QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the deaths of JE and JJ**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Mackay
FILE NO(s):	2008/525 and 2008/538
DELIVERED ON:	9 June 2015
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HEARING DATE(s):	23 May 2011 & 21-23 June 2011
FINDINGS OF:	Terry Ryan, State Coroner
CATCHWORDS:	Coroners: inquest, youth suicide, contagion, suicide cluster, community response, suicide prevention

REPRESENTATION:

Counsel Assisting:	Mr Simon Hamlyn-Harris
Department of Communities: (Child Safety Services)	Ms Lisa O'Neill (Crown Law)

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Introduction

This inquest investigated the deaths of JE and JJ. These Indigenous young men were born within a week of each other in April 1992 and both died at the age of 16 years in the second half of 2008. As their deaths formed part of an apparent cluster of suicides involving young people in Mackay during 2007-2008, it was considered important to examine the circumstances of the deaths, and to consider ways to prevent similar deaths.

A cluster is considered to exist when an unusually high number of suicides occur in a small geographical area or institution and over a relatively brief period of time.[1]

Suicide clusters are fortunately very rare. There is considerable debate about the mechanisms underlying clusters, the related concept of contagion, and the efficacy of post-vention strategies in these circumstances in reducing other deaths due to intentional self-harm.[2]

On 29 November 2007, a 15-year-old Indigenous girl from Mackay took her own life by hanging. She was JE's cousin.[3] On 27 August 2008 at Palmer Street, Mackay, JE took his own life by hanging. JE had given no indication that he may have been thinking about taking his own life. JE was aged 16 years and 4 months.

On 30 August 2008, a 15 year old boy took his own life at Mackay after standing in the path of a train. On 2 September 2008, the 15 year old boy's cousin, Mark, hanged himself in Mackay. Mark was aged 18 years and had become aware of his cousin's death while attending the funeral of another cousin who had committed suicide in Ayr.

On 20 December 2008, JJ took his own life by hanging. JJ was aged 16 years and 8 months. Unlike JE, JJ had regularly spoken of suicide after the death of his friend, Mark, which affected him deeply. He had made at least one attempt to take his own life, but did not give any indication to others that he may have been contemplating suicide in the days just prior to his death.

It is clear that the cluster of suicides not only affected the families and friends of the young people. The entire community of Mackay experienced a sense of crisis and loss, and sought to respond in a practical way and with a sense of urgency to prevent similar deaths.

Data provided by the Australian Institute for Suicide Research and Prevention suggests that the Mackay community response to the crisis was effective. There were six suicides involving young people in Mackay in 2007 and 2008. In contrast, over the six years from 1 January 2009 to January 2015 there have been three recorded suicides involving a young person aged between 12 and 17.

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[1] Australian Human Right Commission, Children's Rights Report 2014, p81

[2] Ibid, p88.

[3] An inquest was held into her death and findings were delivered by Coroner Athol Kennedy on 5 March 2010.

The Mackay community's initiatives included research overseen by a reference group comprised of community and agency representatives. The subsequent report was published in 2010. Entitled "The Life Promotion Project: An Indigenous Community Response to Suicides in Mackay"[4] it outlined the local community's call for a range of strategies to respond to the issue. The recommended strategies are as relevant today as they were in 2010.

The role of the coroner

JE and JJ's deaths were reported to the coroner for investigation under the *Coroners Act 2003* because the circumstances of their deaths were violent or unnatural.[5]

An inquest is a fact finding exercise and not a method of apportioning guilt. The function of an inquest is to seek out and record as many of the facts concerning the death as the public interest requires.[6] The *Coroners Act* also allows a coroner to make recommendations about ways to prevent deaths from happening in similar circumstances in the future.

I convey my sincere condolences to the families of these young men. It is clear from the evidence that they were loved by their families and friends. Their unexpected deaths must have profoundly affected the lives of those close to them.

The inquest

A pre-inquest conference was held on 23 May 2011. Mr Hamlyn-Harris was appointed counsel assisting. Leave to appear was granted to the Department of Communities.

The inquest was held before the Coroner at Mackay from 20 to 22 June 2011. However, at the conclusion of evidence at the inquest there were several matters requiring further coronial investigation.

Allegations arose at the conclusion of the 2011 inquest hearings that third parties were involved in JE's death. These allegations had to be referred to the Queensland Police Service for investigation.

The investigation was then transferred to the State Coroner in January 2014 to enable findings to be completed. I considered that the evidence heard at the inquest gave rise to a number of questions relating to the responses of various agencies to JJ's needs in the final months of his life. This meant that more information had to be obtained from those agencies to enable the investigation into JJ's death to be finalised.

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[4] Barnett L, Kendall E, McKay K, McIntyre M, Kõlves K, De Leo D. (2010) The Life Promotion Project: An Indigenous Community Response to Youth Suicides in Mackay. Australian Rotary Health: Sydney. http://www.grapevinegroup.org.au/pdf/Rotary_funded_Life_Promotion_Report_for_Community.pdf.

[5] Section 8, Reportable death defined

[6] *R v South London Coroner; ex parte Thompson* (1982) 126 S.J 625

The need for these matters to be investigated following the conclusion of evidence at the inquest has regrettably contributed to delays in the preparation of these findings.

JE

Background

JE was one of seven children. He had five sisters and one brother. His father left the family home and moved to Sydney when JE was aged seven. JE's mother is reported to have struggled to cope with the care of the children. JE spent periods of time in the care of other family members, including his maternal grandmother and various aunts and uncles.

The Evidence

At approximately 12:20am on 27 August 2008, Mackay Police Communications detailed Constables Wyatt Telford and Leisa Bye to attend at an abandoned house in Macalister Street, Mackay. When they arrived a short time later they saw three children standing outside the house. The children appeared distressed and were yelling for help for JE. Constable Telford went to assist JE but was unable to find a pulse and commenced resuscitation efforts with Constable Bye assisting.

Shortly afterwards, Senior Constable Richard Whatman and Constable Michelle Hyden arrived at the abandoned house and assisted with the resuscitation efforts. They continued until Queensland Ambulance Service officers arrived at 12:25am. Ambulance officers were unable to locate any signs of life, and JE was declared deceased.

Senior Constable Whatman gave evidence at the inquest. He said that when he arrived there were 10 to 12 people at the scene, but because they were very distressed he decided to obtain statements from them at a later date. Senior Constable Whatman was subsequently able to take a statement from the child who initially found JE but was unable to obtain statements from four other children despite numerous attempts to do so.

