IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 2417

# FINDING INTO DEATH WITHOUT INQUEST

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

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| Findings of: | **Coroner Darren J. Bracken** |
| Deceased: | **Zakiya Crystal Lisa Thomas** |
| Date of birth: | 31 August 1999 |
| Date of death: | 17 May 2015 |
| Cause of death: | I(a) Hanging |
| Place of death: | Mildura Base Hospital, Mildura, Victoria, 3502 |

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**HIS HONOUR:**

## BACKGROUND

1. On 17 May 2015 Zakiya Crystal Lisa Thomas (**Zakiya**) was only 15-years-old when she passed away in the Mildura Base Hospital. Zakiya was a Barkindji Maraura woman, born in Rockhampton, Queensland and was the second eldest of five children born to Darlene Thomas (**Ms Thomas**).

2. In approximately 1997, Ms Thomas began a relationship with Mr Christopher Mason, Zakiya's father. Zakiya was born two years later in 1999. In approximately 2001, the relationship between Ms Thomas and Mr Mason ended.

3. Zakiya attended Chaffey Secondary College in Mildura from Year 7 until Year 9. Records from Chaffey Secondary College indicate that Zakiya's attendance started declining towards the end of Year 8 and by Year 9, she was placed in a part time program which she attended sporadically. During this time Zakiya lived with her mother and siblings in a house in Mildura.

4. In approximately February 2014, Zakiya reported to Ms Thomas that she was having trouble sleeping and had flashbacks about her uncle, Ms Thomas' cousin, sexually assaulting her when she was younger. At the time, this man was scheduled to be released shortly from prison in New South Wales after having been imprisoned for sexually assaulting another young female family member.[1]

5. Zakiya started seeing a counsellor in approximately April 2014 at the Mallee District Aboriginal Service (**MDAS**)[2]. Zakiya did not disclose to her counsellor all of the issues that were concerning her at the time because she believed that other family members were attending the service and she was concerned about confidentiality.[3]

6. In approximately April 2014, Zakiya flew to Queensland to meet her biological father for the first time. Zakiya later commented to her counsellor from MDAS that she was disappointed

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[1] Statement of Darlene Thomas dated 28 October 2015, Coronial Brief, 6.
[2] Mallee District Aboriginal Services is located in the Mallee Region, Victoria and provides a broad range of services including health, family services, housing, aged care, substance abuse, training, community development, rehabilitation and justice.
[3] Records provided by the Department of Health and Human Services (Office of the Chief Psychiatrist) dated 18 August 2015 containing clinical notes for services provided by the Child and Adolescent Mental Health Service based in Mildura Base Hospital.

with the meeting because they had lots of disagreements.[4] Zakiya stopped attending counselling with MDAS in September 2014.

7. On 2 November 2014, Zakiya told her mother that she had had a sexual relationship with her immediate ex-boyfriend before they split up in August 2014. Ms Thomas was upset by this, the ensuing argument resulted in Zakiya leaving home and moving in with a friend elsewhere in Mildura.[5]

8. On 7 November 2014, Zakiya was still living away from home when she approached the school social worker at Chaffey Secondary College to discuss her accommodation. The social worker referred her to the Mallee Accommodation and Support Program (**MASP**).[6]

9. On 12 November 2014, a MASP worker met with Zakiya at Chaffey Secondary College. Zakiya told her that she was unhappy at home due to conflicts with her mother and that the house was overcrowded.[7] The MASP worker assisted Zakiya through the Family Reconciliation Program which aims to assist young people reconcile with their families and return home where appropriate.

10. On 14 November 2014, a MASP worker took Zakiya to see a mental health clinician at the Mildura Base Hospital. The mental health clinician completed a mental health assessment during which Zakiya told him that early in 2014 she had started remembering being sexually assaulted by her uncle when she was a child. Zakiya also disclosed that she had begun feeling low since experiencing these recollections.[8]

11. Zakiya informed the mental health clinician that the uncle who had sexually assaulted her was currently in jail, having been convicted of sexually abusing children in her extended family, and he was due to be released from prison soon.[9] Zakiya further told the mental health clinician that she '*never felt safe around her family due to constant exposure to drugs, alcohol and violence throughout her life*', that she had been subject to '*repeated verbal, emotional and physical abuse*' by her step-father, and that '*her step-father has been abusive towards her since he and her mother got together 11 years ago.*'[10]

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[4] Records provided by the Mallee District Aboriginal Service dated 27 June 2016.
[5] Statement of Darlene Thomas dated 28 October 2015, Coronial Brief, 7.
[6] Records provided by Chaffey Secondary College dated 1 July 2016.
[7] Records provided by Mallee Accommodation and Support Program dated 27 June 2016.
[8] Medical records provided by Mildura Base Hospital, 21; The Mallee Accommodation and Support Program is a program based in the Mallee region of Victoria and delivers a range of services and programs aimed at vulnerable children, youth and families, the disabled and frail aged and the homeless or those people at risk of homelessness.
[9] Medical records provided by Mildura Base Hospital, 43.
[10] Medical records provided by Mildura Base Hospital, 22 and 43.

12. According to the mental health clinician's notes Zakiya was discharged into the care of her MASP worker, with a plan that included her taking time to consider whether she wanted to engage with the Mallee Sexual Assault Unit (**MSAU**)[11] or the Child and Youth Mental Health Service (**CAMHS**).[12]

13. Later on 14 November 2014, at approximately 7.00pm, Zakiya was admitted to the Mildura Base Hospital following a suicide attempt during which she took approximately 13 Promethazine (Phenergan) tablets.[13] As a result of this admission, the hospital made a referral to the Department of Health and Human Services – Child Protection (**Child Protection**).[14]

14. On 17 November 2014, Zakiya was discharged from the Mildura Base Hospital into her mother's care.[15] Zakiya continued to receive support from workers at MASP and was linked in with follow up support through CAMHS.[16]

15. On 8 December 2014, Child Protection closed their referral on the basis that Zakiya had returned home to live with her mother and that Ms Thomas had been assessed as being protective and responsive to Zakiya's needs.[17] This assessment identified that Ms Thomas was '*protective and aware of Zakiya's vulnerability and committed to ensuring she remained engaged with support services*'.[18] The documents reveal that the assessment had been made after Child Protection staff had spoken to Ms Thomas over the telephone. There is no record of Child Protection staff speaking to Zakiya, nor of them visiting the family home.

16. During school holidays in late December 2014 and early January 2015, Zakiya went to stay with her older sister in Robinvale.[19] During this time, Zakiya worked as a tractor driver on a vineyard at Kenley located in regional Victoria between Robinvale and Swan Hill. While Zakiya was staying with her older sister she was not in contact with staff from CAMHS or

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[11] The Mallee Sexual Assault Unit provides services to women, men and children throughout the Mallee region of Victoria including counselling, medical care, victims of crime assistance and information about sexual assault.

