ORDER:
Restriction on publication of reports:
The deceased may be referred to as Grace, aged 13 and living in Darwin at the time of her passing by suicide in January 2022. No other information that is likely to identify her further is to be published. The name of the suburb in which she lived, the names or any images of the schools she attended, the names or any images of her parents and brother, the names or any images of her friends, the names or any images of her school staff (teachers, principal, and school counsellor) and descriptions of the precise method of death are not to be published further.

CITATION: *Inquest into the death of Grace* [2024] NTLC 7

TITLE OF COURT:	Coroners Court
JURISDICTION:	Darwin
FILE NO(s):	D0028/2022
DELIVERED ON:	27 June 2024
DELIVERED AT:	Darwin
HEARING DATE(s):	13-15 February 2024
FINDING OF:	Judge Elisabeth Armitage
CATCHWORDS:	**Self-inflicted gunshot; child suicide; crime scene investigation; gunshot residue, fingerprinting; forensic pathologist; unsecured firearms; suicidal ideation; school counselling; adequacy of school response to disclosure.**

REPRESENTATION:

Counsel Assisting:	Chrissy McConnel
Counsel for Department of Education:	Michael McCarthy
Counsel for NT Police:	Fiona Kepert

Judgment category classification:	A
Judgement ID number:	[2024] NTLC 7
Number of paragraphs:	99
Number of pages:	34

IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0028/2022

In the matter of an Inquest into the death of

GRACE

ON: 28 January 2022
AT: DARWIN

FINDINGS

CONTENT WARNING

These findings discuss child suicide by gunshot

Judge Elisabeth Armitage

Introduction

1. Grace was only 13 years old when she tragically passed away from a self-inflicted single gunshot wound to the chest. She used a .308 Winchester rifle which was stored with ammunition in an unlocked cupboard in her parents' bedroom in the family home. She died on her parent's bed.

2. Grace was born in Phnom Penh, Cambodia. Her mother is Cambodian and her father is Australian. Her parent's met when her father was on a holiday in Cambodia in 2006. He found work in Cambodia and moved there permanently in 2007. They were married and lived in Cambodia until 2016 and during those years they had two children, Grace, who was born in 2008, and a son, AG, born in 2011. I heard that Grace loved growing up in Cambodia and could speak fluent Cambodian.

3. In 2016, the family moved from Cambodia to Vietnam. For 3 years they lived at the Australian Embassy in Hanoi while her father travelled for work. The family moved permanently to Australia, settling in Darwin, in 2019.

4. In April 2019, Grace commenced year 5 at a local primary school and she excelled. She always attended school and attained strong academic results. She was liked and respected, as evidenced by her elections as a school house captain and as a representative on the Student Council. She played netball, volleyball and regularly participated in dancing.

5. In Semester 2, 2019 Grace's student report described her as a positive role model to younger students and a "*confident and amicable student who is always enthusiastic and demonstrates resilience and independence.*"[1] In a 2020 student report from year 6, Grace was described as "*responsible, resilient and astute.*"[2] Her father described her as vivacious, confident and the life of the party; she was a rock star.[3]

Grace commences middle school

6. In 2021, Grace commenced middle school where, after some adjustments, she appeared to settle in. She continued playing netball and was still doing well academically, though there was a drop in her grades in semester 2. Those around her believed that Grace was smart, happy, confident, and popular.

7. Towards the end of 2021, Grace started a relationship with a boy in her year at school. They were in many of the same classes and spent time together outside school hours. Her parents thought she was very happy and content and the relationship seemed to be good for her.[4]

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[1] Statement, Aderyn Chatterton, 25 January 2024, Chatterton, 25 January 2024, [17].
[2] Statement, Aderyn Chatterton, 25 January 2024, 25 January 2024, Annexure AC-2.
[3] Statement, Father, 28 January 2022, [8].
[4] Statement, Father, 1 February 2022, Folio 11, [19].

8. In spite of those appearances, Grace reached out for help. She referred herself to the school counsellor for counselling sessions on three occasions that year. According to the counsellor the first two sessions which were in June, related to what he described as friendship, or peer group, issues, which he considered were common for female students in year 7.[5] But on 13 September 2021, Grace attended for a third counselling session and disclosed that she had thought about suicide. There was no evidence to indicate that Grace had shared these thoughts with anyone other than her school counsellor, but tragically, there is evidence in her private notebooks and drawings that Grace was secretly suffering, and had been since at least 2019.

At home

9. Grace had a generally positive relationship with her family. She shared a special bond with her younger brother, AG, whom she looked out for and spoke of fondly. But on occasions she clashed with her father, particularly over her use of social media and the internet, which he considered excessive. Friends and neighbours recalled that although her father was affectionate towards his children, from time to time he yelled at them, mainly concerning household chores. He was described as "*strict but fair*" and those who knew the family did not hold concerns about the family relationships.

10. Possibly around June 2021, Grace's father learned that she had used his razor to make a small cut to her wrist. When he asked her about it, Grace told him that it was her coping mechanism. She said she had not done it before and her father thought that it was a one-off episode.[6]

11. During the school holidays leading up to 28 January 2022, on several occasions Grace and her father argued over her use of social media and the internet. More than once, her father confiscated her mobile phone and laptop

[5] Statement, School Counsellor, 1 March 2023, [23].
[6] T16 Father.

computer. 26 January 2022 was the last time he confiscated her electronic devices.

12. During the afternoon of 27 January 2022, Grace requested her mobile phone and laptop back. Her father recalled telling her that she could have her laptop, but not her mobile phone. Later that evening, after dinner, Grace disappeared from the lounge room. Her father asked AG to see what his sister was doing. AG returned a short time later and said that Grace was playing on her mobile phone.

13. It was about 8pm and her father became angry. He immediately went to Grace's bedroom and took her phone and laptop. Grace protested that he had given her permission to have her mobile phone. Grace was upset and yelled at her father that she hated him. As he walked away with the laptop her father smashed it on the edge of a doorframe and threw it on the floor. He went to bed and had no further interaction with Grace. However, a little later her mother did check on her. Grace was watching television and seemed her normal self.

The day of her passing

14. On Friday 28 January 2022, her father left for work at around 7am. As it was school holidays, Grace, AG and her mother were at home. During the morning, AG watched television in the living room and Grace remained in her bedroom. Her mother checked on Grace at about 11.40am. Grace said that she wanted to keep sleeping and asked her mother to turn off the air-conditioning. Her mother did not notice anything unusual about Grace's demeanour or behaviour at that time.