JE was well known to the Mackay police, including Senior Constable Whatman. His evidence at the inquest was consistent with the findings in his coronial investigation report:[7]

> *JE was well known to police. He was regularly observed around Mackay in the company of all those persons present at Macalister Street, Mackay on the night of the incident. Speaking from my own experiences when dealing with the deceased, he was nearly always under the influence of solvents and was a difficult person to deal with as he was anti- police and showed complete distain for rules and regulations. That aside, it was very upsetting for attending police and ambulance officers when identifying JE upon arrival at the scene. The*

[7] Exhibit A6

reporting officer is in no doubt that his death was suicide and that there are no suspicious circumstances surrounding his death.

Senior Constable Whatman said that he had spoken to JE on numerous occasions in relation to paint sniffing, but JE was fairly aggressive and unresponsive to any advice that he gave him, such as the possibility of engaging in sporting activities.

JE's body was first located by a 15-year-old female friend early on the morning of Wednesday, 27 August 2008. Just after midnight she went with three other children to the back of an abandoned house in Macalister Street where they found JE hanging from an extension cord tied to some fencing wire hanging down from the floor beams.

On the previous day, JE had been with a group of ten other teenagers at the abandoned house. In the morning they had sniffed paint at the house before going to a place referred to as "the lagoon" for a swim and then to get takeaway food. In the afternoon they continued to sniff paint.

Later that evening there was an argument between JE and his older sister. During this argument she was alleged to have hit him on the head with a bottle causing it to smash. Although JE was apparently uninjured by the bottle, he was angry and did not talk to anyone after this incident.

Senior Constable Whatman said that the abandoned house was one of three in close proximity. Police were called regularly as the place was used as a squat by homeless people. There were often 10 to 15 people sleeping at the house.

JE's mother gave evidence at the inquest. She said that JE was her sixth child. JE had left school during year nine and had been staying in Emerald with his maternal uncle earlier in 2008. He was working there picking watermelons. After his mother went to Emerald for his 16th birthday in April 2008, JE returned to live with her in Mackay.

JE's mother agreed that he had commenced sniffing paint with his siblings when he was in year three. She said that she took JE to Emerald because she had problems with his drinking and chroming in Mackay. She was trying to get him away from the group who engaged in that behaviour. However, when he returned to Mackay he kept going out and committing offences. She said that JE had spent several periods in the youth detention for failing to comply with court orders.

JE's mother stated that she did not notice anything out of the ordinary in the days leading up to his death. While he continued to drink and chrome with his mates, when she saw him he was "smiling and happy-go-lucky". That did not change up until the last time she saw him at around 11:00am on 26 August 2008. They had been into town together and JE was going to register with Centrelink.

JE's mother was unable to identify any reason why he would take his own life. He was a fit and healthy boy who had not been under medical treatment since his detention in Townsville in late 2007, which also coincided with his cousin's death. JE's mother said that he was very close to his cousin but did not remember him speaking of her death. He was not on any medication at the time of his death and continued to take great pride in his appearance.

JE's mother was unable to accept that he would end his own life but had no information to contradict the evidence given by Detective Senior Constable Whatman.

JE's friend Kimberley F gave evidence at the inquest. She said that on the day before his death they had been shopping and swimming at the lagoon in the afternoon. Kimberley F said that the group used to go to the abandoned house and sniff paint together. The paint was usually spray paint stolen from local stores.

Kimberley F said that the group was comprised of 10 to 15 young people. If they were not sniffing paint they would drink alcohol together. Kimberley F described the effect of paint as being "you would not really know what was going on around you" and you would "zone out from everything". Kimberley F's evidence was that when JE sniffed paint he did not get upset and he was generally a very happy person.

Kimberley F recalled the argument between JE and his sister on 26 August 2008. His sister had joined the group and JE was telling her to leave everyone alone and stop picking on them. She then hit him over the head with a glass bottle.

After this JE was very upset and angry. Kimberley F said she left the group to get JE some cigarettes from the city centre. She returned after an hour by which time the Queensland Police Service and ambulance officers were attempting to resuscitate JE.

Kimberley F's recollection was that JE had never said anything about harming himself. She said that JE and JJ did not associate frequently. JJ was not one of the boys who associated with the group who engaged in paint sniffing.

JE's friend Tess also gave evidence at the inquest. Her recollection was that the group of 10 to 15 had been sniffing paint at the abandoned house before lunch. They then went to the lagoon, then to Hungry Jacks and back to the abandoned house where they continued to sniff paint.

Tess' evidence was that sniffing paint "ruined people's lives" because they fought over anything when they were high and they hallucinated. She said that paint sniffing could make you depressed, especially when combined with drinking alcohol when it could make you angry and violent.

Tess said that JE was always happy and was never angry or upset. However, he did get visibly angry when his sister hit him with the bottle. In her

statement to police she said that the bottle had smashed. JE did not fall over and did not seem to be all that hurt by what had happened - he was "more angry than anything".

Tess saw JE's sister run up the stairs into the house and JE followed her. JE later came back down the stairs from where he chased his sister, stating that he was not able to find her.

Evidence from the young people at the house at the relevant time was that soon after the altercation between JE and his sister the police arrived at the house, causing the group to scatter in different directions.

JE's cousin, Lawrence, also gave evidence at the inquest. He recalled that there were 13 or 14 young people at the abandoned house sniffing paint and drinking. After JE was hit with the bottle he chased his sister through the abandoned house but could not find her. He agreed that JE came out of the house after he was unable to locate his sister. The police arrived shortly afterwards and the group scattered. Lawrence did not see any person apart from JE's sister engaging in an argument with him.

Lawrence later returned to the abandoned house with some other young people and JE was located hanging from a cord attached to a piece of wire. Lawrence removed the cord from JE's neck and he fell to the ground. The police arrived soon after and commenced resuscitation.

Autopsy results

On 29 August 2008 Dr Peter Fitzpatrick, pathologist, conducted an autopsy on JE's body. Dr Fitzpatrick determined the cause of death to be "ligature compression of neck (hanging)".

The autopsy report noted an abrasion with bruising on the left side of JE's forehead, 15 to 20mm above the left eyebrow. Encircling his neck was a shallow furrow approximately 6mm in diameter which passed approximately 70mm below the right earlobe across the front of the neck above the Adam's apple and was approximately 20mm below the left ear lobe. This was found to be consistent with having been caused by hanging.

Toxicology results revealed that JE had blood alcohol content of 38 mg/ 100ml. Benzene, ethyl benzene, toluene and xylenes were also detected. These substances are components of petrol and hydrocarbon-based solvents. THC, the main psychoactive constituent of cannabis, was also detected.