[12] Medical records provided by Mildura Base Hospital, 23; Child and Adolescent Mental Health Services is a state-wide service and they provide comprehensive services for children and adolescents experiencing mental health problems. The Child and Adolescent Mental Health Services that was accessed by Zakiya was based out of the Mildura Base Hospital.

[13] Statement of Darlene Thomas dated 28 October 2015, Coronial Brief, 8; Medical records provided by Mildura Base Hospital, 27.

[14] Records provided by the Department of Health and Human Services – Child Protection, 44; The Victorian Child Protection Service is specifically targeted to those children and young people at risk of harm or where families are unable or unwilling to protect them.

[15] Medical Records provided by Mildura Base Hospital, 51.

[16] Records provided by the Mallee Accommodation and Support Program; Statement of Dr Alan Wragg dated 26 June 2016.

[17] Records provided by the Department of Health and Human Services – Child Protection, 68-71.

[18] Records provided by the Department of Health and Human Services – Child Protection, 68-71.

[19] Records provided by the Mallee Accommodation and Support Program, 4.

MASP. Ms Thomas had however informed CAMHS and MASP where she was and that she was residing with her sister.

17. In early January 2015, Zakiya returned to live with her mother,[20] she reconnected with MASP and CAMHS, but her engagement was sporadic.[21]

18. On 18 February 2015, Zakiya met with her MASP worker and the coordinator of the Kokoda Youth Mentoring Program,[22] Mr Ken Innes, to discuss her possible participation in that program. At the time, Zakiya appeared to be very excited about the prospect of participating in the Kokoda program.

19. On 4 March 2015, Zakiya disclosed to a CAMHS worker that two days earlier she had had suicidal thoughts, including a '*plan of hanging self in [the] shed using extension power cords.*' She also showed the CAMHS worker scratches to her right arm from self-inflicted injuries due to the suicidal thoughts she had had days earlier and commented that, '*this helped as she wanted to feel the pain somewhere else.*'[23]

20. During April 2015, Zakiya resided at home with her mother and other family members. She had attended the Kokoda program training sessions sporadically and ultimately told Mr Innes that she did not want to continue as she felt anxious and awkward in the group because she did not know what to say to people and that she was not used to be being around people that she did not know.[24]

21. Approximately two weeks before her death, Zakiya borrowed $300 from her older sister[25] and went to Queensland to visit her father a second time.

22. She returned to her mother's home a week later and was upset because she and her father did not get along; Zakiya told her mother that they had lots of disagreements. She was upset because '*out of all her brothers and sisters she was the only one who didn't have a 'dad' in their life*'.[26]

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[20] Records provided by the Mallee Accommodation and Support Program, 4.
[21] Records provided by the Mallee Accommodation and Support Program, 4; Statement of Dr Alan Wragg dated 26 June 2016.
[22] The Kokoda Youth Mentoring Program provides local disengaged and disadvantaged youth with an opportunity to re-connect themselves with mainstream education, employment, family and the community.
[23] Records provided by the Department of Health and Human Services (Office of the Chief Psychiatrist) dated 18 August 2015 containing clinical notes for services provided by the Child and Adolescent Mental Health Service based in Mildura Base Hospital.
[24] Records provided by the Mallee Accommodation and Support Program, 5-6.
[25] Statement of Darlene Thomas dated 28 October 2015, Coronial Brief, 9.
[26] Records provided by the Mallee District Aboriginal Services, 7.

23. On 8 May 2015, a week prior to her death, Zakiya told her MASP worker that she had stopped participating in the Kokoda program. The last time Zakiya was in direct contact with her CAMHS worker was on 23 April 2015.

## THE PURPOSE OF A CORONIAL INVESTIGATION

24. Zakiya's death constituted a '*reportable death*' pursuant to section 4 of the *Coroners Act* (2008) (Vic) (the **Act**); the death occurred in Victoria, was unexpected and was not from natural causes.[27]

25. The Act requires a Coroner to investigate reportable deaths such as Zakiya's and, if possible, to find the:

    (a) identity of the deceased.

    (b) the cause of death and

    (c) the circumstances in which death occurred.[28]

26. For coronial purposes, '*circumstances in which death occurred*'[29] refers to the context and background the death including the surrounding circumstances. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, required findings in relation to circumstances are limited to those circumstances which are sufficiently proximate to be considered relevant to the death.

27. The Coroner's role is to establish facts, rather than to attribute or apportion blame for the death.[30] Neither is it the Coroner's role to determine criminal or civil liability,[31] nor to determine disciplinary matters.

28. One of the broader purposes 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 making recommendations.

29. Coroners are also empowered to:

    (a) report to the Attorney-General on a death;[32]

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[27] *Coroners Act 2008* (Vic) s 4.
[28] *Coroners Act 2008* (Vic) preamble and s 67.
[29] *Coroners Act 2008* (Vic) s 67(1)(c).
[30] *Keown v Khan* (1999) 1 VR 69.
[31] *Coroners Act 2008* (Vic) s 69 (1).

(b) comment on any matter connected with the death investigated, including matters of public health or safety and the administration of justice;[33] and

(c) 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.[34]

30. Coronial findings must be underpinned by proof of relevant facts on the balance of probabilities.[35] The strength of evidence necessary to so prove facts varies according to the nature of the facts and the circumstances in which they are sought to be proved.[36]

31. Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demand a weight of evidence commensurate with the gravity of the facts sought to be proved.[37] Facts should not be considered to have been proved on the balance of probabilities by inexact proofs, indefinite testimony, or indirect inferences,[38] rather such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence.[39]

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

### Identity of the Deceased - Section 67(1)(a) of the Act

32. On 17 May 2015, Ms Thomas identified the deceased as her daughter Zakiya Crystal Lisa Thomas born 31 August 1999.

33. Zakiya's identity is not disputed and requires no further investigation.

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[32] *Coroners Act 2008* (Vic) s 72(1).
[33] *Coroners Act 2008* (Vic) s 67(3).
[34] *Coroners Act 2008* (Vic) s 72(2).
[35] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.
[36] *Qantas Airways Limited v Gama* (2008) 167 FCR 537 at [139] per Branson J but I note that His Honour was referring to the correct approach to the standard of proof in a civil proceeding in a federal court with reference to section 140 of the *Evidence Act 1995* (Cth); *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at 170-171 per Mason CJ, Brenna, Deane and Gaudron JJ.
[37] *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336, referring to *Barten v Williams* (1978) 20 ACTR 10; *Cuming Smith & Co Ltd v Western Farmers Co-operative Ltd* [1979] VR 129; *Mahon v Air New Zealand Ltd* [1984] AC 808 and *Annetts v McCann* (1990) 170 CLR 596.
[38] *Briginshaw v Briginshaw* (1938) 60 CLR 336, at pp. 362-3 per Dixon J.
[39] *Briginshaw v Briginshaw* (1938) 60 CLR 336, at pp. 362-3 per Dixon J.; *Cuming Smith & CO Ltd v Western Farmers Co-operative Ltd* [1979] VR 129, at p. 147; *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at 170-171 per Mason CJ, Brenna, Deane and Gaudron JJ.

