselling to address these issues, however .... does not feel the need to engage with counselling support at this time;

24. • She does not apply herself to her studies and regularly finds reasons to miss school days.

25. This report expresses the view that there "Is no immediate or significant risk of harm to any of these children while they remain with their present carers". In the case of the deceased this means the carer being

26. Ms Margaret Handy - the paternal grandmother of the deceased.

27. It should be observed that there is some irony in this report in that it is dated some 16 days before the deceased's death and that the last face to face meeting Ms O'Connor (the maker of the report) had with the deceased was on or about 10 October, that is some 55 days before the report was written.

28. Since the granting of the Custody to Secretary Orders, the deceased has mainly resided in the Robinvale area, usually with family members; for some five or six years she resided with her aunt Ms Shirley Handy.

29. There has been at least one significant attempt to have the deceased reside with her mother - this was for a period of some months in late 2006 and early 2007. The Department assisted the deceased in this endeavour providing transport to Melbourne and arranging for the deceased to attend school and paying various fees on her behalf. This move was not supported by the deceased's aunt. This endeavour did not last and resulted in the deceased returning to Robinvale where for a short period she resided with a Ms Shorna Johnson and then in about April of 2007 she moved to live with her grandmother

30. Ms Margaret Handy.

31. The Department accepted the deceased's wish to reside with her grandmother as did (apparently)

32. Ms Shirley Handy.

33. Notwithstanding the deceased's ceasing to live with her mother, she retained a strong desire for close contact with her and it was her hope to again live with her.

34. This continuing desire was, and remained unrealistic due principally to her mother's lifestyle. Indeed,

35. Ms Shirley Handy expressed in no uncertain terms that contact between the deceased and her mother was inappropriate. Ms Shirley Handy stated that whilst the deceased was living with her, she noted great mood swings began whenever there was contact between the deceased and her mother. There is evidence from a number of witnesses - including one of the deceased's teachers that contact between the deceased and her mother had a distinctly unsettling effect upon the deceased.

36. The deceased clearly had a great affection for her grandmother, which was reciprocated, however since moving to live with her grandmother, the deceased began to spend more and more time away from her home - frequently staying out overnight (or nights) and returning in the morning. The deceased spent a lot of time with the Briggs family - one of whom being her closest friend, Maria Briggs. In evidence to this inquest Ms Allison Briggs (the mother of Maria) said she regarded herself as the aunt of the deceased and had even considered adopting the deceased but due to her personal regard for the deceased's grandmother (Ms Margaret Handy) she had not done anything in this regard.

37. Having regard to the evidence presented at this inquest, it would seem that there are a number of reasons why the deceased spent more and more time away from her grandmother's home. Such reasons would include:-

38. • The deceased found increasing difficulty in abiding by her grandmother's rules or boundaries;

39. • The deceased was going through an adolescent stage with which her grandmother could not cope or had difficulty in accepting or controlling;

40. • The living arrangements at the grandmother's house changed in that the deceased did not have a room of her own and at times had to sleep with her grandmother;

41. • The deceased's grandmother, due to ill health, could not adequately set out or enforce adequate guidelines or boundaries;

42. • The deceased was given greater freedoms at the Briggs' home, especially in that there was less and/or very little supervision or control of her movements or the hours that she was able to keep;

43. • There was little or no supervision or control over drinking of alcoholic beverages at the Briggs' home. I comment that the impression one has is that alcohol was freely available - and there was no or little control of the same. In this regard I note the conflicting evidence of Ms Allison Briggs herself who states that she did not see the deceased drink at her home and did not know that young people drank there but on the night before the deceased died Ms Briggs stated that she knew that the girls (Maria, deceased and friends) were going out to drink - at about 10 p.m. - but not to get drunk.

44. I further note and accept that Ms Margaret Handy

45. - and before her, Ms Shirley Handy - did not drink or allow drinking by children at their respective homes.

46. Quite separate from the reasons why the deceased spent more and more time away from her grandmother's home; it is clear that the deceased was facing a number of significant personal issues. These include:-

47. (a) A feeling that she had been abandoned or to use the word of one of the witnesses, "Dumped", by her family and friends. Clearly the deceased wanted to belong to and be part of a cohesive family, which the help and assistance apparently available to her did not address.

48. (b) A feeling of grief. This would appear to have been deep and underlying, being aggravated by a number of significant incidents:-

49. (i) A young relative had committed suicide in late 2006;

50. (ii) A friend - Richard Tou had committed suicide in about September of 2007. This incident being of particular significance in that the deceased seemed to identify with this death in that she placed this person's name on an item of clothing that she wore and further, the manner and place of Richard Tou's suicide was remarkably similar to that of the deceased.