On 9 June 2009, Dr Ian Mahoney, Forensic Medical Officer, Clinical Forensic Medicine Unit, provided a report setting out an opinion on the toxicology report. Dr Mahoney gave evidence at the inquest. He observed as follows:

- the alcohol level of 0.038% was a low level that could produce some mild disinhibition and exaggeration of prevailing mood but was unlikely to have significant effects on the individual;

- the organic solvents are found in a variety of domestic and industrial products such as paints and petrol and are central nervous system depressants. Inhalation causes an immediate high that usually wears off within an hour, and typically individuals experience disinhibition and excitement with confusion, disorientation and drowsiness occurring with higher doses;
- the use of solvents can make people exercise poor judgement. Because they are not focused on the consequences of their actions, they might take excessive risks or act on impulses that they would not normally act on;
- the use of solvents is associated with nerve damage in the brain and can result in permanent mood changes;
- it was not possible to infer that there was recent use of cannabis from the THC reading alone;
- long-term use of solvents can cause brain damage and mood changes, including depression.[8]

Dr Philip Storey, a forensic pathologist, gave evidence at the inquest after reviewing Dr Fitzpatrick's findings. He noted that Dr Fitzpatrick's findings supported that the cause of death was passive suspension or hanging rather than manual strangulation.

Dr Storey's opinion was that the presence of substances indicating petrol sniffing may have had some behavioural consequences but were unlikely to have immediate consequences in terms of cause of death.

Department of Communities - Child Safety Services Review

In February 2009, the Department of Communities (Child Safety Services) completed a Systems and Practice Review. This involved a review of factors influencing that Department's service delivery to JE.

The Department was involved with JE and his family from November 2000. Its review identifies numerous risk factors, which include an extensive history of drug and solvent use from an early age, poor school attendance, a significant history of offending and criminal behaviour and involvement with the youth justice system.

The Department's review noted that JE's cousin committed suicide on 29 November 2007 in Mackay. JE was reported to be close to his cousin, who also associated with the same group of young people as JE.

The report noted that JE was in the youth detention centre in Townsville in November 2007, and it appeared that he was trying to suppress his grief when he was told of his cousin's death. This raised concerns as to whether he was able to appropriately grieve the death, particularly with family and friends.

Paula Giles, Manager of the Mackay Child Safety Service Centre, gave evidence at the inquest with respect to the Department's involvement with

[8] Exhibit D3

JE's family. She informed the court that on 2 November 2000 there was an intake recorded which indicated that JE and his siblings were attending at a school after hours damaging school property. They had physically assaulted students at the school.

On 14 November 2000, the Department received a child protection notification following a visit by police to the family home where the children were found to be unattended, affected by alcohol and paint sniffing. JE would have been only eight years of age at this time.

In the follow-up assessment of these concerns JE's mother told the Department that she was powerless to stop the children's behaviour, and that she was aware that they were involved in offending and paint sniffing.

JE had also been expelled from school by this time. The Department recorded a risk of emotional and psychological harm, risk of physical harm, and determined that it should work with the family to address those issues. However, the family was subsequently reluctant to engage with the Department.

In January 2001, JE and his siblings were placed in voluntary care after his mother indicated she was unable to stop them from sniffing paint. Departmental officers visited the family home and noted that all the children were sniffing paint and were affected by it. However, the children were returned to their mother's care at the end of February 2001 at her request.

A family meeting was subsequently scheduled but JE's mother did not attend and a decision was made to cease involvement with the family.

The Department received further notifications in 2005 and 2006 in relation to extreme conflict between JE and his siblings and chroming at the family home. Both these allegations were substantiated. A decision was made to provide ongoing support to the family through an "intervention with parental agreement". Unsurprisingly, the family continued to be unwilling to engage with the Department.

In 2007 JE commenced several periods of detention at the Cleveland Youth Detention Centre at Townsville. It appears that because JE was in detention, and the Child Safety Officer's efforts to engage with his mother were unsuccessful, the Department closed its file.

Ms Giles acknowledged in her evidence that many different agencies had been involved with JE's family with limited effect. The Department had since adopted a "no wrong door" approach to service delivery which enabled more holistic case planning and intervention for families.

Ms Giles acknowledged that, although JE's family resisted engagement with the Department, more could have been done to provide assistance in terms of the high risk taking behaviour that was witnessed by Departmental officers.

The Court was also provided with a report of the Child Death Case Review Committee in August 2009. That Committee concluded that the actions or inactions of the service system were not linked to the JE's death, but that "the cumulative effect of the missed opportunities may have adversely affected the Department's service delivery to JE".

Youth Justice – Department of Communities

Greg Strohal, Manager of the Mackay Youth Justice Service, Department of Communities gave evidence at the inquest.

Mr Strohal first met JE when he was in year two at school. Mr Strohal was then employed with the Education Department. He noted that JE's behaviour was very challenging for school staff to manage and included non-attendance and disciplinary issues within the classroom and school grounds.

He noted that JE had been subject to 11 supervised court orders and six of those orders were the subject of breach action. The breaches were primarily in relation to non-compliance with community service orders.

Further allegations concerning JE's death

A letter from JE's mother dated 14 June 2011 was provided to the Coroners Court on 20 June 2011. In the letter JE's mother asserted that he would have been drowsy following the assault by his sister, and unable to reach the rafter from which he was hanging. She stated that in her view third parties must have been involved in his death.

Following the conclusion of evidence at the inquest the Coroner also received a letter from other members of JE's family dated 21 June 2011 expressing non-specific concerns about his death.[9] It was suggested that he had been in possession of a large sum of money that was not located after his death.

Attempts were made by the Queensland Police Service on a number of occasions to obtain statements from those who made the allegations in the letter of 21 June 2011. Appointments were made for these persons to attend to make statements but each time they failed to appear. Eventually, when officers attended at their address to take statements they refused to assist.

Having regard to the failure of the persons making the allegations to assist police, statements were obtained from other persons referred to in their correspondence to the Coroner. These persons were also generally reluctant to assist police.

The investigating officer, Detective Senior Constable Hambleton, concluded that nothing had come to his attention during the course of his inquiries to suggest that JE's death was accompanied by any suspicious circumstances.[10]

[9] Exhibit G2
[10] Report of DSC Hambleton

Conclusions

I have had regard to Detective Senior Constable Hambleton's report and the evidence of the young people who were with JE on the night of his death. That evidence indicated that there were no persons apart from members of his peer group present prior to his death.

I have also considered the findings at autopsy which indicate that that the cause of death was hanging, in particular the evidence of forensic pathologists that the cause of death was passive suspension or hanging rather than manual strangulation.