**Cause of death - Section 67(1)(b) of the Act**

34. On 20 May 2015 Dr Sarah Parsons, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an external examination upon Zakiya's body and provided a written report, dated 26 May 2015, in which she opined that the cause of Zakiya's death was "*1(a) Hanging*". I accept Dr Parsons' opinion.

35. Toxicological analysis of post mortem blood samples taken from Zakiya's body detected Citalopram[40] (0.2 mg/L)[41] a level not outside therapeutic parameters. Citalopram had been prescribed to Zakiya by Dr Alan Wragg.

**Circumstances in which the death occurred - Section 67(1)(c) of the Act**

36. In the early afternoon, around 4.30pm on Sunday 17 May 2015, Ms Thomas convened the weekly family meeting with all of her children at her home. At these meetings the family discussed things including recent events, cleaning chores around the house and the like.[42]

37. During this meeting, Ms Thomas told Zakiya that she ought to pay back her sister the $300 that she had borrowed. For reasons that are not clear, this upset Zakiya and she left the house. Ms Thomas followed her out to the back yard and as punishment for her outburst, asked Zakiya to handover over her mobile telephone. In response, Zakiya threw down the phone, breaking the screen, and went to the bedroom that she shared with her older sister.[43] Ms Thomas picked up the broken mobile telephone and put it on the dressing table inside the house.

38. Ms Thomas then made coffee and went back out to the rear yard for a cigarette. When she had finished her coffee and cigarette, she went to Zakiya's bedroom and apologised to Zakiya about fighting with her at the family meeting. Ms Thomas then returned inside the house.

39. Ms Thomas prepared some of the other children for bed and shortly before 7.00pm, noticed that Zakiya's broken telephone was still on the dressing table. Ms Thomas decided to take the telephone out to Zakiya. Ms Thomas knocked on the bedroom door and when she received no response, unlocked the door and entered the room. Ms Thomas found that the lights would not work and used the torch on Zakiya's phone to look around. She found Zakiya hanging by an extension cord around her neck from the roof.

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[40] Citalopram is a selective serotonin reuptake inhibitor with antidepressant activity.
[41] Consistent with a relevant therapeutic level.
[42] Statement of Darlene Thomas dated 28 October 2015, Coronial Brief, 9
[43] Some months earlier Mrs Thomas had converted the garage at the back of the house into a bedroom for Zakiya and her older sister to share.

40. Ms Thomas called out to Zakiya's older sister and whilst she tried to lift Zakiya's body and untie the extension cord, Zakiya's older sister called emergency services. Ms Thomas untied the extension cord and placed Zakiya on the floor and commenced cardiopulmonary resuscitation **(CPR).**[44] Ambulance services arrived at Ms Thomas' house at approximately 7.15pm.[45]

41. Ambulance officers transported Zakiya to Mildura Base Hospital arriving at approximately 7.32pm. Emergency department medical staff unsuccessfully attempted to resuscitate Zakiya and she was pronounced deceased at approximately 7.42pm.[46]

42. Some two days after Zakiya's death Ms Thomas and Zakiya's older sister found a note written on the wall of Zakiya's bedroom reading "*I love you guys and if you love me too then you'll let me go. I'm not happy here*".[47] The note was written in Zakiya's handwriting in a skin coloured crayon and was located when Ms Thomas was looking to see if Zakiya had left a written note anywhere in the room.

43. I am satisfied, having considered all the available evidence, that no further investigation into Zakiya's death is required.

## COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

44. A finding of suicide can impact upon the memory of a deceased person and can reverberate throughout a family for generations. Such a finding should only be made on compelling evidence, not indirect inferences or speculation.

45. It is often difficult to determine what may have precipitated a decision to end one's own life. There are sometimes issues known only to the deceased person and sometimes events in the person's life suggest a reason.

46. On the available evidence, there were several significant factors affecting Zakiya on and proximate to 17 May 2015. That her suicide was apparently spontaneous, a spur of the moment act, is not uncommon in cases of suicide generally and is not uncommon in the suicides of children. The argument that she had with her mother shortly before her death is likely to have been one of many factors in Zakiya's decision to end her life. Of concern,

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[44] Statement of Darlene Thomas dated 28 October 2015, Coronial Brief, 10; Statement of Sharni Karpany dated 12 October 2015, Coronial Brief, 13.
[45] Emergency admission form from the Mildura Base Hospital dated 17 May 2015.
[46] Statement of Dr Daniel Turner dated 26 October 2015, Coronial Brief, 15.
[47] Statement of Darlene Thomas dated 28 October 2015, Coronial Brief, 10.

however, is that Zakiya was known to be at risk of suicide to several agencies[48] whose role it was to prevent precisely what occurred on 17 May 2015. How those agencies failed to make proper enquiries, adequately assess risks of self-harm and share relevant information concerning serious risk factors, is a cause of real and substantial concern. This is particularly so given the rate of non-Aboriginal and Aboriginal youth suicide in the Mildura area.

*Family violence and Aboriginal youth suicide*

47. For the purposes of the *Family Violence Protection Act 2008* (Vic) (**the Act**), Zakiya's uncle and step-father were 'family members'.[49] The alleged sexual abuse committed by Zakiya's uncle, and the alleged physical and emotional abuse committed by Zakiya's step-father constitute 'family violence' as defined in that Act.[50]

48. In light of a possible connection between Zakiya's death and the alleged family violence perpetrated against her by her uncle and step-father, I requested that the Coroners Prevention Unit (**CPU**)[51] examine Zakiya's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[52] Such an examination utilises several tools including the *Family Violence Risk Assessment and Risk Management Framework*, also known as *The Common Risk Assessment Framework* (**CRAF**)[53].

49. The CRAF was first introduced in 2007 to assist service providers from a wide range of fields to understand and identify risk factors associated with family violence and respond consistently. Practitioners like Child Protection workers, Victoria Police members, mental health clinicians and medical professionals utilise the content in the CRAF as a best practice model for identifying risks and responding consistently in services provided to family violence victims or perpetrators.

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[48] Specifically CAMHS, MASP, Child Protection and MBH were aware that Zakiya had attempted suicide on 14 November 2014.

[49] Family Violence Protection Act 2008, section 8(1)(d)

[50] Family Violence Protection Act 2008, section 5(1)(a)(i)

[51] 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.

[52] 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.

[53] The Victorian Government recognised the need for an integrated and consistent approach to providing family violence services and in 2008, commissioned a consortium composed of agencies including the Domestic Violence Resource Centre Victoria, Swinburne University and No to Violence to develop and deliver the *Family Violence Common Risk Assessment and Risk Management Framework* (CRAF).

