IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2014 0172

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	**JUDGE SARA HINCHEY, STATE CORONER**
Deceased:	**SHARNEE NGATAI**
Date of birth:	21 September 1990
Date of death:	11 January 2014
Cause of death:	Penetrating and blunt force trauma to the head
Place of death:	The Alfred Hospital, 55 Commercial Road, Prahran, Victoria

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HER HONOUR:

BACKGROUND

1. Sharnee Ngatai (**Ms Ngatai**) was born 21 September 1990 and was 23 years old at the time of her death. She had three children, Shavanna, Aeriss and Azariah.

2. Ms Ngatai's childhood was unstable. Shortly after her birth, she was removed from her mother's (Raewyn Ngatai) care by her maternal grandfather and lived with various members of the family until the age of nine. In 1998, Raewyn Ngatai's step-sister, Louise Bowman (**Ms Bowman**) and her partner, Sam Korau, became Ms Ngatai's full time carers. Since that time, Ms Bowman considered Ms Ngatai to be part of her family.

3. Between 2002 and 2009, Ms Ngatai lived in New Zealand in an effort to get to know her father. In 2009, she returned to Australia and commenced studying mechanics in Sydney before becoming homesick and returning to Melbourne.

4. In September 2010, Ms Ngatai met and quickly began a relationship with Stevie Ray Cook. When the two met, Ms Ngatai was pregnant with Shavanna. The available evidence suggests Ms Ngatai's relationship with Mr Cook was a significant one in her life, Mr Cook having fathered two of her three children.

5. The available evidence suggests that the violence perpetrated by Mr Cook against Ms Ngatai began early in their relationship.

History of family violence against Ms Ngatai by Mr Cook prior to her death:

March 2011

6. On 12 March 2011, the Department of Health and Human Services[1] (**DHHS**) Child Protection services was notified of concerns about the welfare of Ms Ngatai's then unborn child, Shavanna. On 19 March 2011, Ms Ngatai was transported by ambulance to the Royal Women's Hospital complaining of pain. Ms Ngatai had sustained bruising to her neck, arms and face and indicated that Mr Cook had been responsible for her injuries but declined to make a complaint to police at that stage. Ms Ngatai's baby was then overdue and she was concerned that the baby had been hurt during the assault.

[1] Then called the Department of Human Services.

7. Shavanna was born on 23 March 2011. The evidence suggests that at some stage prior to Shavanna's birth, it became clear to Mr Cook that he was not Shavanna's father. After Shavanna was born, Ms Ngatai decided to surrender Shavanna's care to DHHS. Shavanna was placed with, Ms Ngatai's maternal aunt, Ms Bowman and Ms Ngatai maintained her relationship with Mr Cook.

May 2011

8. On 8 May 2011, Ms Ngatai presented at the Northern Hospital with significant facial injuries, including a full thickness laceration to her left nostril and two broken teeth. Ms Ngatai reported at the time that she had been punched in the eye by "*someone*." The assault was not reported to police.

9. On 19 May 2011, Ms Ngatai presented to the Northcote Hospital in Epping, suffering a lacerated liver, punctured lung, broken rib, broken finger, bleeding on her brain and severe bruising to her face and body. At the time, Ms Ngatai reported that the injuries had been caused by an attack on her by two unknown females. However, she later disclosed that Mr Cook had been her attacker and that she did not want to get him into trouble. Following this incident, the Magistrates' Court heard and granted an application for an Intervention Order in favour of Ms Ngatai, against Mr Cook. The available evidence suggests that this order was never served upon Mr Cook and was therefore inactive.

October 2011

10. Several months later, across 9 and 10 October 2011, Mr Cook again assaulted Ms Ngatai, who was then 21 weeks pregnant with Aeriss. The assault began after an argument between the couple escalated. Mr Cook repeatedly struck Ms Ngatai to the face and head until she lost consciousness. Following her loss of consciousness, Mr Cook continued the attack by kicking Ms Ngatai about her body. At some later stage, Mr Cook carried the still unconscious Ms Ngatai to bed, where she woke the following morning. That morning, Mr Cook resumed his attack on Ms Ngatai, again hitting her in the eye and ear area that he had injured the night before.

11. Mr Cook was taken into custody later that day on an unrelated matter and Ms Ngatai contacted members of Mr Cook's family who took her to the Casey Hospital for treatment of her injuries.