I conclude that third parties were not involved in JE's death.

There was no evidence that JE had ever discussed suicide with his peer group. There was no evidence that he gave any indication that he may have contemplated suicide. Similarly there is no evidence of a history of self-harm or suicide attempts.

JE's background did give rise to a number of risk indicators including a breakdown in family relationships, substance abuse, incarceration, unemployment, interpersonal conflict and the recent loss of a relative to suicide. While these factors were present it was not possible to predict that JE would actually take his own life.

This conclusion is supported by the evidence of Mr Strohal that in the week leading up to his death he appeared to be doing well, and on one view appeared to have turned a corner. For five working days in a row leading up to the day when he died he had attended and performed community service.

As noted below, Dr De Gioannis, Psychiatrist, considered that JE's death was preceded by anger as a result of the argument with his older sister and intoxication from a combination of alcohol and other substances.

I agree with Dr De Gioannis' conclusion that JE's suicide appears to be purely impulsive following of the loss of the normal process of inhibition produced by paint sniffing and alcohol.

Because of the death of his cousin on 29 November 2007, it is also possible that JE was more disposed to consider suicide in the circumstances that arose after sniffing paint, becoming disinhibited, and then being upset following the altercation with his sister.

Findings required

The *Coroners Act* requires that I find, as far as is possible, who the deceased person was, how he died, when and where he died, and what caused his death. As a result of considering all the material contained in the exhibits and the evidence given by the witnesses, material parts of which have been summarised above, I am able to make the following findings.

Identity of the deceased – The deceased person was JE

How he died – He died after a period of prolonged paint sniffing with a group of other young people in Mackay. While under the influence of solvents, he became angry after he was assaulted by his sister. When he became separated from the group he took his own life.

Place of death – Macalister Street, Mackay in Queensland

Date of death– He died on 27 August 2008

Cause of death – He died from hanging

JJ

Background

JJ was the youngest of five children. He lived with his mother and brother, who was one year older than him. Prior to his death, JJ's mother was employed in Moranbah and, as a consequence, JJ and his brother would spend most of their time alone.

JJ was a talented artist. An exhibition of his works was hosted at Artspace in Mackay three years after his death.

The Evidence

The inquest heard evidence from a number of JJ's friends.

Krystal described herself as a good friend of JJ. She had known him for about four years and was aged 22 years at the time of his death. Krystal lived in a house that backed on to a CWA Hall in Mackay. Her brother, Mark, was a friend of JJ and had taken his own life at the hall in September 2008.

On 20 December 2008, Krystal woke at 8:00am. Her sister, Kimberley W, told her that she had seen their brother's bike over the back fence. Her sister asked her for the keys to the back gate. Together they went to retrieve their brother's bike when they saw JJ hanging from the rafters of the CWA building. They returned to their home and called 000 and JJ's mother.

Krystal's evidence was that on 19 December 2008, JJ was at her home and they were talking about him returning to Mount Isa and about how much he missed Mark. They were not drinking alcohol. JJ left at about 8:30pm and Krystal did not see him again that night.

Kimberley W was also JJ's friend. She was aged 15 years at the time of JJ's death. Her evidence was that, as far as she knew, JJ had been drinking with

her brother the night before he died. This may have been after JJ left their home.

JJ had borrowed her brother's bicycle at around 2:00 or 3:00am. He came to her home and asked her for a smoke and to call him a taxi. She stated that just before he left he asked her to tell his friends that he loved them and then left. She said that he seemed "a little bit drunk".

According to Kimberley W, JJ and her brother, Mark, were best mates. She said "I guess if you wanted to be dead that's probably the place he would do it". She said he had not spoken to her about suicide but was aware that he had spoken to others while he was under the influence of alcohol.

Senior Constable Ryan Mortimer gave evidence at the inquest. He said that he spoke with JJ's mother after she arrived at the scene of his death. She told him that JJ had been working in the Mount Isa area for some time and had returned to Mackay to collect a few belongings before returning to Mount Isa. JJ's mother told police that he had made three attempts at suicide over the past four months. He had been seen by mental health staff in Mackay and Mount Isa, but was released on each occasion.

JJ's mother gave evidence at the inquest. JJ's mother said that after his friend Mark died she thought it was best for him to go and live with her sister in Mount Isa, where he obtained an apprenticeship as an auto electrician. However, he was arrested by police after drinking and called her. She went to Mount Isa for two weeks and JJ said that he wanted to come back to Mackay to say goodbye to his friends and then return to Mount Isa to finish off his apprenticeship.

JJ's mother said that he had been depressed following Mark's death in September 2008. He had not been with Mark on the night that he died and felt responsible for his death. JJ's suicide took place in the same location and manner as that of Mark. JJ had expressly stated to his mother that he planned to kill himself after Mark's death.

JJ's mother said that on the day after Mark died she took JJ to the morgue because he wanted to see Mark's body. After this JJ went out with a bunch of boys and, according to his mother, they got "absolutely wasted" and JJ was threatening to harm himself. An ambulance was called to take him to the hospital but he left before being assessed.

JJ's mother had subsequently attempted to have him engage with mental health workers but he was suspicious and concerned that she was trying to get him locked up in a secure facility. She said that when workers visited the home he would "tell them what they wanted to hear, that he was okay, or he would were just run away". She said that she was informed by people from the mental health branch that they were "unable to help JJ until he actually attempted to kill himself".

After this JJ's mother engaged with the Youth Information and Referral Service (YIRS) and asked if they would be able to assist. She also sought assistance from the Queensland Police Service who would come around and visit on a welfare check.

JJ's mother recalled that in November 2008 at Mount Isa JJ became upset after being assaulted by three other young men. He had returned home and grabbed a knife and was going to "hunt them down". After JJ's mother tried to take the knife from him he held it against his throat and then stabbed himself in the arm. JJ underwent a mental health assessment at the Mount Isa Hospital but was not admitted. She and JJ caught a train back to Mackay two days later.

According to JJ's mother, he told the mental health worker who assessed him that he had acted like that because he was under the influence of alcohol, and that he was okay, so they released him.

When asked at the inquest if anything could have been done to prevent JJ from committing suicide his mother indicated that a facility such as Headspace would have assisted because JJ was under the impression that he would be locked in a psychiatric ward if he sought help.

Threats of suicide - 2 September 2008, Mackay

On the day after his friend Mark committed suicide, JJ was taken to the Mackay Base Hospital by the Queensland Ambulance Service after he threatened to commit suicide at his home.

Mackay Hospital and Health Service records indicate that JJ was questioned by paramedics at his home. He advised he would be okay and did not intend to harm himself.