15. Around 20 minutes later, Grace entered her parent's bedroom and locked the internal door. She opened the built-in wardrobe in the bedroom where she knew her father's .308 Winchester rifle and ammunition were stored. The

rifle had one bandolier that had rounds of .308 ammunition attached to the rifle sling.

16. Grace loaded a round of ammunition into the rifle, likely taken from a box of bullets which was later found in a drawer of her bedside table. She shot herself and the catastrophic injury immediately caused her death.

17. Her mother and brother heard the gunshot. AG ran downstairs to his mother who was in the garden and they both looked up and saw a hole in the main bedroom window. Grace's mother ran upstairs and tried to enter the main bedroom, but the internal door was locked. She ran back downstairs and then went up the external stairs to access the bedroom through an unlocked external fire-exit door. She found Grace lying diagonally across the bed, on her back, with her head facing the fire-exit door and the rifle on the bed next to her. When he heard his mother screaming, AG also ran upstairs and discovered his sister. No one else was at the premises at the time.

18. Her mother immediately called her husband on his mobile, but he did not answer. The logged time of this missed call is 12.07pm. She unsuccessfully tried again at 12.10pm, and then sent a text message which read, "*come home quickly.*" When he saw the missed calls and the text message he called back and AG answered. AG was hysterical and said, "*we think Grace has shot herself.*" He immediately left work and drove home.

19. Next door neighbours, Christopher and Annie, also heard the gunshot, and initially thought it was a firecracker. They then heard distressed screaming and went onto their balcony. They saw AG and his mother running towards them. Christopher ran downstairs and met them in the driveway. AG was very distressed. He said that Grace had shot herself in the chest and, "*I love her so much, I can't lose my sister.*" Christopher

called 000 at 12.11pm and emergency services were immediately dispatched.

20. Christopher went with them back to their home and saw Grace's father drive in and run upstairs. Her father found Grace, deceased, on the bed with a bullet wound to her chest. His rifle was beside her with the muzzle pointing in the same direction as her head. He picked up the rifle and removed the bandolier which still contained a number of unspent rounds. He cleared the breach and confirmed there were no further rounds in the chamber or magazine. He placed the rifle back on the bed and cradled Grace's body.

First responders

21. Police were the first responders, arriving at approximately 12.19pm. When the two attending officers entered the bedroom, they found Grace's father kneeling on the floor next to the bed. There was a pillow over Grace's chest and he was hugging Grace, applying pressure to her chest, and crying. The rifle was removed from the bed and placed on the floor. The pillow was removed from Grace's chest and the police saw a large circular wound which they thought looked like a bullet wound. One of the officers attempted to resuscitate Grace with a portable defibrillator but when it was connected the machine stated, No Shock Advised.

22. Moments later St Johns paramedics arrived and confirmed that the injury suffered by Grace was not compatible with life. She was declared deceased at 12.27pm.

The Crime Scene

23. A crime scene was immediately established with Major Crime Detectives arriving at around 1.12pm. Forensic Crime Scene Examiners attended soon after and were provided a briefing before processing the

scene. The police examined the main bedroom and observed Grace lying on her back, on her parent's bed, with her head closest to the external door and her feet closest to the internal door. They observed a hole in the window. They obtained or secured the following evidence:

- Photographs of the scene including of the deceased (which included rolling her on to her side[7]).
- The rifle (which was swabbed), the bandolier with live rounds and an air rifle (which was located in the main bedroom wardrobe) were seized.
- A spent round from under the bed and a live round next to the mattress were seized.
- Grace's confiscated mobile phone (hidden on the air conditioner behind books) was seized.
- A sketch of the crime scene was made which included measurements of the main bedroom.
- Biological swabs of the crime scene were taken including swabs from Grace's hands and feet.
- Grace's fingerprints were **not** taken

24. From Grace's bedroom the police located, photographed and seized:
    - Handwritten notebooks and sketch pads which appeared to be Grace's.
    - A box of .308 ammunition from her bedside table with one round missing.

25. From the bin in the kitchen they seized a broken laptop.

26. No information could be recovered from the laptop. Grace's phone records were recovered and examined but nothing was identified that appeared relevant to her passing. Grace's DNA was found on the rifle. Significant

[7] Statement, Crime Scene Examiner, 12 May 2022, p2.

evidence was found in Grace's extensive writings and drawings referencing her depression, and thoughts of self-harm and suicide.

Autopsy

27. On 31 January 2022, an autopsy was conducted by Forensic Pathologist, Dr Marianne Tiemensma.

28. Dr Tiemensma identified the precise measurements and locations of the entrance and exit wounds and reported that "*the track of the gunshot wound was from front to back and in a slightly downwards direction. The track of the gunshot wound perforated the anteromedial aspect of the left 2nd intercostal space, the pericardium, the heart, the descending aorta, the lower lobe of the left lung and the posteromedial aspect of the left 8th intercostal space.*"[8]

29. She described the entrance wound as having a wide surrounding rim of blackening measuring up to 0.6cm. Some light purple bruising on the surrounding skin was noted but no smoke or soot deposition or tattooing/peppering was seen.

30. Dr Tiemensma observed no other injuries and concluded that the cause of death was a single contact gunshot wound to the chest.

Issues for inquest

Youth suicide

31. In 2012, a Select Committee on Youth Suicides in the NT report, *Gone Too Soon*, cited the Northern Territory as having a youth suicide rate of 3.5 times the national average, with girls comprising 40% of suicides of children under

[8] Post Mortem Examination Report for the Coroner, Folio 5, p4.

the age of 17.[9] A 10 year review of the Northern Territory coronial records identified 52 suicide deaths by children under the age of 18 years, a distressing average of just over 5 child suicide deaths per year. The Australian Bureau of Statistics (ABS) reported that when all child suicide deaths are combined for the years 2012 to 2016, the Northern Territory reported the highest jurisdictional rate of deaths from suicide for children aged between 5 and 17 years, with 13.9 deaths per 100,000 people. To put that in context, all other States and Territories reported rates ranging from 1.7 to 3.1 deaths per 100,000 and the corresponding rate for Australia as a whole for this age group, was 2.3 deaths per 100,000 persons.[10]

32. Across Australia, in 2017 suicide was the leading cause of death for young people aged between 5 and 17 years with 98 deaths recorded, an increase of 10.1% from 2016.[11] In 2018, there were 103 child deaths from suicide. In 2019, there were 98 child deaths by suicide. In 2020, there were 100 child deaths by suicide. In 2021, there were 112 child deaths by suicide. And in 2022, there were 77 child deaths by suicide (the lowest rate in 5 years as recorded by the ABS).[12] In 2022, 15.5% of all the child deaths in Australia were due to suicide.[13]

33. Sadly the tragedy of youth suicide is not confined to Grace. Of all of the states and territories, it is the Northern Territory that has the highest rates of child and youth suicide in Australia. There is clearly a significant body of work still to be done if our agencies are serious about reducing risks and preventing youth suicide in the Northern Territory.