12. Following this assault, Ms Ngatai made a statement to police in relation to Mr Cook's assaults on her in March, May and October 2011.

Mr Cook's first period of imprisonment for offences against Ms Ngatai (June 2012)

13. Ultimately, Mr Cook was charged with and, on 15 June 2012, pleaded guilty to recklessly causing injury (in relation to the March assault) and recklessly causing serious injury (in relation to the October assault), in the County Court.[2]

14. In August 2012, Mr Cook was sentenced to six months' imprisonment for the March assault and 18 months' imprisonment for the October assault, with a non-parole period of nine months' imprisonment.

15. Shortly after Mr Cook's release from custody, Ms Ngatai resumed a relationship with him and the couple moved into 35 Willow Drive in Hampton Park, with Aeriss.

Child Protection involvement

16. In August 2013, Ms Ngatai gave birth to their son, Azariah. During Ms Ngatai's time in hospital, DHHS Child Protection (**Child Protection**) received a report regarding her children. Ms Ngatai denied having any contact with Mr Cook at this time and demonstrated reluctant co-operation with Child Protection. In the period August to October 2013, the available evidence indicates that Child Protection conducted five home visits to their Hampton Park address, to conduct welfare checks. On one occasion, Ms Ngatai refused the Child Protection workers entry and the visit was rescheduled. On another occasion, Ms Ngatai rescheduled the visit. On the third occasion, Child Protection workers visited and did not note any concerns for the children's welfare, nor was there any evidence that Mr Cook resided at the premises. On two later occasions, Child Protection workers conducted unscheduled visits, nobody was home at the time of one visit and on the other occasion nobody answered the door.

17. On 11 November 2013, the evidence suggests that Child Protection workers requested that the Casey Maternal Child Health Service (**MCHS**) monitor the family and contact Child Protection if required. On 15 November 2013, Child Protection determined that there was insufficient evidence to suggest the children were at risk in Ms Ngatai's care and closed the case.

THE PURPOSE OF A CORONIAL INVESTIGATION

18. Ms Ngatai's death constituted a 'reportable death' under the *Coroners Act 2008* (Vic) (**the Act**), as the death occurred in Victoria and was violent, unexpected and not from natural causes.[3]

[2] *DPP v Cook* [2012] VCC 2204
[3] Section 4 *Coroners Act 2008*

19. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[4] The Act provides for a system whereby reportable deaths are independently investigated to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.

20. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[5] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

21. The expression "*cause of death*" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

22. For coronial purposes, the phrase "*circumstances in which death occurred*," refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

23. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the "*prevention*" role of the Court.

24. Coroners are also empowered:

    (a) to report to the Attorney-General on a death;

    (b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

    (c) to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice. These powers are the vehicles by which the prevention role may be advanced.

25. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in

[4] Section 89(4) *Coroners Act 2008.*
[5] *Keown v Khan* (1999) 1 VR 69.

Briginshaw v Briginshaw.[6] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

26. In conducting this investigation, I have made a thorough forensic examination of the evidence including reading and considering the witness statements and other documents in the coronial brief.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Identity of the Deceased, pursuant to section 67(1)(a) of the Act

27. On 11 January 2014, Mr Cook's mother, Lucy Romana visually identified the Deceased[7] as being Sharnee Ngatai, born 21 September 1990.

28. Identity is not in dispute in this matter and requires no further investigation.

Medical cause of death, pursuant to section 67(1)(b) of the Act

29. On 11 January 2014, Dr Sarah Parsons, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an autopsy upon Ms Ngatai's body. Dr Parsons provided a written report, dated 23 April 2014, in which she concluded that Ms Ngatai died from '*penetrating and blunt force trauma to the head*.'

30. The report noted a number of bruises and abrasions which were in keeping with defensive injuries.

31. Toxicological analysis of a pre mortem blood sample, taken at the hospital, identified the presence of ethanol (alcohol), at 0.19 grams per 100 millilitres. Toxicological analysis of post mortem samples identified the presence of ethanol, at 0.14 grams per 100 millilitres.

Circumstances in which the death occurred, pursuant to section 67(1)(c) of the Act

32. On 10 January 2014, the available evidence suggest Ms Ngatai and Mr Cook had been drinking alcohol at their Hampton Park home. At approximately 2.00am, they had a verbal disagreement and Mr Cook told Ms Ngatai to leave the house, which she did.