50. The CRAF contains several evidence-based risk factors which have been found to impact on the likelihood of family violence occurring and its severity.[54] These risk factors are divided into three categories: those which relate to the victim of family violence, those which relate to the perpetrator, and those which relate to the relationship. The CRAF also identifies several additional factors which can impact on the options and outcomes available to family violence victims.[55]

51. I note that the CRAF was primarily developed to assess for risk within heterosexual intimate partner relationships.[56] As a result, it may not adequately identify the risk posed to those who experience family violence outside of heterosexual intimate partner relationships.[57] So much was acknowledged by the Royal Commission into Family Violence (**the Royal Commission**), which specifically recommended that a revised CRAF be developed which reflects "*the needs of the diverse range of family violence victims and perpetrators.*"[58]

52. The Victorian Aboriginal Family Violence Task Force define family violence as:

> *An issue focused around a wide range of physical, emotional, sexual, social, spiritual, cultural, psychological and economic abuses that occur within families, intimate relationships, extended families, kinship networks and communities. It extends to one-on-one fighting, abuse of Indigenous community workers as well as self-harm, injury and suicide.*

53. Aboriginal women experience significantly higher levels of family violence than non-Aboriginal women, with significant under-reporting of family violence in Aboriginal communities. Aboriginal children are seven times more likely than non-Aboriginal children to be the victims of substantiated child abuse.[59]

54. From an Aboriginal perspective, this high prevalence of family violence is attributed to several factors, many of which relate to the impact of white settlement on Aboriginal culture.[60] These include:

    (a) dispossession of land and traditional culture through colonialism;

    (b) breakdown of community kinship systems and Aboriginal lore;

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[54] Department of Health and Human Services, *Family Violence Risk Assessment and Risk Management Framework and Practice Guides 1-3* (2012), 2nd Edition.
[55] Ibid, 30.
[56] Jude McCulloch et al, 'Review of the Family Violence Risk Assessment and Risk Management Framework (CRAF)' (2016) *Monash University*, 11.
[57] Ibid.
[58] State of Victoria, Royal Commission into Family Violence, *Final Report* (2016) vol 1, 138.
[59] State of Victoria, Royal Commission into Family Violence, *Final Report* (2016) vol 2, 112.
[60] State of Victoria, Royal Commission into Family Violence, *Final Report* (2016) vol 5, 10

(c) racism and vilification;

(d) economic exclusion and entrenched poverty;

(e) alcohol and drug abuse;

(f) the effects of institutionalism and child removal policies such as the White Australia Policy;

(g) a collective intergenerational grief and trauma; and

(h) the loss of traditional Aboriginal male roles, female roles and associated status.[61]

55. Service responses to Aboriginal women and children need to be based on an understanding of these issues and incorporate appropriate consultations with Aboriginal organisations. Agencies working with Aboriginal clients must provide a holistic service that takes into account relevant clan or family arrangement. Ideally, Aboriginal women should be offered an opportunity to choose the service they wish to engage with, whether that be an Aboriginal-specific or mainstream family violence service.

56. Following the recommendations of the Royal Commission, the Victorian Government developed the *Family Violence Multi-Agency Risk Assessment and Management Framework* (**MARAM**) to support practitioners in assessing, monitoring and managing risk of family violence.[62] The Victorian Government announced that the development of the MARAM and the accompanying risk assessment tools will integrate the experiences of family violence and presentation of family violence risk recognized within Aboriginal communities.[63]

57. The court has been advised by Family Safety Victoria that the development of the MARAM Framework has been undertaken in consultation with Aboriginal communities and organizations, including through the '*Dhelk Dja: Safe our way Strong Culture Strong Peoples Strong Families*' and the Dhelk Dja Partnership Forum.

58. The '*Dhelk Dja: Safe our way Strong Culture Strong Peoples Strong Families*' was released in October 2018 and is an Aboriginal-led, Victorian Agreement, that draws Aboriginal communities, Aboriginal services and government together to work collaboratively to ensure

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[61] Ibid.
[62] Family Safety Victoria, *Family Violence Multi-Agency Risk Assessment and Management Framework* (2018).
[63] Family Safety Victoria, *Responding to Family Violence Capability Framework* (December 2017), 11.

that Aboriginal people, families and communities '*are stronger, safer, thriving and living free from family violence*'.[64]

59. I have considered the risk factors as they are set out in CRAF; the risk assessment tool available to support services at the time they had contact with Zakiya and her family.

60. There are several victim specific risk factors applicable to Zakiya. In particular, her age and mental health condition meant that she was more vulnerable to family violence, her suicidal ideation and attempts also indicated that she was 'extremely vulnerable'[65] and that the situation had 'become critical.'[66] These were very significant factors that should have been considered by practitioners conducting a family violence risk assessment in relation to Zakiya's safety prior to her death.

61. Data from the Australian Bureau of Statistics relating to suicides across Australia between 2001 and 2010 suggests that the '*overall rate of suicide for Aboriginal and Torres Strait Islander peoples was twice that of non-Indigenous people, with a rate ratio of 2.0 for males and 1.9 for females.*'[67] Furthermore, '*suicide rates for Aboriginal and Torres Strait Islander females aged 15-19 years were 5.9 times higher than those for non-Indigenous females in this age group.*'[68] However, it is important to note that:

> *...caution should be exercised when undertaking analysis of Aboriginal and Torres Strait Islander deaths and, in particular, trends in Aboriginal and Torres Strait Islander mortality. This is due to data quality issues, including the under identification of Aboriginal and Torres Strait Islander people in deaths data and the uncertainties inherent with estimating and projecting the size and structure of the Aboriginal and Torres Strait Islander population over time.*[69]

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[64] *Dhelk Dja: Safe our way Strong Culture Strong Peoples Strong Families*, available online at: https://www.vic.gov.au/sites/default/files/2019-06/Dhelk-Dja-Safe-Our-Way-Strong-Culture-Strong-Peoples-Strong-Families-Poster.pdf

[65] Department of Health and Human Services, above n 23, 26.

[66] Ibid.

[67] Australian Bureau of Statistics, *Aboriginal and Torres Strait Islander Suicide Deaths*, http://www.abs.gov.au/ausstats/abs@.nsf/Products/3309.0~2010~Chapter~Aboriginal+and+Torres+Strait+Islander+suicide+deaths?OpenDocument

[68] Australian Bureau of Statistics, *Aboriginal and Torres Strait Islander Suicide Deaths*, http://www.abs.gov.au/ausstats/abs@.nsf/Products/3309.0~2010~Chapter~Aboriginal+and+Torres+Strait+Islander+suicide+deaths?OpenDocument.