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[9] Report of the Select Committee on Youth Suicides (nt.gov.au)
[10] 3303.0 - Causes of Death, Australia, 2016 (abs.gov.au)
[11] 3303.0 - Causes of Death, Australia, 2017 (abs.gov.au)
[12] Causes of Death, Australia, 2022 | Australian Bureau of Statistics (abs.gov.au)
[13] Causes of Death, Australia, 2022 | Australian Bureau of Statistics (abs.gov.au)

NT Police

Forensic Pathologist

34. At the time of the police investigation into Grace's death, NT Police General Order - *Coronial Investigations & Inquests* applied.[14] It required that:

    Notifications to Forensic Pathologist

    Prior to an autopsy being conducted, it is imperative that the Pathologist is properly briefed on the circumstances surrounding the death and any additional information police may have regarding the possible cause of death.

35. Immediately following Grace's death, Chief Forensic Pathologist Dr Tiemensma was not afforded the opportunity to attend the scene and nor was her expertise sought concerning the collection or preservation of forensic evidence. As she was concerned by this lack of communication, in her summary post mortem report Dr Tiemensma documented that she had received *"no information about any evidence collection at the scene"* and "*the body …was received clad with urine soaked underwear, and the hands were not bagged, with no requests for evidence collection (until half-way through the post mortem examination).*"[15] Additionally, in her final report she recorded that no police were present at the autopsy.[16]

36. Assistant Commissioner Wurst described these failings as a breakdown in communication and a *"legacy hangover."* Following this incident the NT Police and the Chief Forensic Pathologist have agreed on a best practice approach moving forward. In all suspicious, firearm related, or suicide deaths of a child or youth, NT Police have undertaken to contact the on-call pathologist so that s/he can determine whether to attend the scene in person or view the scene remotely (for example, via iPad/phone video).

[14] NT Police General Order – Coronial Investigations & Inquests (OP:C-14) – 4 December 2024, [83].
[15] Summary to Post Mortem Report to the Coroner, Folio 5.
[16] Post Mortem Examination Report for the Coroner, Folio 5, p2.

37. This change was communicated to Forensic Crime Scene Investigators, Investigators and Coroners Constables by email on 25 August 2022 headed **MANDATORY PATHOLOGIST NOTIFICATION-CHILD DEATHS**, as follows:

> **Importance:** High
>
> Hi Team,
>
> After higher level discussions about missed opportunities with regard to child deaths (Under 18 years) a decision has been made with regard to mandatory notification to the Forensic Pathologist for these cases.
>
> **Notification Steps by attending Crime Scene Examiner (CSE)**
>
> - Scene Attendance by relevant CSE
> - Phone call to Pathologist (Marianne or Althea) — Give briefing on scene / deceased / circumstances.
> - From the briefing the Pathologist may attend the scene/or not. They may make suggestions/or not.
> - Share all images with the Pathology Unit via AXON Evidence.com - as per usual procedure [redacted]@gmail.com
>
> I have attached a copy of the Pathologists on call roster — I don't expect you to know it — ring Marianne (TL) in the first instance if you don't know who is on.
>
> - Dr Marianne TIEMENSMA— [redacted]
> - Dr Althea NEBLETT— [redacted]
>
> Please save the above numbers into relevant CSEU on call phones.
>
> The Coroners Constables and Investigators have been given the same message, so there may be double up, but at least notification won't be missed.
> This is all about engaging and seeking input early, trying to negate any concerns and attempting to do things better.
>
> I will update CSTM25 — Death Investigation to reflect this change.

38. Concerning the lack of police attendance at the autopsy, I was informed that this once standard practice[17] has fallen away over recent years with staff changes. However, NT Police have committed to ensuring that autopsies for suspicious, firearm related, or suicide deaths of a child or youth, will now always be attended by Investigators or Crime Scene Investigators, as appropriate.[18]

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[17] Affidavit, Travis Wurst, 5 February 2024, [23].
[18] Affidavit, Travis Wurst, 5 February 2024, [14-15] and [21].

39. Concerning both, opportunities for the forensic pathologist to attend the scene and police attendance at autopsies, the Assistant Commissioner has assured me these changes will be embedded in policy to avoid any uncertainty in the future.

40. As to Grace's hands not being bagged, I understood that Dr Tiemensma was concerned about the potential for any evidence on her hands to be lost or compromised. I understood that she was concerned that moisture in Grace's clothing (urine in her underpants) or in the environment (heavy downpour) may have affected the skin on her hands, which she noted were *"wrinkl[ed] in keeping with prolonged exposure to moisture."*[19] However, Assistant Commissioner Wurst was not concerned. He said, "*given police took GSR swabs and photographs at the scene, I am satisfied that bagging of the hands prior to moving the body was not necessary in this particular case."*[20]

41. While this unresolved issue assumed little significance in this case, it has the potential to be significant in others. The on-scene communication which is now required between investigators and the forensic pathologists should in future provide an opportunity for the views of the forensic pathologist to be considered when investigators are determining how best to collect and preserve forensic evidence.

Gunshot residue (GSR)

42. Before Grace was removed from the scene, and approximately 2¼ - 2½ hours after the discharge of the firearm, the Crime Scene Investigators swabbed her hands and feet for GSR. These swabs were submitted for analysis and no GSR was detected.

43. Assuming that Grace had fired the .308 Winchester rifle, to my mind the lack of GSR required explanation. Dr Kari Pitts, a GSR expert from the

[19] Post Mortem Examination Report for the Coroner, Folio 5, p3.
[20] Affidavit, Travis Wurst, 5 February 2024, [42].

Chemistry Centre of Western Australia, provided evidence on the issue.[21] Dr Pitts explained that firing of a firearm does not always lead to the deposition of GSR. She pointed to several factors which may explain why no GSR was found on Grace's hands or feet. Those factors included:

- The .308 rifle is long- barrelled, hence, if Grace's hands (or toes) were on the trigger they were distant from the muzzle.
- If the muzzle of the gun was in contact with a surface (in this case, the body[22]) this reduces the likelihood of GSR being found anywhere other than the wound.
- A well maintained and well-sealed firearm reduces the escape of GSR from anywhere other than the muzzle.[23]
- Any movement of the body can redistribute GSR.[24]
- Any brushing or rubbing of the body can redistribute GSR.[25]
- Air movement, air temperature and humidity levels[26] in the room where the firearm was discharged can affect where the residue settles, GSR is easily moved and even opening a door can lead to redistribution.[27]

44. While the 2½ hour delay between the discharge of the firearm and the collection of GSR swabs was not, in and of itself, a factor which may result in the redistribution or loss of GSR,[28] in my view it provided a window of opportunity for other factors to play-out and potentially produce that result.