51. (iii) Sadness over the Kerang rail disaster - some of the victims of which were known to and friends of the deceased;

52. (c) The statement of suicidal thoughts and an attempt at self harm. The deceased cut her wrists - scarring of some ten wounds were observed by some witnesses. Following the disclosure to a school teacher of these thoughts the deceased was referred to, "Child Adolescent and Mental Health Services" (CAMHS) a referral which was completely appropriate at the time.

53. (d) A general lack of self esteem and lack of interest generally. The deceased's grandmother states that she had difficulty in having the deceased attend to her own personal hygiene and cleanliness - other witnesses observed a distinct dropping off in the deceased's general care for herself and her appearance and the clothing that she wore during the last months of her life.

54. From the evidence of witnesses who came into contact with the deceased - friends, family, teachers, it is clear the deceased was extremely moody, being happy and engaging if she got what she wanted, however if she did not get what she wanted she became solemn, angry, morose and withdrawn, or as one witness stated, "Flighty".

55. B THE DECEASED'S SCHOOLING/ACTIVITIES AND DEALING WITH THE DEPARTMENT

56. The deceased attended, or perhaps a more accurate description would be "Was enrolled" at the Robinvale Secondary College, where it would appear that she was in Year 9 at the time of her death. The school records disclose that for the 2007 school year up to the date of her death, the deceased was absent without explanation on some 68 days - further and just as important, she was frequently/regularly late for classes - according to the records tendered such lateness ranged from five minutes to 35 minutes. Little attention seems to have been taken of these facts although the Acting School Principal at the time did have a meeting with the deceased and her grandmother approximately one month prior to the deceased's death, concerning such absences. It is not known what action if any, was taken, or was to be taken in the future as a result of this meeting - the Acting Principal who had only been at the school for the final term - stated that he could not remember the details of the meeting; apparently no records of the meeting other than it having taken place had been made.

57. Evidence was presented by three teachers at the school who came into contact with the deceased regularly (so far at least as her attendance would allow)

58. - Ms Helen Sullivan the school nurse and chaplain;

59. Ms Helen McColl the deceased's home room teacher and Ms Myrtle Sampson, the Koori education officer.

60. Ms Sullivan when asked to comment about the deceased's absences stated -

61.

62. "I know you're talking about truancy but the kids - the school'/s their safe place, that's where they come for their friendship, they don't come to learn, they come for friendship I can tell you that. But the school's the place the kids come for protection, for safety and support and someone who's positive about them. So, yeah, it's a place the kids like to be. They come for friendship and the social side but you hope to slip in some learning in there along the way?"

63. Ms Sullivan was aware of the deceased having suicidal tendencies and as a result as I have said, had the deceased sent to CAMHS. This however was not relayed to Ms Sampson (the Koori officer) the reason being that there were, "Principles of privacy" involved. Indeed the clear impression of the overall attitude and practices of teachers at the school was a general lack of communication between each other concerning the problems of any particular student. At most any communication being on a "Need to know" basis only, and not for any real concern for addressing or even being aware of a particular student's problems.

64. I comment, that it seems that "Privacy" was a concept that teachers seemed to hide behind to protect themselves rather than as a protection for the person involved which of course is what the Privacy Legislation is designed to achieve.

65. None of these teachers was aware that the deceased had an alcohol problem but all conceded that alcohol (and drugs) were problems with all teenagers. Ms Sampson stated quite bluntly that -

66.

67. "You can't stop kids doing what young kids do and that alcohol and drugs is a problem over all for teenagers of all ages. Kids using it on a regular basis."

68. None of the teachers was aware of any bullying concerning the deceased - one of them saying that anyway the deceased could, "Give as well as she got."

69. Ms Sampson, who in addition to being a Koori educator at the school had known the deceased all of her (the deceased's) life, however was not aware that the deceased;

70. (1) Had expressed suicidal feelings;

71. (2) Had self harmed;

72. (3) Had been referred to CAMHS;

73. (4) Had expressed a wish to leave Robinvale;

74. (5) Had complained of hearing voices.

75. However Ms Sampson was adamant that if children

76. - especially Koori children, had any problems, they knew to

come to her. Ms Sampson made it clear that if she thought that a child had problems she would tell the coordinator or Principal and if she thought that a child was depressed she would take the matter up with the child's family. Ms Sampson stated that whenever she saw the deceased the deceased appeared happy and when asked how she was responded, "OK".

77. Ms Sampson was particularly critical of the Department - saying simply that the Department was not doing its job. It is clear that in reality however, she had little to do with the Department specifically concerning the deceased. However Ms Sampson in her views does illustrate a perceived impression that the Department is somewhat highhanded and even offhanded in carrying out its duties concerning children generally under its care. At any event, there seems to be a general lack of trust or perhaps "Openness" between the Department and the school and the teachers thereat.