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[6] (1938) 60 CLR 336

[7] A Statement of Identification dated 11 January 2014 was also made by Ms Romana to this effect while Ms Ngatai was being treated at the Alfred Hospital

33. Ms Ngatai attended their neighbour's home at 37 Willow Drive and spoke to the resident. Ms Ngatai asked the neighbour for permission to sit on his porch while she waited for a taxi. She asked him to turn off the porch light so that she could not be seen sitting there and to call her a taxi. The neighbour agreed and, at 2:48am,[8] he called her a taxi, which collected her a short time later and took her to Lucy Romana's (**Ms Romana**), Mr Cook's mother, house at Cranbourne.

34. The available evidence suggest that Ms Ngatai used Ms Romana's home as a safe-haven for herself and her children at various times.[9]

35. Ms Ngatai stayed with Ms Romana that morning and, at approximately 5am, Ms Romana collected the children, Aeriss and Azariah, from Mr Cook at Hampton Park and returned to her Cranbourne home with them.

36. At approximately 3.00pm, Ms Ngatai caught the bus back to the couple's Hampton Park address to speak with Mr Cook. The two had spoken earlier on the phone and Mr Cook wanted Ms Ngatai to come home.[10] Ms Romana agreed to have the children stay with her and told Ms Ngatai she would drive them back to the Hampton Park house at lunch time the following day.

37. Ms Ngatai and Mr Cook invited a small group of people to their house, including Mr Cook's two cousins, Ms Casey Curry (**Ms Curry**) and her two children, Ms Drifter Curry and two males, Nofo and Tuvale Taele.

38. The four guests drove to Mr Cook and Ms Ngatai's Hampton Park home and then the Taeles and Mr Cook went out and bought three 24 packs of beer and brought them home.

39. At some time between 10.00pm and 10.30pm, the group played a drinking game. By this time, each person in the group was intoxicated. The group was seated under a small shelter off the garage, in the rear yard. After a time, the Taele's began to play darts in the yard and Ms Ngatai asked Ms Curry to sit with her, stating that she could see Mr Cook was getting jealous of Nofo Taele.[11] Drifter Curry and Tuvale Taele had returned inside the house after having a small argument and Nofo Taele also left the rear yard and headed toward the front yard. Ms Ngatai and Ms Curry went inside, leaving Mr Cook alone, asleep on a couch under the garage shelter.

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[8] *Coronial Brief,* Statement of Sasa Trifunov, 33
[9] *Coronial Brief*, Statement of Lucy Romana, 169 [19]
[10] *ibid*, 169 [20]
[11] *Coronial Brief*, Statement of Casey Curry, 71-2.

40. At some time shortly prior to 1.40am, Ms Ngatai and Ms Curry decided to wake Mr Cook and move him inside the house. The two women approached Mr Cook and began to nudge and shake him. Ms Ngatai was shaking his feet and leg area, while Ms Curry began to shake him around the shoulder area.

41. Mr Cook awoke, sat up and immediately launched a violent, physical attack on Ms Ngatai, repeatedly punching her to the head and body. Ms Curry attempted to intervene and shoved Ms Ngatai out of the way and stood between Mr Cook and Ms Ngatai. Mr Cook pushed Ms Curry with sufficient force to cause her to fall backwards into Ms Ngatai, after which both women fell into the card table, causing it to collapse and break.[12]

42. Mr Cook then continued his attack on Ms Ngatai. Ms Curry attempted to intervene a second time, but Mr Cook pushed her against a nearby pole, causing her to fall to the ground in pain. Ms Curry then ran inside to get help.

43. Mr Cook, who had Ms Ngatai pinned to the ground, picked up a nearby steel-framed chair and raised it above his head, before striking Ms Ngatai with the chair in a forceful downward motion. Mr Cook struck Ms Ngatai several times with the chair in this manner, to her head and body.

44. Ms Curry and others returned to the yard to find Ms Ngatai unconscious and unresponsive. They observed her to be suffering from a severe head injury.[13]

45. At approximately 1.41am, an ambulance was called and the operator began to give Nofo Taele first aid instructions. Mr Cook was holding Ms Ngatai's head in his arms and not letting anyone near her. He was saying, "*Wake up, babe. Wake up. I love you, babe. I killed – this is my wife. I killed my wife*."[14]

46. Nofo Taele relayed first aid instructions to the others, who were trying to revive Ms Ngatai.

47. At approximately 1.50am, paramedics arrived at the scene. They found Ms Ngatai to be in cardiac arrest and immediately began CPR. Ms Ngatai was transported to the Alfred Hospital and arrived approximately 3.08am. She did not respond to treatment and was declared deceased at 4.42am.