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[21] Statement, Dr Kari Pitts, 8 May 2023.
[22] The findings at autopsy established that the muzzle was in contact with the skin.
[23] Whether this rifle was well-maintained and sealed is unknown, it was not examined by an expert.
[24] Grace was moved by paramedics during care attempts and the Crime Scene Examiner so that photos could be taken, and possibly also her father, before her hands and feet were swabbed.
[25] Her father was hugging and cradling Grace's body before police attended the scene.
[26] As can be seen on BWV, there was a downpour of rain while the crime scene was being examined and while Grace was in situ and family members, paramedics and police moved around the room with the door open.
[27] T 50 Dr Pitts; Grace's mother opened an external door to enter the room and police and paramedics attending the scene also entered through doors into the room; BWV indicates that neither the ceiling fan nor air conditioner were running.
[28] T 52 Dr Pitts.

Police are now on notice to be mindful of the potential secondary impacts of delay on gunshot residue in future investigations.

45. In his evidence, Assistant Commissioner Wurst told me that "*testing had been undertaken to confirm that Grace was physically able*" to inflict the fatal wound with the firearm in "*hard contact*" with her chest.[29] Although no statement from the person who carried out the tests was provided, in his oral evidence the Assistant Commissioner assured me it had occurred and I accept his evidence on this issue.[30]

46. In all the circumstances, I am satisfied that there are reasonable explanations for there being no gunshot residue on Grace's hands or feet. I particularly take into account the length of the barrel and the close contact of the muzzle to Grace's skin. Accordingly, I am satisfied the lack of GSR does not preclude the gunshot being self-inflicted.

Fingerprinting

47. Grace's fingerprints were not taken as part of the investigation and unsurprisingly (given her young age and lack of prior involvement with the police), her fingerprints were not on police records. Accordingly, police could not confirm or exclude whether fingerprints located on the box of bullets in Grace's bedside table and in her notebooks were hers. However I was satisfied, from an otherwise strong circumstantial case, that the notebooks were Grace's and there was no evidence to suggest that anybody else had placed the box of bullets in her bedside table. As no fingerprints were found on the weapon, the omission to take her fingerprints assumed little significance in this case.

48. However, it was acknowledged by the Assistant Commissioner that Grace's fingerprints should have been taken, either as part of the scene examination

[29] Affidavit, Travis Wurst, 5 February 2024,[75].
[30] T 41 Travis Wurst.

or at the autopsy (by request of the investigating police). Explanations as to why this was not done included:

- The policies in place were too subjective.
- Some police were operating under the misapprehension that fingerprinting was done as a matter of course by scene investigators.
- The standard fingerprint form did not specify fingerprinting for comparative purposes as compared to identification purposes.

49. Assistant Commissioner Wurst readily acknowledged that the NT Police policies in force at the time provided insufficient guidance as to when and why fingerprints should be taken,[31] and further readily acknowledged that even the current policies did not adequately address this aspect of investigation. He identified these policies (among others) as needing updating:[32]

- *General Order – Crime (Homicide and Serious Investigation),*
- *General Order – Forensic Sampling and Examination,*

and in the meantime advised that steps have been taken to ensure officers of the Forensic Science Branch are "*alive to the need to take fingerprints for comparative purposes in appropriate circumstances.*"[33]

50. The Assistant Commissioner considered that taking fingerprints for children should be mandated in circumstances where the death is suspicious or an apparent suicide but was careful to qualify that such a procedure should apply within reason, based on the circumstances of the case. I am not sure that I fully understand the reasons for this qualification. I presume he considers, for example, that fingerprints are likely unnecessary when the deceased is an infant. I consider that, if there is to be any discretion, it should be accompanied by clear and concise guidelines.

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[31] Affidavit, Travis Wurst, 5 February 2024, [51-55].
[32] Affidavit, Travis Wurst, 5 February 2024, [54].
[33] Affidavit, Travis Wurst, 5 February 2024, [58].

Storage of firearms and ammunition

51. The .308 Winchester rifle, the air rifle and another firearm were registered to Grace's father, who was the holder of a Northern Territory Shooter Category A and B Firearms License, issued on 28 August 2019.[34] A *Permission to Store Firearms Notice* had been issued to store the firearms at an address in Wanguri (which had appropriate storage facilities) but that was not the address where they lived at the time of Grace's death, and he failed to comply with that Notice or to otherwise safely store his weapons and ammunition.

52. When one compares the numbers of licensed shooters in the Northern Territory against the resourcing allocated to the NT Police Firearms Policy and Recording Unit (FPRU), the importance of firearms license holders taking their responsibilities seriously becomes readily apparent. As at 28 January 2022, the FPRU had 4 full time equivalent staff in the roles of audit and enforcement.[35] At that time there were 15,825 firearms licenses in the Northern Territory and 66,446 registered firearms. The number of unregistered firearms is not known.[36] As explained by Assistant Commissioner Wurst, although the legislative obligation is on a license holder to notify the FPRU of any change to their licensing compliance, this does not always happen and there is no capacity within the FPRU to conduct physical checks. As it currently stands, the sad reality is non-compliance is often only identified when other offences or tragedies which warrant the attendance of police, such as this one, occur.

53. It is an offence, punishable by either a maximum fine of 50 penalty units ($7,850 at the time of Grace's passing) or up to 12 months imprisonment,[37] if firearms and ammunition are not kept safely in accordance with the

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[34] Affidavit, Travis Wurst, 5 February 2024, [86].
[35] Audit and enforcement are responsible for conducting checks and inspections on all Northern Territory license holders, dealerships and clubs, and also for revocations and seizures of firearms.
[36] Affidavit, Travis Wurst, 5 February 2024, [93]-[96].
[37] *Firearms Act* 1977, s 46; *Penalty Units Act 2009*, as at 1/7/2021 – 30/6/2022 a penalty unit was $157, but it is now $176.

requirements of the *Firearms Act 1997*. Category A and B firearms must be stored in a suitable locked receptacle (normally a gun safe) and ammunition must be kept locked in a separate suitable locked receptacle.[38] Sadly, those safeguards were ignored and the .308 Winchester rifle and the air rifle were stored, with ammunition, in the family home, in an unlocked bedroom, and in an unsecured wardrobe, pictured below.