[69] Australian Bureau of Statistics, *Aboriginal and Torres Strait Islander Suicide Deaths*, available online at: http://www.abs.gov.au/ausstats/abs@.nsf/Products/3309.0~2010~Chapter~Aboriginal+and+Torres+Strait+Islander+suicide+deaths?OpenDocument

62. A search of the Victorian Suicide Register, a database of suspected and Coroner-determined suicides[70], was undertaken by the CPU to identify relevant deaths of Aboriginal and Torres strait youth in Victoria.

63. The result of the CPU interrogation of the Victorian Suicide Register revealed that between 2009 and 2015, there were 11 suicides in Victoria of Aboriginal and Torres Strait Islander people aged 25 years or under, the majority of these deaths (7 of 11) occurred in the Mildura region.[71]

64. That family violence against Aboriginal women and girls is a significant contributing factor to youth suicide is reinforced by recent conclusions drawn by her Honour, State Coroner Fogliani, who delivered her coronial findings on 7 February 2019 into the 13 deaths of Aboriginal youth and children in the Kimberley region of Western Australia between November 2012 and March 2016 (**WA Inquest**).[72] Her Honour noted that:

*"Those multifactorial problems (described previously under the heading Intergenerational trauma) have created the environment that has generated despair amongst many Aboriginal children and young persons and some have tragically been overwhelmed by it and have acted to end their lives. The flow on effects of intergenerational trauma include domestic violence within families, alcohol and illicit drug abuse, child sexual abuse, poverty, neglect, low school attendance, lack of employment opportunities, overcrowding in houses, poor physical health and untreated mental health conditions."*[73]

65. I confirm that recommendations in the WA Inquest also referenced missed opportunities to help children by child protection services operating in the Kimberley region of Western Australia.[74] In the WA Inquest, it was similarly commented that child protection services had

[70] The Victorian Suicide Register (VSR) is a state-based suicide surveillance system that contains detailed information on people who die by suicide and the circumstances surrounding their death. The VSR uses enhanced data (pertaining to stressors, service contacts and legal system contacts), this enhanced data is coded into the VSR after the coronial briefs of evidence are received and the Coroner has made a determination regarding intent.

[71] *Coroners Prevention Unit Aboriginal Youth Suicide Research Memorandum*, dated 5 December 2018, 2-3. It is important to note that the identification of Aboriginal and Torres Strait Islander people among Victorian suicide deceased is challenging. When a person had died, only secondary sources are available like medical, legal and other documents. These secondary sources are an inadequate substitute for what people can tell the Court about who they are and how they identify themselves.

[72] Inquest into the 13 Deaths of Children and Young Persons in the Kimberley Region, 7 February 2019, available online at:
https://www.coronerscourt.wa.gov.au/I/inquest_into_the_13_deaths_of_children_and_young_persons_in_the_kimberley_region.aspx

[73] Inquest into the 13 Deaths of Children and Young Persons in the Kimberley Region, 7 February 2019, paragraphs 1034-1035.

[74] Inquest into the 13 Deaths of Children and Young Persons in the Kimberley Region, 7 February 2019, available online at:

failed to undertake an assessment of the child's wellbeing with the information available to them or the information ought to have been available to them, had proper enquiries been made with other agencies supporting the children.[75]

66. Axiomatically family violence has a serious impact on the health and wellbeing of children and young people[76] the long-term impacts of which may not always be apparent in the short term.[77] The North and West Children's Resource Program noted that the impacts "*on children who live with family violence may be acute and chronic, immediate and accumulative, direct and indirect, seen and unseen*."[78]

*Royal Commission into Family Violence and relevant government responses*

67. The Royal Commission made recommendations concerning the assistance that should be provided to children exposed to family violence and particularly with respect to those who identified as either Aboriginal or Torres Strait Islander. The progress of recommendations made by the Royal Commission as they are relevant to Zakiya's case include Recommendation 145 of the Royal Commission which suggests that the Victorian Government continue to work in partnership with Aboriginal communities to develop a statewide strategic response to improving the lives of vulnerable Aboriginal children and young people. The result of the Victorian Government's work in respect of this recommendation has resulted in the signing and launch of the Wungurilwil Gapgapduir: Aboriginal Children and Families Agreement and Strategic Action Plan on 26 April 2018 with a commitment to $47.3 million in the 2018-19 State Budget to support implementation.[79]

68. I further note that Recommendation 146 of the Royal Commission highlighted the need to prioritise adequate funding to Aboriginal community-controlled organisations for culturally appropriate family violence services for Aboriginal women and children. The Victorian Government has provided for $13.5 million over four years in the 2018/2019 State Budget for the Dhelk Dja Agreement to ensure expanded funding for Aboriginal frontline family violence services, including culturally appropriate responses for Aboriginal Victorians experiencing family violence.

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https://www.coronerscourt.wa.gov.au/I/inquest_into_the_13_deaths_of_children_and_young_persons_in_the_kimberley_region.aspx, 231

[75] Ibid.

[76] State of Victoria, Royal Commission into Family Violence, *Final Report* (2016) vol 2, 101.

[77] Ibid 105.

[78] North and West Regional Children's Resource Program, *Through a Child's Eyes: Children's Experiences of Family Violence and Homelessness* (2013) 4.

[79] More details about the implementation of Recommendation 145 can be found online at: https://w.www.vic.gov.au/familyviolence/recommendations/recommendation-details.html?recommendation_id=112

69. I also note that Recommendation 23 of the Royal Commission suggested priority funding for therapeutic interventions and counselling for children and young people who are victims of family violence. This included the extension of the Homeless Children's Specialist Support Service (or a program with similar features) and ensuring that children and young people affected by trauma associated with family violence are eligible for the 'Take Two Program', or similar intensive therapeutic programs.[80]

*CAMHS and the Mildura Base Hospital*

70. During times relevant to this investigation, CAMHS provide comprehensive services for children and adolescents experiencing mental health problems. These services assessed and treated children and adolescents (0-18 years) with moderate to severe, complex and disabling problems and disorders. They assisted those with less severe problems with information and advice about where and how to get help and facilitate referral as appropriate. Vulnerable children and young people and families, including, those involved in statutory services, were prioritised. The CAMHS that operated in the Mildura region is a part of mental health services delivered by the Mildura Base Hospital (**MBH**).

71. Zakiya had engaged with CAMHS services during the period of 12 November 2014 until 30 March 2015. During this time, Zakiya told workers at MBH and CAMHS, that her experiences of family violence allegedly perpetrated by her step-father and the historic child sexual abuse allegedly perpetrated by her uncle, had impacted on her physical health (sleep disturbances) and mental health (suicidal ideation and depression).[81]

72. Although Zakiya made the above disclosures to her CAMHS mental health worker, without Zakiya's consent and without Zakiya being at risk of imminent harm, CAMHS were obligated to consider their duties to maintain confidentiality and did not inform her parents of the information disclosed.