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[12] i*bid*
[13] i*bid*, 94
[14] i*bid*, 106

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

Criminal Proceedings

48. On 20 July 2015, Mr Cook pleaded guilty to the murder of Sharnee Ngatai. On 19 August 2015, Mr Cook was convicted and sentenced to a total effective sentence of 21 years and 6 months' imprisonment, with a non-parole period of 17 years and 6 months.

Family Violence

49. The unexpected, unnatural and violent death of a person is a devastating event. Violence perpetrated by a family member is particularly shocking, given that the family unit is expected to be a place of trust, safety and protection.

50. For the purposes of the *Family Violence Protection Act 2008*, the relationship between Ms Ngatai and Mr Cook fell within the definition of '*family member.*'[15] Moreover, Mr Cook's actions in attacking Ms Ngatai and causing her death constitutes '*family violence*.'[16]

51. I requested that the Coroners' Prevention Unit (**CPU**)[17] examine the circumstances of Ms Ngatai's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[18]

52. The CPU identified the several known risk factors for family violence in this case. Alcohol consumption is a common element in family violence homicides, present in approximately one-third of cases.[19] The available evidence suggests that the homicide occurred in the context of a group of adults drinking heavily, where both the Ms Ngatai and Mr Cook were intoxicated. Further, pregnancy and the early post-natal period have been recognised as times of adjustment, where the accompanying risk of family violence occurring is elevated.[20] Ms Ngatai and Mr Cook's youngest child, Azariah, was less than six months old at the time of Ms Ngatai's death. The available history suggests that Mr Cook's violence against Ms Ngatai spiked during

[15] *Family Violence Protection Act 2008,* section 8(1)(a) identifying as a spouse or domestic partner
[16] *Family Violence Protection Act 2008*, section 5(1)(a)(i)
[17] The Coroners Prevention Unit is a specialist service for Coroners established to strengthen their prevention role and provide them with professional assistance on issues pertaining to public health and safety
[18] The VSRFVD provides assistance to Victorian Coroners to examine the circumstances in which family violence deaths occur. In addition the VSRFVD collects and analyses information on family violence-related deaths. Together this information assists with the identification of systemic prevention-focused recommendations aimed at reducing the incidence of family violence in the Victorian Community
[19] Bryant, W & Cussen, T. 'Homicide in Australia: 2010-11 to 2011-12: National Homicide Monitoring Program Report' (2015) *Australian Institute of Criminology Monitoring Reports* 23
[20] Victoria, Royal Commission into Family Violence, *Report & Recommendations*, (2016) Vol. 1, Ch.2, 20

the pregnancy and post-natal periods in relation to each of her children.

53. Mr Cook himself exhibited high risk factors for the perpetration of family violence, including a history of jealous and controlling behaviour, physically assaulting Ms Ngatai while pregnant, alcohol and substance use, unemployment, as well as demonstrating generalised violent behaviour. Ms Ngatai exhibited recognised vulnerabilities to family violence, including pregnancies and the associated post-natal periods, as well as alcohol use.

Engagement with Services

54. Ms Ngatai engaged with health services on several occasions, in large part due to her pregnancies, but also on other occasions to treat injuries inflicted upon her by Mr Cook. There is no indication in the evidence that the responses of the health services was inappropriate, based on the information Ms Ngatai provided them. The appropriate reports were made to Victoria Police following each presentation at hospital, as well as contact with Child Protection, often informed by Ms Ngatai's visits with the Maternal Child Health Service (**MCHS**). After Azariah's birth, Ms Ngatai informed the MCHS that she was living alone with the children and had no contact with their father, Mr Cook. She also reported having good support from her family and friends.

55. While she was in hospital in August 2013, around the time of Azariah's birth, Child Protection received a report regarding Ms Ngatai's children. Ms Ngatai again reported that she had no contact with Mr Cook and did not know his whereabouts. However, Mr Cook's aunt reported to Child Protection that the couple had continued their relationship following Mr Cook's release from prison, but that she believed there was no further violence in the relationship. When confronted by this information by Child Protection workers, Ms Ngatai maintained that she did not have contact with Mr Cook and was unable to explain the discrepancy in reports.