54. Her father said that he brought the firearms with him when the family moved into their home, about two years before Grace's passing. Both of his children knew where the guns were kept and had been taught how to shoot.[39] He knew that he was required to safely store the guns, in an approved manner at the approved address in Wanguri, but said he had become complacent and did not appreciate the risk.[40] The risk, of course, was not limited to his children, but extended to visitors to the property (including other children) and potentially others (for example, if the weapons were stolen). As I said at this inquest, "*we have safe storage requirements in our legislation because, although individuals might not identify an immediate risk from their own weapons in their own home, as a community we recognise the risk of firearms more generally and broadly…and it is important that when*

[38] *Firearms Regulations* 1977, reg 21.
[39] Statement, Father, 28 January 2022, [31-32].
[40] T 22-23 Father.

people take on the responsibility of a firearm they comply with all [of] the legislative requirements including safekeeping."[41]

55. Following Grace's death, NT Police did not charge him with available offences under the *Firearms Act 1997* even though it appears there was prima facie evidence that he had not complied with his obligations. However, his firearms license was disqualified for 10 years, a consequence which he successfully appealed, with the disqualification period being reduced to 7 years.

56. NT Police sought to justify the decision not to charge by relying on reasons provided by the Director of Public Prosecutions (DPP) in a prior case which bore similarities to this case. However, the comments in that earlier advice, concerning whether or not it was in the public interest to proceed to charge, appear to have been both misunderstood and misapplied to the circumstances of this case.

57. To avoid doubt, I am advised that on 1 December 2022, an internal broadcast was communicated to all NT Police that in Coronial matters involving firearms, where there is evidence (a prima facie case) of a firearms storage and safekeeping offence, any decision on whether or not to proceed to charge is to be determined by the DPP and not Police.[42]

58. Assistant Commissioner Wurst provided some additional evidence about technological reforms to the FPRU designed to improve compliance with the *Firearms Act 1997*. An automated 6 monthly text messaging system now reminds license holders of their obligations and of the requirement to report any relevant changes in circumstances. Three alerts are also sent to remind license holders when their license is due to expire. The messaging system alerts FPRU registry staff if a licensee does not receive the text, so that

[41] T 23 Father.
[42] Affidavit, Travis Wurst, 5 February 2024, Annexure AC-07.

further manual follow-up can be conducted. *Project Tracer,* an integrated firearms licensing and registration system which is intended to replace the existing *Shooting and Firearms Easy Registration (SaFER),* is under development with a plan to go live by the end of 2025.[43]

Scene Reconstruction

59. NT Police did not have the expertise to accurately reconstruct and record a crime scene involving firearms, nor any ballistics expertise. The Crime Scene Examiners were not trained to take scene measurements for the purposes of reconstruction and, although they did their best, the measurements they took were not sufficient to enable a reliable reconstruction. It was frankly conceded that, "*the ballistic/trajectory rods and protractor were used incorrectly, the minor and major axis of the bullet hole in the window was not measured and alternative methods (packing the wound to midpoint) should have been utilised.*"[44] A major crash reconstruction expert was called upon for assistance, but with inaccurate measurements and lack of expertise in firearms trajectory, the reconstruction exercise undertaken was unable to produce any reliable results and he also frankly conceded, "*I have no training in firearm reconstruction.*"[45]

60. That the NT Police have no expertise in this area is disturbing. In 2018, in the *Inquest into the death of Matthew Rosewarne*,[46] (also a death due to gunshot) the NT Police investigation identified their lack of forensic expertise in firearms deaths. Acting Assistant Commissioner Travis Wurst (as he then was) assured the then Territory Coroner, Judge Cavanagh, that an independent review which had been commissioned by Police (in August 2018) would include a review of the adequacy of skills, experience, training, expertise and supervision in crime scene, fingerprints and firearms units

[43] Affidavit, Travis Wurst, 5 February 2024, [98]-[105].
[44] Affidavit, Travis Wurst, 5 February 2024, [71].
[45] Email, Major Crash Investigation Unit, 26 May 2022, Folio 24.
[46] [2018] NTLC 024.

within NT Police. In that inquest Judge Cavanagh did not make any formal recommendations, expressing his confidence that the review and additional training would occur. Several years have passed, any improvements that were achieved have been lost, and the Territory is again left without expertise in this area. Like Judge Cavanagh, I too am asked to be reassured that an agency wide review of Police which was commenced by the Northern Territory Government in 2023 will specifically report on forensic capabilities, identify gaps and future priorities.[47] Even with that assurance, I am concerned that reviews achieve nothing without implementation and steadfast commitment (even in spite of new competing priorities).

61. However, I am told and accept that since Grace's passing action has been taken to improve capability concerning the investigation of firearms incidents. NT Police now have a Leica RTC360 3D scanner and drones to assist in recording scenes and taking measurements. Four police members have received training in shooting reconstruction with the NSW Police (although one of these has since left the NT Police). While NT Police acknowledge that they do not possess and do not have a plan for achieving ballistics expertise, they have a "*letter of exchange with the Australian Federal Police in relation to providing this capability.*"[48]

Conclusion NT Police

62. Assistant Commissioner Wurst acknowledged that the issues raised in this investigation provided significant learning opportunities for the police in relation to improved investigation practices. Despite any shortcomings in the investigation, I was satisfied that there was no third party involvement in Grace's death.

[47] Affidavit, Travis Wurst, 5 February 2024, [85].
[48] Affidavit, Travis Wurst, 5 February 2024, [84].

Department of Education

Year 7 and a disclosure of suicidal ideation

63. Grace shared a warm relationship with her homeroom teacher. They chatted from time to time and her teacher considered Grace to be "a star student who had everything going for her."[49] In semester 2 Grace's grades dropped slightly but the work was more difficult and her teachers were not overly concerned.

64. However, her homeroom teacher noticed that in mid-September of 2022 there was a two week period when Grace was arriving late, was tired and "*didn't appear to be her normal self*." Grace had started sitting towards the back of the classroom and appeared less engaged with the other students. Her school attendance records reveal that Grace was late to school 8 out of 10 days during this period.

65. Appropriately in my view, her homeroom teacher raised this with Grace and asked her if she needed someone to talk to, or whether there was anything she could do to help. Grace indicated that she was speaking with the school counsellor but provided no further detail. On 17 September 2021, her teacher was concerned enough to email the Acting Year 7 Coordinator (a member of the Wellbeing Team and responsible for the wellbeing of year 7 students) as follows:

> *Sorry to add to your workload but l am concerned that Grace might be having a few problems. Up until recently she was always a great student and worked very hard in class. I do know she has seen [redacted] for a counselling session recently.*
> *She is continually coming in late for lesson 2 and when I asked her what was happening she said she is just going to bed late and can't get up. Apparently, her mum knows and her dad has already left for work so is unaware.*
> *She doesn't really want to talk to me, but I am concerned as she just isn't herself and is not as focused. If there is anything I should or can be doing please let me know.*

[49] Statement, Teacher, 12 February 2024.