73. The 14 November 2014 mental health triage assessment performed by CAMHS, indicated that Zakiya had disclosed a significant family history of physical and sexual abuse, neglect, violence, substance abuse and suicidality. These disclosures of abuse and the multiple risk factors facing Zakiya at this time, were not shared with Child Protection or other relevant

[80] State of Victoria, Royal Commission into Family Violence, *Final Report* (2016) vol 2, 147.
[81] Medical records provided by Mildura Base Hospital – Mental health assessment dated 14 November 2014.

service providers. As a result, these agencies did not have an opportunity to contribute to Zakiya's care or safety in the months leading up to her death.

74. As at March 2015, CAMHS was aware that Zakiya had made a clear statement of her previous intentions to suicide and had articulated a means to enact it. She had disclosed her family's drug and alcohol abuse issues and the problematic and abusive relationship that she had with her step-father. This critical information does not appear to be communicated to Child Protection in any way and was a potential missed opportunity for intervention.[82]

75. Despite the lack of CAMHS' critical information sharing with relevant agencies, CAMHS managed Zakiya's issues with face to face contact during the period of November 2014 and April 2015. CAMHS engaged with the family, were involved in discharge planning, made frequent and direct contact with Zakiya and performed appropriate safety planning when assessing her risk of self-harm.

76. Information provided to me evidences the existence of an Aboriginal Health Unit operating within the MBH that aims to provide cultural support and advocacy for Aboriginal and Torres Strait Islander patients and staff.[83] However, records provided to the Court by the MBH indicate no referral was made by mental health or medical practitioners on behalf of Zakiya and her family to the Aboriginal Health Unit to receive additional support.

*MDAS and ACSASS*

77. The Aboriginal Child Specialist Advice and Support Service (**ACSASS**) was created to provide expert advice and case consultation to Child Protection about culturally appropriate intervention in respect of all reports regarding the abuse or neglect of Aboriginal children and regarding significant decisions in all phases of Child Protection intervention. In the Mildura region, ACSASS is operated as part of the Mallee District Aboriginal Services (MDAS).

78. I note that the *Victorian Aboriginal Cultural Competence Framework (2008)* (**'VACCF'**) provides:

*"Aboriginal communities believe the child's relationship to the whole family, and not just mum or dad, are part of the child's key relationships. Therefore, it is important that interventions reflect this broad understanding and seek from the family their definition of*

[82] Child Protection records did not contain any references to significant disclosures Zakiya made to CAMHS regarding her March 2015 suicidal ideation, family history of drug and alcohol abuse and historic abusive relationship with her step-father.
[83] Email communications between the Coroners Court of Victoria and the Mildura Base Hospital dated 30 December 2019.

*who should be involved in particular assessments, interventions or planning activities, rather than assumptions being made about, for instance, who is 'family'. Workers may feel uncomfortable talking where there may be many members of the family present. However, effective interventions with children and families can only be realised if the key people as defined by the family are engaged in the process.'*[84]

79. It was important that services seeking to support Zakiya engage not only Zakiya and her mother but with Zakiya's consent, engage her extended family members and the Aboriginal community to support her in a culturally sensitive manner.

80. Records provided by Child Protection indicate that they notified ACSASS about the initial report of Zakiya's attempted suicide on 14 November 2014. The records further indicate that Child Protection advised ACSASS that they would provide them with an update following their meeting with Zakiya on 17 November 2014. The records contain no reference to Child Protection providing ACSASS with an update nor any reference to ACSASS seeking such an update.

81. I note that Zakiya had disengaged from counselling services with MDAS prior to her November 2014 suicide attempt, yet MDAS records do not evidence any attempt to follow up with Zakiya to ensure continuity of mental health treatment. I note that Child Protection and CAMHS also did not contact ACSASS to consult on cultural issues and strategies to address Zakiya's support from her extended family. This lack of information sharing and cooperation between support services was a significant missed opportunity for intervention.

*Child Protection*

82. The Victorian Child Protection Service is specifically targeted to those children and young people at risk of harm or where families are unable or unwilling to protect them. The main functions of Child Protection are to investigate matters where it is alleged that a child is at risk of harm; refer children and families to services that assist in providing the ongoing safety and wellbeing of children and take matters before the Children's Court if the child's safety cannot be ensured within the family.

[84] Victorian Aboriginal Child Care Agency, *Aboriginal Cultural Competence Framework* (November 2008), 18.

83. Child Protection initiated their engagement with Zakiya after being notified that she was admitted following a suicide attempt. A Child Protection practitioner report dated 14 November 2014 noted concerns that:[85]

(a) Zakiya had attempted suicide, '*had a complex relationship with her mother and had not been residing with her mother recently*';

(b) Zakiya did '*not have a place to live at the moment and therefore [was] not supported by a care giver to ensure her current safety*;' and

(c) The intake summary listed areas of concern as '*chaotic family lifestyle, emotional trauma, likelihood of significant emotional harm, and suicidal action.*'[86]

84. On 17 November 2014, a Child Protection worker spoke to staff at the Mildura Base Hospital over the telephone and was advised that Zakiya was due to be released at noon that day. A worker from Child Protection contacted ACSASS and enquired if an ACSASS worker could visit Zakiya at the hospital with them. A worker from ACSASS was said to be unavailable. The notes from this contact suggest that the ACSASS worker requested that the Child Protection worker who visited the hospital update ACASS after the visit. [87]

85. Child Protection records indicate that on 17 November 2014, a Child Protection worker went to the Mildura Base Hospital and spoke with both Zakiya and Ms Thomas.[88] Both Zakiya and Ms Thomas explained that their relationship had been strained, and this was explained as being largely due to Zakiya's sexual relationship with her ex-boyfriend. Zakiya stated the reason for her suicide attempt was because she was tired and wanted to rest, and she had not felt comfortable discussing her mental health distress with her mother '*as they had argued a lot recently due to her relationship with her boyfriend.*'[89]

86. Zakiya told the worker that she wanted to return to live at Ms Thomas's residence and access support services from there. The worker determined that it was appropriate for Zakiya to reside with Ms Thomas on the basis that Ms Thomas agreed to get a lockable container for her medication, Zakiya had advised that she would get mental health assistance from CAMHS and had agreed that she would tell Ms Thomas if she felt unwell or wanted to self-harm. The Child Protection worker requested a copy of the discharge summary for Zakiya from the

[85] Records provided by the Department of Health and Human Services – Child Protection, 44.
[86] Records provided by the Department of Health and Human Services – Child Protection, 45.
[87] Records provided by the Department of Health and Human Services – Child Protection, 48.
[88] Records provided by the Department of Health and Human Services – Child Protection, 64.
[89] Records provided by the Department of Health and Human Services – Child Protection, 64.