78. The Department does however visit the school on a fairly regular basis and is known to attend from time to time on certain specific days.

79. The school does have in place a number of ways in which it can assist students with varying problems - it has or offers counselling as needed; a room to which students may retire if they feel the need et cetera; further a number of sporting and other activities are offered, generally on a seasonal basis.

80. In my view the problem is that these programs are there, but not actively pursued or monitored. Constant observations from witnesses express this in terms of

81. - "If a child does not want to participate or engage et cetera there is nothing that can be done - he or she cannot be forced." The general attitude being for example, that if a child had a problem, say drinking, the child was referred to counselling - the consequence of this being that that is all that can be done and therefore the problem has been rectified and puts an end to the same. There is no follow-up or reinforcing of anything learned or achieved in any such counselling.

82. This attitude is similarly apparent in the procedures of the Department. When the deceased's drinking problem became apparent she was simply referred to counselling, there being no monitoring or realistic following up of the same. On an occasion when the deceased apparently expressed dissatisfaction with the counselling offered, it was simply stated by the Department that, well the Department continued to offer counselling as needed. In my view this is just an easy acceptance of a major problem. It should have been addressed in my view in a more persistent and determined way.

83. A similar attitude seems to be prevalent in the Department in relation to the receiving of reports from persons to whom a child, in this case the deceased, was sent.

There is no formal reporting of the same, however, there is a verbal reporting of the same but no specific report is presented to the Department. In the instance where the deceased was referred to CAMHS, she attended with a Ms V Chong on some six occasions .

84. Ms Veronica Chong, a counsellor and social worker who had worked with children suffering mental health issues over a number of years assessed the deceased and found that she (the deceased) did not have any major psychiatric issues and that she did not need to be referred to a psychiatrist. Ms Chong however did express the view that the peer group with whom the deceased mixed did place her at some risk When Ms Chong last saw the deceased (July 07), the deceased appeared happy and stated that she has resolved her problems with her cousins and did not need further counselling.

85. I note further that in the counselling sessions the deceased had with Ms Chong, the deceased:-

86. • Did not want to engage in activities through the Aboriginal Co-Op (a matter referred to by other witnesses at this inquest);

87. • Was pretty much concerned with her relationship with her cousins and friends;

88. • Was sad at the way her mother was treated by her father;

89. • Did not state that she wanted to leave Robinvale (In passing I note the evidence of a number of teachers that it was not unusual for young people to state that they wanted to leave Robinvale);

90. • Declined any alcohol abuse on her own behalf – but did not say how much or how often she drank alcohol.

91. Ms Chong stated that she made a formal report but did not provide either the Department or the school with a copy of the same, however she spoke about the report verbally to Ms O'Connor of the Department.

92. In any event the general attitude of the Department's officers seems to be simply that a problem is dealt with and finished if the appropriate referral has been made.

93. C THE EVENTS OF THE DAY AND EVENING PRIOR TO THE DECEASED'S DEATH

94. The deceased at around midday on 20 December 2007 left her grandmother's home and went to the Briggs' house to be with her friends - Maria Briggs and others. Descriptions of the deceased's behaviour during the day varied, however it would appear that during the day and evening the deceased displayed various moods being at times happy and joining in with others in the general activities and at other times being morose, withdrawn, quiet, angry and irritable. At one stage the deceased became emotional and upset which led to an altercation of some sort, however this

was resolved. At about

95. 10 p.m. the deceased and her friends left the Briggs' home and went to wander around the town of Robinvale. The deceased then came away from her friends and refused to stay with them.

96. The deceased was last seen by her friends walking across the school grounds at a time which was some time after midnight. When she was last seen her friends believed that she was returning to her grandmother's home. What is very clear about the day and evening prior to the deceased's death was that the deceased and the people with whom she was mixing were drinking alcohol and drinking far from moderate quantities of the same. It is reported that the deceased was drinking cans of spirits and coke and also drinking from a bladder of a Moselle cask. A number of witnesses variously described the deceased's condition during the evening as being very drunk. This is clearly borne out by the fact that the autopsy report disclosed that the deceased had a blood alcohol content of .140.

97. D THE POSITION AND ACTIONS OF THE DEPARTMENT

98. I have already made mention of the acts of the Department concerning its dealings and relations with the deceased. Clearly the deceased had many problems in her life which weighed heavily upon her and her perception of herself. The major problem being her relationship with her immediate family, especially with her mother. One of her teachers describes this problem, by saying:-

99.

100. "She always wanted to be with her mother but it was very soul destroying for her - her mother had drinking and alcohol problems which concerned her (the deceased), and she wanted to fix it".