He was subsequently transported to the Mackay Base Hospital. He ran away from the hospital before being assessed by mental health staff. Police were advised of an authority to return him to the hospital on 3 September 2008 at 12:00pm. This authority expired at 6:50pm on 3 September 2008.

Enquiries were then made with a YIRS counsellor, Jeff Lawton, who told police that he had known JJ since he was a young child and had spent a lot of time speaking with him. Mr Lawton believed that JJ was not going to harm himself. In his view, while he was grieving the loss of his friend, he was not suicidal.

Staff from the Mackay Mental Health Unit then advised police that if JJ was in the company of his family they did not think he was at risk and no further concerns were held for his welfare. It appears that it was considered there was no need to have him assessed in the circumstances, and the authority to return previously issued was recalled.

Attempted suicide – 14 October 2008, Mt Isa

JJ was taken by ambulance to the Mount Isa Hospital on 14 October 2008 at 10:44pm. Notes from the Mount Isa Hospital Emergency Department record that he stated that two of his friends had recently committed suicide. The notes also record that JJ's aunt stated that he was grieving but he would not acknowledge it.

The Mount Isa Hospital recorded that JJ was walking home when he saw a piece of wire cable and suddenly felt that he wanted to die. He tied the cable around his throat and the other end around the top of a fence and was slipping in mud. He started to choke and get dizzy when a friend came along and untied the cable.

On 15 October 2008, a document was completed at the Mount Isa Hospital, entitled "Report of a Reasonable Suspicion of Child Abuse and Neglect." This document noted that JJ was heavily intoxicated on presentation to the hospital. After arguing with his sister's partner he was walking home and found a wire cable. He had denied drug use, but reported that recently two of his friends had completed suicides. JJ stated that he "wanted to join his best friend who committed suicide by hanging a month ago".

According to a document completed on 17 October 2008, by the Mount Isa Hospital's Child Protection Liaison Officer, JJ was reviewed by Community Youth Mental Health when he was sober. He was assessed at the time of discharge to have a low suicide risk. A follow-up with the mental health team was arranged.

JJ was then followed up by an Aboriginal liaison officer attached to the mental health service. JJ indicated that he was working as a panel beater and he had agreed to commence boxing training. His service episode was then closed on 23 October 2008.

Further self-harm – 21 November 2008, Mt Isa

On 21 November 2008, police were called after JJ had been throwing knives at cars and cutting himself. He informed police that he wanted to kill himself and he was detained for the purpose of an emergency examination order at 8:10am and transported to the Mount Isa Base Hospital.

JJ was examined at the Mount Isa Mental Health Service at 1:30pm on 21 November 2008. However, a decision was made by the authorised mental health practitioner not to complete assessment documents because the emergency examination order had expired prior to examination. Staff were waiting for his alcohol level to subside. He was again assessed as not suffering from a mental illness.

The Mount Isa Hospital's notes indicate that JJ's mother arrived to take him home to Mackay. JJ was happy to be discharged to his mother's care. The notes also record that four of his friends had recently committed suicide by hanging and that he was "teary".

Clinical notes prepared by the psychologist who reviewed JJ indicated that there were no abnormal perceptions or thought content, and no evidence of suicidal ideation. However, he did express an intention to harm an unspecified person. The psychologist noted that JJ had insight into his presenting problems - namely alcohol abuse and lack of coping skills. Risk of suicide was flagged as "none" and overall assessment of risk was "medium".

It was resolved that JJ would travel to Mackay with his mother and his case was closed to the Mount Isa Mental Health Service.

Despite the fact that JJ had been taken to the Mt Isa Hospital on two occasions, there is no record of any consideration being given to a referral to the Mackay Community Youth Mental Health Service, or any other appropriate service, for follow up on his return to Mackay.

Department of Communities Review

Like JE, JJ had extensive involvement with the youth justice system. He was first placed on probation in 2003 at the age of 10. His offending behaviour continued and he received a total of 17 supervised orders and detention orders. He had been remanded in custody at the Townsville Youth Detention Centre between December 2007 and June 2008.

Department of Communities' records indicate that JJ had been excluded from school since 2006. The records also indicated that there were significant issues with non-compliance, and several of his supervised orders were breached. The main factors identified as contributing to his offending behaviour were lack of structured activities, parenting and supervision issues, peer associations, alcohol misuse, poor impulse control and anger management issues.

The Department of Communities (Child Safety Services) completed a case review of its involvement with JJ in March 2009. The review document noted that case reviews, as opposed to a root cause analysis, were conducted and there was limited potential for identifying and modifying any substantive systemic or practice issues, and there was limited educative value in conducting a broader root cause analysis.

The review document sets out a significant involvement of the Department with JJ and his family, particularly when he was an infant.

The notes for the period for October 2008 to 11 December 2008 include the following entry:

> ***CP suicide risk alert****: Subject child attempted to hang himself while heavily intoxicated after an argument with his sister's partner. He was taken to hospital by ambulance and reviewed by mental health services. Recorded that the subject child had made a previous suicide attempt in March 2008 by jumping from a balcony. Alcohol problem and intoxication identified in relation to this attempt also. In August 2008*

the subject child expressed suicidal ideation to his mother. In September 2008 a friend of the subject child suicided after asking the subject child to come and see him. The subject child was reported to feel substantial guilt for not going to see him when asked.

Youth Justice Services had recorded suicide risk alerts in relation to all of the above incidents. YJS had developed a risk management plan in relation to the previous suicide attempt involving CYMHS and ATODS engagement and YJS caseworker to facilitate counselling support.

A further entry relating to 21 November 2008 recorded that the Youth Justice Service in Mount Isa was contacted seeking information regarding the involvement of the Department, and advice was provided that there was no current Department of Child Safety involvement.

The Child Death Case Review Committee subsequently reviewed the Department of Communities (Child Safety Services) review of its involvement with JJ. That Committee agreed that JJ's death was not linked to any action or inaction of the service system.

However, concern was expressed about the failure to assess JJ's mental health following his suicide attempt in September 2008. This was referred to the Health Quality and Complaints Commission by the Commission for Children and Young People and Child Guardian.

The Committee was also of the opinion that Child Safety Services should have conducted an assessment of JJ's protective needs following his further suicide attempt on 14 October 2008.

The Committee also referred several service system issues it considered required further action to the Child Safety Directors Network.

Youth Justice – Department of Communities

Greg Strohal noted that JJ had been subject to 17 supervised orders, and 9 of those orders were the subject of breach action.