Mildura Base Hospital. I note that the discharge summary contains very little information and did not indicate any of the follow up services or appointments that Zakiya would be engaging with.[90]

87. The Child Protection records I have been provided contain no reference to the Child Protection Worker who spoke to Zakiya and her mother at the hospital on 17 November 2014 updating ACSASS prior to the closure of Child Protection engagement.[91]

88. On 27 November 2014, a worker from Child Protection contacted Ms Thomas by telephone. Ms Thomas told the Child Protection worker that Zakiya was going well and had been engaging with several services including CAMHS and MASP. Ms Thomas explained that she was in the process of arranging a bungalow for Zakiya to live in at her home.[92] Although a home visit was arranged for 28 November 2014, this was postponed as Zakiya was not at home. There is no record that this home visit took place.[93]

89. Between 18 November 2014 and 8 December 2014, no worker from Child Protection spoke to Zakiya despite a Child Protection worker and a supervisor having determined that such a meeting was appropriate. On 8 December 2014, Child Protection decided to close Zakiya's file on the grounds that concerns about harm to Zakiya were not substantiated and Ms Thomas was acting protectively to ensure Zakiya's wellbeing and safety.[94] The Child Protection closure summary noted that there was nothing to indicate that the conflict between Zakiya and her mother was more than typical parental/adolescent conflict.[95]

90. Whilst Child Protection may have been aware of Zakiya's engagement with CAMHS and MASP, they did not independently verify this engagement by contacting the services directly at any time during their engagement with Zakiya. I note that on only one occasion did a Child Protection employee speak to Zakiya face to face and that this occurred prior to her moving back in with her mother. The value of direct contact in these circumstances cannot be over stated; communication by telephone is a poor substitute.

91. The prevailing Child Protection practice advice in place at the time of Zakiya's death titled *"Concluding the investigation and assessment phase"*[96], stipulates that practitioners should advise agencies and services who have had or will have significant ongoing involvement with

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[90] Records provided by the Department of Health and Human Services – Child Protection, 59.
[91] Records provided by the Department of Health and Human Services – Child Protection, 62.
[92] Records provided by the Department of Health and Human Services – Child Protection, 66.
[93] Records provided by the Department of Health and Human Services – Child Protection, 67.
[94] Records provided by the Department of Health and Human Services – Child Protection, 68.
[95] Records provided by the Department of Health and Human Services – Child Protection, 69-70.
[96] *Child Protection Service - Concluding the investigation and assessment phase* dated 5 November 2012.

the child and their family, in writing, of Child Protection's intention to close. There is no record of this action taking place and whilst Child Protection claims that a rescheduled home visit to Zakiya and her mother did proceed, similarly, there is no record of this occurring.[97]

92. I further note that the Child Protection practice advice, "*Gathering information from other sources in initial investigation advice*", outlines the purpose and process of gathering information from sources other than the child's immediate family during the investigation of a protective intervention report. The advice states that the purpose of contacting sources, other than the family, to collect information during an investigation is to:

*"verify, clarify or corroborate information, which has been provided by the family (or other sources) on the first or subsequent contacts; and gather further specific and comprehensive information to inform an assessment of safety, stability and development"*[98]

93. I note that the same practice advice goes on to confirm that, "*Information provided by parents in initial and subsequent home visits may or may not be accurate, and on its own is generally not sufficiently comprehensive for the purposes of investigation and assessment to ensure the protection of the child...Sources who know the child or family well and have regular contact with them including extended family and professionals can assist in clarifying and corroborating information about significant events or issues which have been provided by parents and children.*"[99] The records provided by Child Protection evidence a failure to take these necessary steps to corroborate information provided by Zakiya and her mother, including relevant information from the mental health clinician who saw Zakiya before her attempted self-harm on 14 November 2014.

94. The failure of Child Protection to engage with other support services prior to the closure of their investigation in December 2014 was a missed opportunity for intervention in this case.

95. An internal review conducted by Child Protection[100] found that the Child Protection workers failed to comply with applicable procedures, which required that a formal closure meeting be undertaken with agencies working with Zakiya so that case planning could occur prior to the

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[97] Statement of Tracy Beaton dated November 2019, 8.
[98] Department of Health and Human Services – Child Protection – *Gathering information from other sources in initial investigation* practice advice dated 5 November 2012, 1.
[99] Ibid, 2.
[100] Records provided by the Department of Health and Human Services – Child Protection, 89-90.

file being closed.[101] Such a failure to consult with other agencies also breaches the tenants of ASCASS and existing Child Protection policies.

96. I am informed by Child Protection that the divisional Child Protection Principal Practitioner has worked with practitioners to provide reflective practice and training sessions to address these issues.[102] I am further informed that in February 2019, the Department of Health and Human Services implemented updated program requirements for ACSASS that include the closure decision as a significant decision requiring ACSASS consultation, especially when a matter is closed at the Child Protection investigation phase.[103]

97. The Royal Commission made several recommendations to improve the way that Child Protection responds to family violence and operates within the wider family violence system. Of relevance to the facts of this matter are Recommendations two, three, 26 and 29.[104] With respect, I endorse and reiterate the Royal Commission's conclusions and related recommendations in relation to changes to the policies, procedures and practices of Child Protection.

98. Specifically, I endorse Recommendation two that the *Family Violence Protection Act 2008* (Vic) **(the FVPA)** be amended to require prescribed agencies to align their risk assessment policies, procedures, practices and tools with the MARAM.[105] This recommendation has been implemented and Child Protection are a prescribed agency.[106]

99. I also endorse Recommendation three which suggests a sustained workforce development and training strategy that includes whole-of-workforce training for Child Protection in relation to minimum standards to guide identifying, risk assessment and risk management practice in relation to family violence.[107] I note that the MARAM guidelines were completed on 27 September 2018 and the workforce development and training strategy is currently in progress.[108]

100. Further to this, Recommendation 26 suggests that Child Protection strengthen their practice guidelines in cases where family violence is reported to and investigated by Child Protection

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[101] State of Victoria, Royal Commission into Family Violence, *Final Report* (2016) vol 2, 205.
[102] Statement of Tracy Beaton dated November 2019, 8.
[103] Department of Health and Human Services – *Program requirements for the Aboriginal Child Specialist Advice and Support Service* (February 2019), Child Protection Manual – *Additional requirements when intervening with an Aboriginal child* (19 November 2019) and Child Protection Manual – *Closing a case* (19 November 2019).
[104] Ibid 203-204.
[105] State of Victoria, Royal Commission into Family Violence, *Final Report* (2016) vol 1, 139.
[106] <https://www.vic.gov.au/familyviolence/recommendations/recommendation-details.html?recommendation_id=2>
[107] State of Victoria, Royal Commission into Family Violence, *Final Report* (2016) vol 1, 141.
[108] < https://www.vic.gov.au/familyviolence/recommendations/recommendation-details.html?recommendation_id=3>

but the statutory threshold for protective intervention is not met. This is to help ensure comprehensive and robust safety planning is undertaken, either by Child Protection or a family violence service and formal referrals are made to relevant services such as specialist family violence services.[109]