101. This background alone posed enormous problems for the Department in finding an appropriate placement for the deceased. It seems to me that the final placement by the Department of the deceased with the fraternal grandmother - was at the time appropriate. It in fact complied with a number of protocols and practices followed by the Department - namely keeping the deceased with family members and in an area where she could be and mix with her friends et cetera. It should be remembered that this was simply an acceptance or approval by the Department of a decision made by the deceased herself. As I have said, this deceased's decision was supported by the deceased's auntie Ms Shirley Handy and it would appear also by Ms Sampson.

102. Criticism - not without some foundation, has been made that this placement was or became inappropriate as time went on as clearly the deceased lacked supervision and to put it quite plainly discipline. However, to say that another placement should have been made by the Department in the

circumstances of this case is a statement that perhaps is easily made without regard to the realities of the case. There was apparently no other placement readily available, particularly in the Robinvale area. To simply say that the deceased could have been sent to her mother or a friend in Echuca or some other place was simply an opportunistic statement as any such placement would of course have had to have been checked out. In any event one of the priorities is to so far as possible keep any placement within family areas, places where the deceased would be at home.

103. Ms O'Connor stated that there was no alternative place available. Ms O'Connor discussed this fact with

104. Ms Chong in one of her discussions with her concerning the counselling given by Ms Chong to the deceased.

105. The Department through its officers, did in fact act when it became aware of a problem, appropriately; but the Department did not follow through once an action had been decided upon or taken; as I have already observed the Department simply treated a problem as having been solved once the relevant decision had been made. The Department should have kept greater vigilance in overseeing the life and situation of the deceased - this course can only be done by having and maintaining close contact with all relevant parties, that is the parties with whom the deceased had been placed and the school to which the deceased attended; and the immediate family of the deceased.

106. The Department seems to have taken some matters for granted, specifically in the making of the report tendered to the Children's Court on the final application for an extension order. I have already observed that such report was made some 55 days after a last meeting between the Department officer making the report and the deceased. This is a situation that should not have happened, clearly any report tendered to a court must be clear, concise and up to date and above all accurate.

107. Equally however, the deceased's family and friends can be criticised for not advising the Department of what was happening and of course for not themselves imposing suitable boundaries or limits on the behaviour and activities of the deceased.

108. Also the school can be criticised for not advising the Department or really the deceased's carers, of the situation of the deceased in relation to her school, that is her absences, her conduct and her lateness.

109. CONCLUSION

110. In my opinion the deceased did not receive the care and attention due to her from her family, friends and community, from her school and from the Department.

111. The prime responsibility for the day to day welfare of a child must be with the person or persons with whom such child has been placed or with whom such child is

living. That responsibility being to ensure that appropriate boundaries are not only set in place, but maintained. In this case as regards to the problems of drinking and maintaining unfettered movement at late hours there were it would appear no boundaries. Further, there seemed to be a family or community attitude to let children do as they please. In some sections of the community, and unfortunately the grouping of the deceased's friends fall into this, there is a complete laxity concerning alcoholic drinking. It is unnecessary to say that a child in the position of the deceased should not have been allowed to have access to alcoholic drink at all let alone in the quantities which were obviously made available to her on the evening prior to her death. This is a concern of the community as a whole and not simply confined to any particular grouping within a community.

112. There is also a responsibility upon the Department to frequently check the position of a child under its care - the frequency of such will depend upon each particular case - however in this case, given the background history of the deceased this checking should clearly have been much more direct and frequent than was in fact the case.

113. In my opinion the school also has, in this matter had, a direct and important responsibility to follow the progress of the deceased, it should have kept her family (i.e. the person with whom she was placed) and the Department fully informed of her progress and activities and especially of her constant lateness and absenteeism.

114. In the generality of the circumstances of this matter the actions of the Department, and to a lesser extent the school, were appropriate in themselves, but the actions and decisions made should have been followed through consistently and regularly. This would no doubt need a great deal of perseverance and understanding. However, problems should be addressed in a realistic and practical manner. To simply look as if something is being done and assume that this cures the problem is completely absurd.

115. Many possible recommendations that could be made are obvious and indeed much would seem to have either been the rule and not followed or have since become the rule i.e. adequate planning and programming. However I do make two recommendations.

*RECOMMENDATIONS:

Pursuant to section 72(2) of the Coroners Act 2008, I make the following recommendation(s) connected with the death:

1 The supervision of the Department must be meaningful and direct. Actions taken should be followed through and acted upon or changed as circumstances dictate. The Department should institute a procedure by which this is achieved effectively and meaningfully.

2 There must be meaningful communication concerning a child under care between the Department, the carer (being the person with whom a child is placed), and the school. This communication should not be restricted by considerations of "Privacy", where the welfare of the child in care is concerned. Each of these three parties should be fully informed of problems suffered by the child and actions taken to remedy the same..

Signature:

**Date: 14th January 2010**

**Delete if inapplicable*