56. On 21 August 2013, Child Protection conducted a scheduled home visit and did not note any concerns for the children's welfare, nor any evidence of Mr Cook living in the house. Ultimately, on 15 November 2013, Child Protection closed the case due to insufficient evidence that the children were at risk in Ms Ngatai's care.

57. Taking into account Ms Ngatai's reluctant compliance and ongoing suspicions of Ms Ngatai's ongoing contact with Mr Cook, Child Protection's response remains reasonable in the circumstances. The statutory threshold[21] for the children to be considered in need of protection

[21] *Children, Youth and Families Act 2005* (Vic) s162.

was deemed not to have been met.

58. Ms Ngatai also engaged with the legal system in relation to the abuse she was suffering prior to her death. Ms Ngatai was hospitalised in March 2011 and twice in May 2011 as a result of attacks by Mr Cook. After an attack spaning two days in October 2011, Ms Ngatai complained to police. Following the October 2011 attack, Ms Ngatai made a statement to police regarding the events which led to each of the hospitalisations in March and May 2011. Notwithstanding that Mr Cook was convicted and sentenced to a term of imprisonment in June 2012 in relation to that offending, the evidence suggests that Ms Ngatai remained closely connected with Mr Cook's family while he was in prison and the couple reunited shortly after his release.

59. In the four months prior to Ms Ngatai's death, she had contact with both health and Child Protection services but did not report any current family violence. The available evidence suggests that Ms Ngatai was consistent in reporting that she did not live with, nor have any contact with, Mr Cook and lived alone with her children. The services she engaged with were misled in this regard and this precluded further risk assessments and responses. In the circumstances, it appears likely that Ms Ngatai was motivated by a fear that her children would be removed from her care, had her contact with Mr Cook become known.

Mr Cook's non-compliance with parole order

60. Mr Cook was released on parole on 11 July 2012, after serving nine months' imprisonment for his offending against Ms Ngatai in October 2011. The Office of Correctional Service Review (**OCSR**) advised this Court that, as part of his parole order, Mr Cook was required to undertake an intensive program that targets reoffending. The OCSR further advised that there were numerous instances of non-compliance with Mr Cook's parole order. The non-compliance included failures to attend supervision, as well as returning urine tests positive for cannabis. Despite this, Mr Cook was allowed to remain on parole and completed his order on 6 April 2013.

Parole Reform: the Callinan Review

61. In July 2013, Justice Callinan undertook a comprehensive review of the parole system in Victoria, which became known as the '*Callinan Review*' (**the Review**). Broadly, the Review highlighted that the parole system was extremely under-resourced, experiencing an "*intolerably*

heavy"[22] volume of work and that the Adult Parole Board's (**APB**) decisions failed to sufficiently emphasise the safety and protection of the community.[23] Mr Cook's parole order concluded in the month prior to Justice Callinan being appointed to commence the Review.

62. The Review recognised that prisoners were not adequately supervised, citing a lack of experienced parole officers and that breaches of parole conditions were "*very frequent, and sometimes [went] undetected or [were] left unremarked*."[24] While it is not reasonable to conclude that Ms Ngatai's death could have been prevented by a more risk-averse management of Mr Cook on parole in this instance (as recommended by the Review), it does highlight that the issues raised in the Review are relevant to more closely managing risk in this case, in particular Mr Cook's risk of reoffending.

63. The post-Review improvements to the resourcing and process of the APB, as well as an "*increased preparedness*" to cancel parole for those prisoners representing an increased risk to the community, each demonstrate positive steps towards addressing the concerns raised in this case. In particular, the increased resourcing to the APB since Mr Cook's parole order have facilitated the creation of Community Corrections Officers specialising in parole, who have the ability to more actively supervise parolees and notify the APB of breaches accordingly. The Victorian Auditor-General's '*Administration of Parole Report*'[25] concluded, however, that it was too early to fully assess the impact of the reform program on community safety outcomes.

Third party reporting of family violence

64. Ms Ngatai's death, and deaths similar to hers, highlights the difficult and often dangerous predicament that family violence presents to family, friends and others who either become aware of it, or suspect it is occurring. Coupled with this is the reoccurring indication within the relevant research, that female victims of family violence are more likely to disclose the violence to family or friends, rather than to authorities or specialist services. Many times, third parties feel, understandably, ill-equipped to assist or are concerned that any intervention may increase the danger for the victim or themselves.