66. The teacher did not receive a response to her email and heard nothing further. The teacher presumed that her concerns would be raised at the school Wellbeing Meeting. Following on from that two week period, Grace appeared to be back to her usual self and her attendance went back to normal. The Acting Year 7 Coordinator made follow up enquiries concerning Grace's school attendance and also noted that it had returned to normal.

67. School counsellors[50] are employed by the Department of Education (the Department) to provide services that enhance whole of school approaches to student wellbeing. In 2021, there was one school counsellor for the 800+ students enrolled at Grace's Middle School (and four primary feeder schools). The school counsellor, a registered psychologist,[51] was employed by the Department in 2006 and had been at Grace's school since 2009. He was well regarded by the Principal who described him as a warm and caring staff member who built good relationships with students.

68. Department records reveal that Grace self-referred to the school counsellor and she had three sessions, on 4 June 2021, 11 June 2021 and 13 September 2021. During the session on 13 September 2021, Grace disclosed that she had thought about suicide. The school counsellor said that each session generally lasted approximately 1 hour.[52] He said that he made hand written notes sometime after each session concluded and relied on those hand written notes to later update the electronic record. All of Grace's notes were entered into the Content Manager (also known as TRM) electronic records on 16 March 2022,[53] approximately 9 months after the first counselling session, six months after her suicidal disclosure, and two months after her

[50] Who are either qualified social workers, eligible for membership with the Australian Association of Social Workers or psychologists, registered with the Australian Health Practitioners Regulation Agency (AHPRA).
[51] Since 2004.
[52] T 63 School Counsellor.
[53] Statement, Aderyn Chatterton, 9 February 2024, [65].

passing. Grace's electronic *School Counselling Service Term Progress Notes* were as follows:[54]

DATE	NOTES – Recollection of counselling sessions as listed below.
4.6.21	Self referral. Discussed counselling rules / informed consent. Please note I am unable to find the signed consent form. Friendship issues. Discussed the frequency of friendship transitioning and the difficulties this causes, sensitivities and changing nature of growing up. Session: Grace was insightful, chatty, friendly and appeared to enjoy session.
11.6.21	Peer group issues continued.
13.9.21	Due to attend on Friday, but fogot. Rescheduled for Monday 13.9. Grace feeling down. Just overall, nothing particularly. Doesn't feel important. Has thought about suicide. Plan? None. What would impact on those around her be? Discussed impact. 'Won't do it (suicide)', but feels life can be pointless at times. What to look forward to? Grace easily recognised that seeing her friends is good and an upcoming party should be fun. Assessed low suicidality. T.c. to Father – [redacted] updated about Graces suicidal thoughts, offered ongoing counselling.

69. Although he had no independent recollection of calling Grace's father, relying on his notes and usual practice, the school counsellor believed that he did call him to advise that Grace had expressed suicidal thoughts and offer ongoing support.[55] However, her father said that he never received a call in which suicidality was raised or discussed.[56] He said that he called the school after he heard that Grace had been to see the school counsellor, possibly in June. He recalled speaking with a male school counsellor but no concerns were raised with him about Grace at that time.[57]

70. The school operated under a departmental *Student Wellbeing and Positive Behaviour Policy.*[58] The school had a Wellbeing Team consisting of the Assistant Principal, year level coordinators, the school counsellor and others. The Wellbeing Team met weekly to address student wellbeing matters.[59] However, the Acting Year 7 Coordinator did not raise Grace's

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[54] Coronial Brief folio 28
[55] T 74 School Counsellor.
[56] T 15 Father.
[57] T 14 Father.
[58] Statement, Aderyn Chatterton, 9 February 2024, [62], AC-40.
[59] Statement, Aderyn Chatterton, 25 January 2024, [54].

teacher's concerns at the Wellbeing Meetings and the school counsellor failed to raise that Grace had disclosed suicidal thoughts. In my view, and one shared by the school Principal,[60] this was an appropriate forum for raising those issues and the failure to do so was a missed opportunity to share information relevant to understanding her risk. Given the purpose of the meeting, it is hard to fathom why these concerns were not shared. To my mind it suggests the meetings were likely failing to fulfil their intended purpose.

School Counsellor Record Keeping

71. From 2018, the Department expected school counsellors to contemporaneously maintain detailed file notes and supporting evidence in TRM and high level data in the Student Services Information Database (SSID), in accordance with the *School Counselling Service Handbook.*[61]

72. From as early as 2019[62] it was identified that the school counsellor was not maintaining student counselling records as expected. Over the next 3 years it was identified that he was failing to maintain daily or even weekly entries, files were not created for each student or each session, essential information (such as consent forms, case notes, external referrals) were not uploaded and files were not closed when sessions ceased.[63] There were several meetings to discuss, among other things, his record keeping. One meeting was on 4 August 2021. The Manager of the School Counselling Service met with the school counsellor to discuss ongoing record keeping issues, concerns that the school counsellor was not capturing his work in a timely way and was not up to date with *Be You* training. Another was on 23 November 2021, when his record keeping was again identified as being non-compliant and he

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[60] Statement, School Principal, 8 February 2024, [58]
[61] Statement, Aderyn Chatterton, 25 January 2024, [59(d)], AC-12.
[62] Initial Supervision meeting: 13.2.2019, "hasn't done SSID for Term 4 2018"; 6/2/20, "discussed case notes and these need to be entered in TRM" and "Discussed informed consent and students should be signing consent…spoke about the importance of creating student counselling files and uploading request form and session notes" and "Action: to schedule time in week for case notes on TRM, to commence new referrals with consent form being signed and uploaded into TRM".
[63] Statement, Aderyn Chatterton, 9 February 2024, [45].

was granted "*three weeks off line*" and "*further support*" with student files. Ongoing he was to be off the school site on Wednesdays so that he could update and maintain his records.