JJ had been in youth detention on remand from 2 February 2008 for a period of 4 months. On 22 August 2008 he was sentenced in relation to the violent assault of a 16 year old male in Mackay that took place in late 2007. Following release from detention he was subject to a probation order.

Mr Strohal's evidence was that in the two years prior to his death JJ was reluctant to engage with Youth Justice workers. He had discussed suicidal ideations with his case workers, leading to suicide risk alerts being placed on his file.

However, Mr Strohal's evidence was that Youth Justice's primary focus was on addressing the offending behaviour of young people. Youth Justice found it particularly challenging to engage with young offenders who lacked structure

in their life. He also noted that many young men involved in the youth justice system lacked suitable male role models.

Autopsy results

On 23 December 2008, Dr Peter Fitzpatrick, pathologist, conducted a post-mortem examination at the Mackay Base Hospital. He recorded the cause of death as ligature compression of the neck due to, or as a consequence of, hanging.

A toxicology report recorded that no drugs were detected but that alcohol was detected at a concentration of 136 mg/100ml of blood.

Dr Philip Storey, an experienced forensic pathologist, gave evidence at the inquest after reviewing Dr Fitzpatrick's findings in relation to JJ's death. He noted that Dr Fitzpatrick's findings supported that the cause of death was passive suspension or hanging rather than manual strangulation.

Dr Ian Mahoney's evidence was that JJ's blood alcohol concentration may have resulted in mood changes and an increased tendency to take risks. It would also have caused the exaggeration of any prevailing depressed mood.

Conclusions

There is clear evidence that JJ was deeply distressed following the death of his friend, Mark. He spoke to a number of people about missing Mark and the sense of guilt he felt because he was not with Mark on the evening of his death.

Like JE, JJ's life was marked by a range of problems including engagement with the criminal justice system, depression, and estrangement from his family.

JJ had expressed the intent to take his life to his mother and a number of other persons. He had willingly relocated to Mount Isa, at his mother's suggestion, to remove himself from negative influences in Mackay.

His intent to take his own life manifested itself at particular times of crisis, when he was affected by alcohol and in conflict with family members. There had been several previous incidents where he had self-harmed including an attempt to hang himself in October 2008.

It appears that on the night of his death he had formed the intention to end his life when he asked Kimberley W to convey to his friends that he loved them. It is particularly significant that he used the same method to end his life and the identical location as his friend Mark.

I have had regard to the Queensland Police Service report and the evidence of the young people who knew JJ. I have also considered the findings at autopsy which indicate that that the cause of death was hanging. I find that no other person was involved in JJ's death.

Findings required by s. 45

As a result of considering all the material contained in the exhibits and the evidence given by the witnesses, material parts of which have been summarised above, I am able to make the following findings.

Identity of the deceased – The deceased person was JJ

How he died – JJ was deeply affected by the death of his friend Mark in September 2008. He expressed a specific intent to end his own life. After several subsequent episodes of self-harm he was assessed as not suffering from a mental illness. On 20 December 2008 he hanged himself at the location of Mark's death while under the influence of alcohol.

Place of death – Palmer Street, Mackay in Queensland

Date of death– He died on 20 December 2008

Cause of death – He died from hanging

Expert Review - Australian Institute for Suicide Research and Prevention

A review of JE and JJ's deaths was conducted by Dr Angelo De Gioannis, Consultant Psychiatrist, and lecturer at the Australian Institute for Suicide Research and Prevention.[11]

Dr De Gioannis considered that JE's death was preceded by anger as a result of the argument with his older sister and intoxication from a combination of alcohol and illicit substances. Both factors have been found to increase the risk of suicide, particularly in young men.

Dr De Gioannis considered that JE's suicide appeared to be purely impulsive, which can occur as a result of the loss of the normal process of inhibition produced by both alcohol and inhaled solvents. Dr De Gioannis considered there is no evidence that JE was experiencing suicidal ideation prior to his death and that his cousin's suicide in 2007 was not sufficiently proximate to have played a significant role.

On the other hand, Dr De Gioannis concluded that JJ's death appeared to have followed a completely different path. In the weeks preceding his death JJ appeared to be going through significant grief following the loss of a number of important people in his life. It is clear that a large number of family members, clinicians and government agency staff were aware of the level of risk that JJ displayed.

[11] Exhibit D4

It was not clear to Dr De Gioannis how much effort was put into trying to engage JJ in treatment and support strategies, or whether he was willing to accept any help that was offered. Dr De Gioannis was not able to conclude what admission to a psychiatric unit would have achieved, but it may have assisted in enabling a more accurate assessment of his mental health.

Dr De Gioannis identified several common aspects of JE and JJ's background:

- *Both appeared to receive limited adult supervision and guidance and when contact was made with the adult world the outcome was usually superficial or hostile. Their primary relationships were with their peer group. It is possible in both cases that the loss of support and validation offered by their peers may have contributed to the development of the sense of hopelessness and from that suicide was the only solution.*
- *Both were exposed to alcohol and illicit substances from a very young age. The developing brain is extremely susceptible to damage substances induce on the neurological system. The impact of that kind of damage can often be seen both intellectually and emotionally.*
- *Most importantly, both of them by the time they had died had accumulated many of what are known as significant risk factors for suicide such as isolation, substance abuse, incarceration, unemployment, low socio-economic status, past history of deliberate self-harm and suicide attempt, interpersonal conflict, and recent loss of a friend or relative to suicide.*

Dr De Gioannis concluded that contagion was not relevant to JE's death. In in relation to JJ's death it was possible to speculate that contagion was relevant as the death emulated the method and location of the suicide of his friend three months earlier.

Contagion refers to the process by which a prior suicide or attempted suicide facilitates or influences suicidal behaviour in another person. In 2013-14 contagion was identified as a potential factor for seven of the 23 children and young people aged between 10 and 17 who suicided in Queensland.[12]

With respect to prevention strategies, Dr De Gioannis concluded that JE's death would have been very difficult to predict. A greater level of adult supervision and restricted access to alcohol and illicit substances would have assisted.

With respect to prevention strategies arising from JJ's death, Dr De Gioannis concluded that every possible effort should be made to identify and approach individuals who require help following the suicide of a loved one.

He considered that whenever individuals, particularly young men, expressed distress in the way that JJ did leading up to his death, it is imperative not to

[12] *Queensland Child Death Register (2013–14)*

miss any of the opportunities given to intervene. The first priority is to ensure that the person feels connected to the rest of the world and that somebody cares.