65. In an effort to address the barriers that third parties face in obtaining access to information about family violence, and providing information and assistance to victims of family violence, the

[22] Callinan, Ian. 'A Review of the Parole System in Victoria' for the Minister for Corrections and Minister for Crime Prevention, July 2013, 87
[23] Adult Parole Board of Victoria, *Annual Report 2015-16*, http://www.adultparoleboard.vic.gov.au/publications-and-news/annual-reports, 11
[24] *ibid*
[25] https://www.audit.vic.gov.au/report/administration-parole

Royal Commission into Family Violence (**the Royal Commission**)[26] reviewed the available resources for third parties.

66. At its conclusion, predominantly by way of recommendations 10 and 37, the Royal Commission encouraged the adoption of a model whereby third parties (as well as victims and perpetrators of family violence) can access information via a website to assist in recognising family violence and how to seek help, both in the crisis period and during longer term recovery.[27] This Court is advised that the Victorian Government has selected "*The Lookout*"[28] website as the most suitable existing site with the capacity to develop into a space for the delivery of accessible information for those experiencing, witnessing and being affected by family violence. The Court is also informed that, in line with the Royal Commission's recommendation, the website is now currently in operation.[29]

The introduction of Support & Safety Hubs

67. A central feature of the State Government's response to the Royal Commission's recommendations is the introduction of Support and Safety Hubs (**SSHs**)[30] at 17 locations across Victoria, a central point for the family violence response network which will:

a) receive police referrals, referrals from non-family violence services, including family and friends, as well as self-referrals;

b) provide a single, area-based entry point into local specialist family violence services, perpetrator programs and integrated family services and link people to other support services;

c) perform risk and needs assessments and safety planning using information provided by the recommended state-wide central information point;

d) provide prompt access to the local Risk Assessment and Management Panel;

e) provide direct assistance until the victim, perpetrator and any children are linked with services for longer term support;

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[26] Victoria, Royal Commission into Family Violence, *Final Report* (2016) http://www.rcfv.com.au/Report-Recommendations
[27] Victoria, Royal Commission into Family Violence, Recommendation 10
[28] http://www.thelookout.org.au
[29] http://www.vic.gov.au/familyviolence/recommendations/recommendation-details.html?recommendation_id=12>; *The Lookout* website can be found at http://www.thelookout.org.au
[30] Victoria, Royal Commission into Family Violence, Recommendation 37

f) book victims into emergency accommodation and facilitate their placement in crisis accommodation;

g) provide secondary consultation services to universal or non-family violence services; and

h) offer a basis for co-location of other services likely to be required by victims and any children.[31]

68. This Court is informed that the Department of Premier and Cabinet, along with Family Safety Victoria, is currently collaborating with partner agencies to design and implement SSHs State-wide. These are forecast to be completed by 31 March 2021, by which time 17 SSH sites will have been rolled out across Victoria.

69. In light of the comprehensive nature of the Royal Commission's work in this regard, I support the recommendations put forward, specifically in this case as they relate to the issue of assisting third parties to educate and assist both perpetrators and victims of family violence.

70. In Ms Ngatai's case, education and information via a website, such as '*The Lookout*' may have provided an initial avenue for the family members and friends to assist her, while ultimately the SSHs provide an opportunity to report concerns and create more tangible opportunities for intervention and prevention.

FINDINGS AND CONCLUSION

71. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the Act:

(a) that the identity of the deceased was Sharnee Ngatai, born 21 September 1990;

(b) that the death occurred on 11 January 2014 at the Alfred Hospital, 55 Commercial Road, Melbourne, Victoria, from penetrating and blunt force trauma to the head; and

(c) that the death occurred in the circumstances set out above.

72. I convey my sincerest sympathy to Ms Ngatai's family.

73. Pursuant to section 73(1A) of the Act, I direct that a copy of this finding be published on the Coroners Court website.

[31] Victoria, Royal Commission into Family Violence, *Summary and Recommendations* (2016) 55

74. I direct that a copy of this finding be provided to the following:

(a) Louise Bowman, Senior next of kin;

(b) Senior Sergeant Damien O'Mahoney and Sergeant Christopher David Hill, Coroner's Investigators;

(c) Peter Lauritsen, Chief Magistrate; and

(d) Detective Inspector Tim Day, Homicide Squad, Victoria Police.

Signature:

JUDGE SARA HINCHEY

STATE CORONER

Date: 8 August 2018