73. In spite of these, and other, interventions, the school counsellor failed to adequately address his record keeping issues. Those failures negatively impacted the quality of the evidence presented at the inquest about Grace's three hours of counselling. In particular:

- There was no record of informed consent.
- The school counsellor could not confirm whether he made hand written notes on the day of the counselling sessions or sometime later[64] and the hand written notes of the counselling sessions were not retained.[65] Accordingly, it was difficult to be satisfied that any of the hand written notes were contemporaneous with each session, and it was impossible to test or confirm their accuracy or reliability.
- The electronic records were entered months after the sessions were completed and after Grace had passed away. The school counsellor relied on his hand written notes to update the electronic records and had no independent recollection of the counselling sessions.[66] Accordingly, the accuracy and reliability of the electronic records was as tainted as the original notes.
- The information that was entered was scant of detail.
- As there was conflicting evidence about a phone call to Grace's father and no contemporaneous record, I could not be satisfied that such a call had been made.

74. This was unsatisfactory. To be clear, I was particularly concerned by:

[64] T 66 School Counsellor.
[65] T 65 School Counsellor.
[66] T 65 School Counsellor.

- The lack of written informed consent from Grace addressing any explanation of confidentiality and the limits of confidentiality in counselling sessions. There should have been a written record that documented her acknowledgement that, for example, concerns of harm to herself or others could be shared with her parents/caregivers, other staff (such as the Principal and members of the Wellbeing Team) and other professionals (referrals to other services), as considered appropriate.
- The lack of any reliable documented risk assessment.[67]
- The lack of a reliable or detailed record of communication with a parent concerning her disclosure. The circumstances of this case highlight the imperatives of such a communication, particularly around risk and safety planning.
- The lack of a reliable and documented safety plan.[68]
- The lack of any concrete plans for follow up with Grace by the school counsellor or other appropriate service.

75. Following Grace's passing it was identified that the school counsellor's record keeping was still non-compliant and in August 2023 he was placed on a Professional Improvement Plan. He now assures this inquest that he has *"adjusted my professional practice to ensure my record keeping practices meet …expectations and the professional industry standards. I now create electronic notes within 48 hours of a counselling session to ensure the session is accurately recorded. I have increased the depth of my notes, ensuring all aspects of counselling sessions are captured."*[69]

The suicide risk assessment

76. The school counsellor said that following Grace's disclosure of thoughts of suicide he carried out a risk assessment and assessed her risk of suicidality

[67] Discussed in further detail later in these findings
[68] Discussed in further detail later in these findings
[69] Supplementary Statement, School Counsellor, 13 February 2024, [33]

as low. He considered that she demonstrated contra-indicators to suicidality, such as recognising the impact on others, and her plans for an upcoming party. He also considered that there was nothing that indicated Grace's suicidality was more than "*merely thoughts*."[70]

77. While the Department provided training[71] and materials[72] on childhood suicidality, it did not require school counsellors to use any particular risk assessment tool.[73] Instead, the Department relied upon each school counsellor's individual expertise, experience and training. The risk assessment used for Grace was based on the *Applied Suicide Intervention Skills Training (ASIST)* model which the school counsellor said was an established best practice model that he was trained in and had previously used.[74]

78. The evidence as to the risk assessment was limited by the counsellor's poor notes and lack of independent recollections. On the evidence available to me I was not persuaded as to the adequacy or efficacy of the risk assessment that was conducted.

79. In May 2023, the Department produced and implemented a two page *Practice Directive-Responding to Self-Harm and Suicide Risk* which is designed to guide staff responsible for *Student Wellbeing and Inclusion Programs* (SWIPS staff) through compulsory steps in response to self-harm or suicide disclosures.[75] It is not a stand-alone document and instead contains links to the *Beyond Blue Be You*[76] website. That site provides education and information which, among other things, assists the wider

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[70] Statement, School Counsellor, 1 March 2023, [25].
[71] The Black Dog Institute - Youth in Distress (managing suicidality and self-harm); Statement, Amanda Hubber, 2 February 2024, [23], the school counsellor completed this training sometime after September 2021.
[72] Beyond Blue 'Be You' support materials which included the Mental Health Continuum, a screening and assessment tool for mental health.
[73] Addendum statement of Aderyn Chatterton, 9 February 2024, p6.
[74] Statement of AP, dated 1 March 2023, [14]-[16].
[75] T 127; Statement of Aderyn Chatterton, dated 25 January 2024, annexure AC-17.
[76] beyou.edu.au.

school community to identify warning signs of suicidality, conduct initial conversations with children of concern and to ensure they are referred to a staff member with specific training who can conduct a risk assessment. The site does not specify how a risk assessment should be conducted.

80. I wanted to understand what guidance was provided to school counsellors (or persons in similar positions) interstate and obtained Education Department materials from New South Wales, Western Australia and Victoria. In contrast to the more general Northern Territory policy, in NSW there is a specific policy[77] (the NSW policy) designed to guide school counsellor's responses to suicidality in students. It contains checklists that can be used by school counsellors when conducting a "*comprehensive assessment that directly addresses the severity of the suicidal ideation, as well as underlying or external factors contributing to the young person's distress.*"[78] If those checklists had been used, and assuming Grace gave honest answers,[79] in my view it is possible that a more accurate assessment of her risk may have been gauged.

81. A further advantage of the NSW policy is its templates which are to be completed during an assessment and safety planning, and which then become part of a child's electronic record.

82. Certain evidence concerning Grace, which was not widely known (if at all), has been uncovered by this inquest. I consider that it is possible that a carefully conducted conversation, as outlined in detail in the NSW policy, had the potential to elicit relevant information from Grace. If the information we now know had been uncovered earlier, a higher level of risk would have been identified and a different response should have followed. The

[77] NSW Department of Education, Management of suicidality in students: Advice to school counselling staff.
[78] NSW Department of Education, Management of suicidality in students: Advice to school counselling staff, p7.
[79] There is no reason to assume she would not have been honest as she self-referred and was seemingly seeking professional help.

information, now known, and to my mind relevant to a risk assessment, includes the following:

- She had one known act of self-harm.
- She had a box of bullets in her bedside table.
- She knew how to use firearms.
- She had access to unsecured firearms.
- She had one known conversation about her sexual orientation and there is seemingly some limited reference to her sexual orientation in her private writings and drawings.
- For a period of time (albeit limited to about two weeks) she was arriving late at school, appeared tired, and lacked motivation.
- Her grades had reduced across the board, though were still solid.
- She was experiencing some conflict with her father.
- In her private writings she described herself as, "**useless* *stupid* *ugly* *wasted*."*
- In her private writings she vividly and repeatedly described herself as suffering from depression.
- In her private writings she wrote about suicide.
- In her private writings she transcribed lyrics from songs on the topic of suicide.
- In her private writings she drew guns and knives.
- In her private writings she wrote about not having friends.
- In her private writings she repeatedly wrote the word, *"help."*

Response to the disclosure

83. Having assessed her risk of suicidality as low, there was no active follow up with Grace by the school counsellor and no safety planning was undertaken with her or her parents. Under the Northern Territory approach

a safety plan is one option for follow up but is not mandatory.[80] Under the NSW policy, while there remains room for professional discretion, the template for *Assessment of Suicidality Form* requires the completion of an *Actions Taken* section. It prompts the school counsellor to include,*"confidentiality considerations, contact with parent/carer, consultation other agencies, removal of means, supervision, referrals, roles and responsibilities, follow up."* A section headed *Consultation* prompts the school counsellor to record details of consultations with other persons. The NSW policy also contains a *Safety Plan* template which includes identifying supports, limiting means (for example, unsecured weapons), triggers (for example, conflict with a parent) and warning signs, helpful strategies and reasons to live.