101. I also endorse Recommendation 29 which suggests that Child Protection institute training and professional development regarding family violence and the Child Protection practice guidelines for dealing with family violence for all Child Protection practitioners.[110] Whilst I note that Recommendation 29 is still in the implementation stage, this training and professional development will ensure that any practice changes arising from the above recommendations are communicated to, and actioned by, the relevant practitioners. I further note that all Child Protection staff from newly inducted practitioners to those in practice leadership and management roles, are required to attend the training proposed in Recommendation 29.[111]

102. Child Protection have developed a Child Protection Family Violence Steering Committee to drive the implementation of these recommendations, and new practice advice and procedures have been developed to strengthen case planning which require practitioners to consider family violence as part of Child Protection risk assessments.[112]

103. The knowledge provided by Aboriginal services in relation to Aboriginal families, their connections with culture and other services can significantly impact the risk analysis and case management of Aboriginal youth engaged with community support services. Obtaining this information likely would have assisted assessment determinations by Child Protection in relation to Ms Thomas and her extended family's capacity to care to support Zakiya's emotional wellbeing and safety.

104. I note similar observations in the WA Inquest in which her Honour, State Coroner Fogliani, recommended that there be consultation with appropriate representative bodies of the Aboriginal communities by Government and service providers.[113] The WA Inquest also recommended that the Government and its service providers continue to ensure that the strategies for addressing Aboriginal youth suicide are implemented in consultation with

[109] State of Victoria, Royal Commission into Family Violence, *Final Report* (2016) vol 2, 204.
[110] State of Victoria, Royal Commission into Family Violence, *Final Report* (2016) vol 2, 205.
[111] Ibid.
[112] <https://www.vic.gov.au/familyviolence/recommendations/recommendation-details.html?recommendation_id=65>
[113] Inquest into the 13 Deaths of Children and Young Persons in the Kimberley Region, 7 February 2019, available online at:
https://www.coronerscourt.wa.gov.au/I/inquest_into_the_13_deaths_of_children_and_young_persons_in_the_kimberley_region.aspx, 306

appropriate representatives from the Aboriginal community.[114] This includes the opportunity for appropriate representatives from the Aboriginal community to be involved in the co-design of such strategies. I support these recommendations being explored by the Victorian Government and its service providers.

105. It is important to note that Aboriginal and Torres Strait Islander peoples, particularly women and children, are disproportionately affected by family violence and face greater barriers to seeking support and assistance when they do experience violence.[115] For this reason, it is important that they have access to culturally sensitive services for assistance with family violence.

## RECOMMENDATIONS PURSUANT TO SECTION 72(2) OF THE ACT

106. I recommend that the Child Protection and ACSASS consider reviewing their systems for enabling joint input and engagement with vulnerable Aboriginal youth in their catchment areas upon notification of an incident. A protocol should be established to ensure that any investigations involving Aboriginal youth is not completed without input of both services.

107. I further recommend that the Victorian Government, Child Protection and MDAS should consider the high rate of Aboriginal youth suicides in the Mildura region in future planning with respect to the allocation of resources and provision of services to the Mildura community and in dealing with cases such as this one.

108. I recommend that CAMHS review their current policies and training for mental health practitioners, specifically their family violence risk assessments, information sharing with relevant agencies and family violence safety planning for patients who disclose family violence in the home environment.

109. I also recommend that the MBH review their current policies and training for all clinicians and health practitioners to refer patients who identify as Aboriginal or Torres Strait Islander to the internal Aboriginal Health Unit at the MBH to enable additional cultural support and advocacy upon admission or discharge. I further recommend that the current policies and procedures at the MBH be reviewed to incorporate cultural training to improve support provided by hospital staff to patients who identify as Aboriginal or Torres Strait Islander.

110. I recommend that MDAS consider the following:

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[114] *Ibid.*

[115] State of Victoria, Royal Commission into Family Violence, *Final Report* (2016) vol 5, 7.

(a) A partnership with the Youth Affairs Council Victoria and the Koorie Youth Council to develop an Aboriginal youth mentoring program (*Marram Nganyin*) in the Mildura region. I note that in October 2017 the Victorian Government announced the *Balit Murrup: Aboriginal Social and Emotional Wellbeing Framework* and allocated an additional $1.8 million dollars in funding to extend the Aboriginal youth mentoring program.[116] I confirm that MDAS started a Family Wellbeing Program in 2016 that runs over 12 weeks to help vulnerable individuals with self-reflection, relationships and building leadership skills. The Family Wellbeing Program would benefit from additional funding through the Victorian Government to continue its success amongst Aboriginal Youth in Mildura.

(b) Development of a similar program to *Fresh Tracks*, an initiative developed by Geelong-based Wauthorong Aboriginal Cooperative that uses a service model applied to clients with a high degree of complex needs and lower rates of attending clinical care.[117]

**FINDINGS**

111. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the *Coroners Act 2008*:

(a) The identity of the deceased was Zakiya Crystal Lisa Thomas, born 31 August 1999;

(b) Zakiya's death occurred;

i. on 17 May 2015 at the Mildura Base Hospital, Mildura, VIC 3502;

ii. from I(a) hanging; and

iii. in the circumstances described in paragraphs 35-43 above.

112. Pursuant to section 73(1A) of the Act I order that this Finding be published on the internet

113. I direct that a copy of this finding be provided to the following for their action:

(a) The Honourable Mr Daniel Andrews MP, Premier of Victoria;

(b) Ms Kym Peake, Secretary, Department of Health and Human Services;

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[116] State of Victoria, Department of Health and Human Services, *Balit Murup: Aboriginal social emotional wellbeing framework 2017-2027* (October 2017), available online at: https://www2.health.vic.gov.au/about/publications/policiesandguidelines/balit-murrup-aboriginal-social-emotional-wellbeing-framework-2017-2027

[117] *ibid*, p 38.

(c) Mr Ross Hampton, Executive Director (Operations), Mallee District Aboriginal Services;

(d) Ms Julia Morgan, Chief Executive Officer, Mildura Base Hospital.

114. I direct that a copy of this finding be provided to the following for their information only:

(a) Ms Darlene Thomas, Senior Next of Kin;

(b) Mr Christopher Mason, Senior Next of Kin;

(c) Dr Neil Coventry, Chief Psychiatrist, Office of the Chief Psychiatrist;

(d) Ms Liana Buchanan, Principal Commissioner, Commission for Children and Young People;

(e) Ms Colleen Carey, Principal Solicitor for Children, Youth and Disability law team, Department of Health and Human Services;

(f) The Honourable Rosalinda Fogliani, State Coroner, Coroners Court of Western Australia; and

(g) Leading Senior Constable James Matheson Reid, Coroner's Investigator, Victoria Police.

Signature:

**DARREN J. BRACKEN**

**CORONER**

Date: 24 FEBRUARY 2020