Dr De Gioannis noted that a number of brief assessments had been made but there was no evidence of any treatment intervention being attempted. He acknowledged that it was very difficult to impose treatment when it comes to psychological help. He also acknowledged that it was very difficult to provide treatment when people are in acute crisis. In JJ's case there was no evidence of professional contact with him, apart from the points of crisis.

Dr De Gioannis considered that after mental illness has been excluded or treated appropriately, the next step was to ensure the suicidal person receives appropriate follow-up, ideally with a small number of clinicians until the period of crisis is over. It is also important to mobilise as much social support as possible including family members, friends and anyone normally part of the social network.

The Mackay community response

As noted above, the cluster of suicides of young people in Mackay in 2007 to 2008 affected the wider community. In response, a combined effort by various government and community services was implemented.

A statement was obtained from Dr David Farlow, Executive Director, Clinical Services at the Mackay Hospital and Health Service in relation to service enhancements since 2008, and interagency collaboration regarding intervention for young persons at risk.

Dr Farlow noted that from 2007 to 2009, six young persons from the Mackay region committed suicide. The Child and Youth Mental Health Service (CYMHS), together with the Department of Communities and the YIRS held several community meetings to share relevant information and to coordinate efforts to contain what was perceived at the time to be an escalating emergency.

YIRS was identified as a place that many "at risk" young people would attend, and it became the focal point in the effort to manage the consequences and long-term effects of youth suicide. The YIRS centre stayed open 24 hours a day for two weeks during a time when it appeared that some young persons were particularly vulnerable.

CYMHS and YIRS worked together to develop a plan to identify and mitigate potential risks particular to youth in Mackay.

CYMHS subsequently developed a more flexible approach to dealing with young persons, and in particular Indigenous youth, who were more reluctant to engage with the service. The new approach included more home visits and engagement with leaders in the Indigenous community. In 2008, an advanced health worker was engaged to work almost exclusively in providing outreach services, including working with at risk young people in a group setting.

In 2009, CYMHS organised a three-day camp for Indigenous youth overseen by local elders. The camp focused on the themes of culture, health and education and was sponsored by CYMHS, YIRS, Education Queensland, the Department of Communities and the Aboriginal and Torres Strait Islander Health Service.

As noted above, Australian Rotary Health also provided funding to the Australian Institute for Suicide Research and Prevention and a final report was published in July 2010. This research, which was contributed to by Mackay based agencies engaged with young people, focused on the ways to lessen the risk of suicide among the community.

CYMHS staff now actively participate in post-vention responses to suicide in children at schools within the Mackay region, including responding in individual sessions with classroom teachers involved in teaching affected the young people.

For example, CYMHS staff had input into working with primary school classes following the suicide of a child at a local school and were directly involved in the wording of information provided to these children.

CYMHS in Mackay conducted a three-month trial to improve indigenous use of the service. A survey was conducted of indigenous youth in local schools and potential referrers. Issues were identified in relation to a lack of awareness of the service, a lack of information about common mental health issues, concerns regarding confidentiality and the desire for outreach services.

While only one percent of CYMHS clients were Indigenous in 2008, in 2013 approximately 8% of CYMHS clients identified as Indigenous.

It is clear from Dr Farlow's statement that the 2008 youth suicides in Mackay had a significant impact on agencies who work with young people in the local community. It is clear that there is now a greater focus on the coordination of services between agencies.

I accept that there is now a recognition that young people such as JE and JJ require services with the capacity to reach out to young people in the places they naturally occupy, rather than in traditional clinical environments.

I was also informed that at the State level, in 2010 an educational program was developed by the Queensland Centre for Mental Health Promotion, Prevention and Early Intervention. This program was called the Ed-LinQ Initiative, A Framework for Action.

The Ed-LinQ Initiative was established under the Queensland Plan for Mental Health 2007–2017 to improve linkages and service integration between the education, primary care and mental health sectors for earlier detection and treatment of mental illness affecting school-aged children and young people.

The initiative was the subject of a positive evaluation by the Queensland Mental Health Commission in 2014. Ed-LinQ Coordinators work across the mental health, education primary care and community sectors by:

- facilitating a strategic approach for collaboration and integration between the sectors; and
- enabling improved access to mental health consultation, assessment, information and training opportunities.

Dr Farlow advised me that Ed-LinkQ now runs regular youth mental health first aid programs. These are for community agencies that work with youth and have a specific focus on early intervention.

Evolve Therapeutic Services also run regular sessions about mental health issues for child safety staff and other agencies working with vulnerable children.

CYMHS staff are available to consult with local high schools in the support of staff dealing with at risk youth; however its focus continues to be on young people who have already engaged with other agencies and have high needs.

Headspace

A Headspace centre opened in Mackay on 6 February 2013 as a result of submissions made by community groups to secure funding for this service.

Headspace, the National Youth Mental Health Foundation, was established in 2006. It was funded by the Australian Government to deliver youth friendly, stigma-free services at a number of locations around Australia. It is now a major provider of clinical early intervention services specifically targeting youth mental health across the country. Headspace offers services through:

- EHeadspace - a clinical ehealth service;
- Headspace centres; and
- a suicide post-vention program called School Support.

There is a network of 65 Headspace centres offering services to young people aged 12-25 years. These services give priority to young people who have developed or are at risk of developing a mental health and/or substance use disorder for the first time. Headspace centres are designed to be a youth friendly one-stop shop able to address a variety of concerns young people may present with.

I sought information from Headspace in Mackay about services for young people at risk of suicide who are also engaged in the criminal justice system.

I was advised that Headspace does not compel clients to attend its service. However, young people involved with the justice system often attend Headspace centres voluntarily with treatment plans that include working

collaboratively with other agencies and the young person's family and friends to provide support.

As at 30 June 2014 Headspace had delivered services to approximately 600 young people in Mackay. Services are provided by a range of professionals including psychologists, social workers and youth workers funded through a variety of sources.

With respect to the young people seeking assistance from Headspace in Mackay I was advised that:

- 31% are presenting with depressive symptoms as the primary identified issue;
- a further 8.5% present with suicidal thoughts and behaviour as the primary identified issue;
- approximately 10% are referred to Queensland Health services for a higher level of care related to suicide risk;
- there has been one reported suicide of a client who had been seen at Headspace Mackay.

Headspace has recently launched "Yarn Safe" – a campaign that aims to improve mental health literacy among Aboriginal and Torres Strait Islander young people and encourages them to get help at Headspace centres, eHeadspace online and telephone counselling or other appropriate mental health services.

Mount Isa Services

I consider that the response of agencies in Mount Isa to JJ's mental health needs in October and November 2008 was less than optimal.