84. If a similar policy were in place in the Northern Territory I consider it likely that risk assessments following the disclosure of suicidal thoughts would be more thorough, safety planning would more likely take place with the child and parent/carer, and all would be documented. Even simple safety planning after a low risk assessment ought to identify whether a child has access to means (including guns) and should alert parents/care givers to any identified risks.

85. Grace's mother spoke limited English. Regrettably the school never thought to engage an interpreter to inform her of Grace's disclosures or to engage her in safety planning. It seems the father knew of some matters relevant to Grace's risk assessment and her mother knew of others. I consider it important that when conducting safety planning all parents/care givers are provided with an opportunity to contribute.[81]

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[80] *beyou* Risk Assessment p5

[81] Except if this is contra indicated, for example, by the child's disclosures

86. I am presently not persuaded that the Northern Territory *Self-Harm and Suicide Risk* practice directive outlines a sufficient or adequate response to a disclosure of suicidal thoughts to a school counsellor (or indeed a disclosure to any staff member).[82]

Improvements to the Whole of School Approach in 2022

87. Following Grace's passing, the school commissioned a Wellbeing Audit (2022 Audit) to identify to what extent the school was meeting National and Territory Wellbeing Frameworks.[83] As a result of the 2022 Audit, surveys with parents and students and a system review by the Wellbeing Team, I heard that significant changes were made to strengthen the whole of school approach to wellbeing including: [84]
    - Upskilling activities for all staff on Youth Mental Health First Aid Training, designed to support staff to be aware of mental health matters and to build positive student relationships.
    - Delivering youth mental health first aid to year 8 students (as a one-off, not ongoing).
    - Increasing wellbeing programs and supportive initiatives focused on social/emotional learning, implemented across the school and throughout the year (during weekly wellbeing lessons).
    - Introducing a weekly staff bulletin outlining professional learning opportunities, such as Essential Skills of Classroom Management, and activities and resources to support student wellbeing.
    - Improving the process for referring students of concern (academic, behaviour, wellbeing, health and/or attendance) to senior teachers and the Wellbeing Team. This includes using the Student of Concern Form and the schools electronic school management platform *Compass* to record and monitor students.

[82] Statement of Amanda Hubber, dated 2 February 2024, [24].
[83] AC-27.
[84] Aderyn Chatterton, p14.

- Developing a postvention suicide response plan, which outlines roles and responsibilities.
- A plan to develop terms of reference for the Wellbeing Team.

Conclusion - Department of Education

88. These reforms, along with others relayed by the Department through their written materials and oral evidence, are encouraging and positive. It was clear from the institutional response and the evidence given at this inquest that the impact of Grace's passing was broad reaching. While there have been improvements to the wellbeing frameworks and systems in the Departments whole of school approach to student wellbeing, I consider there is still more work to do.

Final Conclusions

89. Tragically suicide cannot always be predicted or prevented. For Grace there was little congruence between her apparently successful and resilient external life and her profoundly depressed and disturbed inner life. Sadly, she successfully kept her inner life a secret from those who knew and loved her. Her secret would have been kept after her passing, but for her notebooks in which she documented her thoughts and feelings.

90. After her passing her notebooks were found on her bedside table and desk, and a box of bullets was in a bedside drawer. None of these items were actively secreted or hidden from view. In the end it seems she wanted them to be found. Her notebooks revealed her cry for help.

91. That she was seeking some help was not a secret. She self-referred to the school counsellor, and this was known to her father and a teacher. In hindsight, this presented as a sliver of opportunity for intervention. It is not possible to know whether Grace's death might have been prevented, but I consider that more decisive policies and guidelines concerning risk

assessments and interventions in schools following suicide disclosures are warranted.

92. It goes without saying that unsecured firearms give rise to preventable risks.

93. It is hard to imagine the pain and suffering felt by Grace's family, friends, and school colleagues. These findings will likely add to their trauma and for that I am sorry. I extend my condolences to all those who mourn her.

Recommendations

Department of Education

94. **I recommend** that the Department of Education ensure that there is appropriate policy, guidelines and training in all schools incorporating best practice following any disclosure of suicidality or suicidal thoughts by a student, including but not limited to, risk assessment, safety planning, follow up or referrals and communication to appropriate persons. Consideration should be given as to whether a policy similar to the NSW *Management of Suicidality in Students* policy should be adopted.

Northern Territory Police Force

95. **I recommend** that NT Police embed in appropriate general orders, and any other applicable policy and training, clear directions as to the circumstances in which it is mandatory to immediately notify the forensic pathologist of a death and provide an opportunity for their attendance at a scene, in person or via videolink.

96. **I recommend** that NT Police amend the appropriate general orders, and any other applicable policy and training, to identify deaths in which it is mandatory for Police to attend autopsies and, guidance as to any discretion (if any).

97. **I recommend** that NT Police amend the appropriate general orders, and any other applicable policy and training, to address fingerprinting of deceased persons for forensic purposes including for comparative purposes.

98. **I recommend** that NT Police establish and maintain internal expertise in firearm crime scene reconstruction and ballistics, or have and maintain sufficient availability of appropriate external expertise.

99. **I recommend** that NT Police review and update appropriate general orders, and any other applicable policy and training, to reflect the Internal Broadcast *Prosecution Opinion files – Coronial Investigations involving unsecured firearms* dated 1 December 2022.

Formal findings

Pursuant to section 34 of the *Coroner's Act,* I make the following findings:

(1) The identity of the deceased is Grace [redacted], born on 18 August 2008 at Phnom Penh, Cambodia.

(2) The time of passing was at 12.27pm on 28 January 2022. The place of death was [redacted] Street, [redacted] in the Northern Territory.

(3) The cause of death was suicide by self-inflicted single contact gunshot to the chest.

(4) The particulars required to register the passing will be provided to the Office of Births, Deaths and Marriages.

Dated this 27th day of June 2024.

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ELISABETH ARMITAGE
TERRITORY CORONER