Following his second suicide attempt, JJ was discharged from hospital without any obvious intervention or treatment plan. Dr De Gioannis gave evidence to the effect that a clinician should have made direct contact with him within three days of discharge to assess his safety and decide whether further intervention was required.

A statement was obtained from the Director of Mental Health and ATODS at the Mount Isa Health Service in relation to improvements to the care and follow-up of young persons at risk in that area.

I was informed that there is now an increased clinical workforce which includes an additional full-time senior clinical lead, and an additional consultant psychiatrist to provide clinical governance.

I was informed that Evolve Therapeutic Services had been implemented in Mount Isa in collaboration with the Department of Child Safety and other key stakeholders for case coordination and intervention. A review of the referral management system was completed in 2012 which lead to the amendment of processes for prioritising referrals and timely follow-up.

Comments and recommendations

Section 46, insofar as it is relevant to this matter, provides that a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

Missed opportunities

There were signs that the families of both young men were struggling to cope very early in their lives. The inquest did not examine in detail the child protection response of the agencies in contact with their families at that time. However, I agree with the conclusion of the Child Death Review Committee that the cumulative effect of missed opportunities may have adversely affected the Department's service delivery. This applies to both deaths.

There were opportunities for early intervention before JE and JJ developed the behaviours that saw them excluded from school, were exposed to alcohol and substance misuse, and commenced the seemingly inevitable trajectory into the criminal justice system that led to their eventual incarceration.

It appears that when confronted by an unwillingness by the families to engage, Child Safety officers simply closed their files. A continued failure to respond early to childhood neglect, loss and trauma will continue to ensure that such young men will accumulate the significant risk factors for suicide referred to by Dr De Gioannis.

The complex issues of early intervention and overrepresentation of Indigenous children in the child protection system were addressed in the Queensland Child Protection Commission of Inquiry final report, and the Queensland Government's response to those recommendations. I make no recommendations in relation to the child protection response arising from this inquest.

Suicide prevention

As evidenced in the more recent responses from the Mount Isa and Mackay Hospitals, CYMHS and Headspace, there here have been significant enhancements to service provision for young people at risk of suicide across Queensland since 2008.

There is evidence of greater access to services, such as Headspace and Evolve Therapeutic Services. There is also improved coordination among agencies and a willingness to reach out to those unwilling or unable to attend at services.

Since JE and JJ's deaths, the issue of youth suicide has also received greater recognition at the national and state level. There now appear to be a range of strategies and action plans aimed at addressing the issue. The following are some examples:

- In 2011, the Commission for Children and Young People and Child Guardian published *Reducing Youth Suicide in Queensland*. This report included a discussion of opportunities for future action to help prevent youth suicide in Queensland.

- In 2013, the Australian Government released the first National Aboriginal and Torres Strait Islander Suicide Prevention Strategy.

- Indigenous suicide prevention and support, including mental health support is now an identified priority of the COAG Health Council.

- In 2014, the National Children's Commissioner undertook an examination on how the human rights of children and young people engaging in intentional self-harm with and without suicidal intent can be better protected.[13] The outcome of that investigation was a series of recommendations relating to research, surveillance and data collection.

- The Australian Government has funded the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP) to evaluate the effectiveness of existing suicide prevention services and programs. A report, expected by August 2015, will recommend improvements to, or alternative evidenced-based service and program delivery models, where indicated by the evaluation.

- In October 2014, the Queensland Mental Health, Drug and Alcohol Strategic Plan 2014-2019 was launched. Suicide prevention has been identified as a priority under the plan and a Suicide Prevention Action Plan for Queensland is currently being developed. The Action Plan is expected to be released later in 2015.

This range of activity might suggest that there is reason to be optimistic that new strategies will be formulated to reduce the number of suicides among young people in Queensland, particularly among Indigenous youth.

This will not be an easy task. The data relating to suicides indicates that there has been no reduction in suicide rates in recent years. Rates have remained relatively static. At the national level, suicide accounted for 2,520 deaths in 2013 at a standardised death rate of 10.7 per 100,000 people compared to the 2011 rate of 9.9 per 100,000. The rate in Queensland from 2009-2013 was 13.3 per 100,000.

Since 2008, suicide has surpassed traffic accidents as the leading cause of death for young people aged between 15 and 24 years. While Queensland's road toll reduced to 223 in 2014, based on the number of deaths reported to coroners it is expected that over 700 Queenslanders will take their own lives in 2015.

[13] *Children's Rights Report 2014, National Children's Commissioner*

Rates of suicide for young Indigenous Australians have been consistently disproportionate. Across Australia, young Indigenous Australians up to age 24 years are 5.2 times more likely to die due to intentional self-harm than other young people in the same age range.[14]

In Queensland, the average yearly suicide rate for young Indigenous Australians aged between 10 and 17 years is more than six times higher than for other youth.[15] There were 149 suicides involving children between 10 and 17 recorded in the Child Death Register in Queensland between 2004 and 2012. Forty-seven percent of those suicide victims were Indigenous Australians.[16]

The development of the Suicide Prevention Action Plan for Queensland presents a significant opportunity for the community to consider how suicide rates can be reduced.

The evidence received at this inquest has suggested that broad suicide prevention strategies need to be complemented by practical and funded actions at a local level involving those directly responsible for the identification of people at risk, particularly the most vulnerable, in the design of responses that meet their needs.

Marginalised young people such as JE and JJ will continue to be unwilling to engage with traditional service responses. The particular context of Aboriginal and Torres Strait Islander communities has to be accommodated in the design and delivery of services and prevention strategies. These need to recognise the effects of trans-generational trauma and grief on the mental health and wellbeing of Indigenous communities.[17]

While it is important not to impose programs on communities that do not recognise local culture and conditions, I recommend that the Mackay community response to these deaths be considered in the finalisation of the Queensland Suicide Prevention Action Plan. It is an example of an effective local response, elements of which may be adapted in other parts of the State.

I also recommend that the Queensland Suicide Prevention Action Plan include specific strategies aimed at addressing the unacceptably high rate of deaths from suicide for young Indigenous Australians.

I close the inquest.

Terry Ryan
State Coroner
9 June 2015

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[14] Australian Bureau of Statistics, Causes of Death, Australia, 2012, Catalogue Number 3303.0 (2014)

[15] Trends and Issues paper: Child deaths– Overrepresentation of Aboriginal and Torres Strait Islander youth who suicide Number 11, December 2012, Commission for Children and Young People and Child Guardian

[16] Soole et al, 2014. Factors related to childhood suicides: Analysis of the Queensland Child Death Register

[17] National Aboriginal and Torres Strait Islander Suicide Prevention Strategy