LEGISLATIVE ASSEMBLY OF THE NORTHERN TERRITORY

11th Assembly

Select Committee on Youth Suicides in the NT

Public Hearing Transcript

10.00 am, Wednesday, 14 March 2012

Litchfield Room, Parliament House, Darwin

Members: Ms Marion Scrymgour, MLA Chair, Member for Arafura
Mr Michael Gunner, MLA, Member for Fannie Bay
Mr Peter Styles, MLA, Member for Sanderson
Ms Kezia Purick, MLA, Member for Goyder

Witnesses: NT CORONER'S OFFICE
Mr Greg Cavanagh, NT Coroner

The committee convened at 10.08 am.

Madam CHAIR: On behalf of the select committee, I welcome everyone to this public hearing into current and emerging issues of youth suicide in the Northern Territory. I welcome to the table to give evidence to the committee the Northern Territory Coroner, Mr Greg Cavanagh. Thank you for coming before the committee today. We appreciate you taking the time to speak to the committee, and look forward to hearing from you today.

This is a formal proceeding of the committee and the protection of parliamentary privilege and the obligations not to mislead the committee apply. A transcript will be made for the use of the committee and may be put on the committee's website. If, at any time during the hearing, you are concerned that what you will say should not be made public, you may ask that the committee go into a closed session and take your evidence in private.

I will ask you to state your name for the record and the capacity in which you appear. I will then invite you to make a brief opening statement before proceeding to the committee's questions.

Mr CAVANAGH: Thank you, Madam Chair. My name is Greg Cavanagh. I am the Territory Coroner. I have been in the Territory some 30 years. I will tell you the truth as I know it to be. I have been the Northern Territory Coroner for 15 years, and a magistrate for 16 years. Before that, I ran a large criminal practice as a defence lawyer, after getting here as a wet-behind-the-ears junior in March 1982.

I hesitated, initially, whether to come and see you all. I knew about your activities. Sometimes, it is difficult to actually work out whether to appear in public as a judicial officer, where objectivity and distance from popularity is important. Having said that, your activities, in my view, are so important and so raw in regard to people's love and attention that, at the end of the day I accepted your persuasion, Marion, especially after I received that letter from you with the desires of that particular academic institution, which I will talk about later.

I want to talk about what the Coroner does and why we do it. The Coronial Office is the oldest judicial post in our legal system. It is 800 years old and the reason it is the oldest and has stayed in the public forum is it is all about the importance of human life - that which we hold most precious is life. Accordingly, what is most profound is the reason for termination of that life.

When I give lectures to the police and others I personalise it. The person you most love - your brother, your sister, your child, your wife, your husband, your mum, your dad - dies unexpectedly. You are not quite sure what happened. You are upset it happened. You want to know what happened to get closure on your grief. 'I put my mum in hospital with a sore toe and she is dead', or 'went into police custody and died in that cell and he did not have that bruise when he went in', or 'there was a motor vehicle crash and he was not drunk. They reckon he was drunk, he was not drunk. I love him, I want to know'. People want to know why their beloved died and that is the essence of what I do.

Sometimes the Coroner's Office is seen to be a place that is part of the Work Health and Occupational Safety carriage - what we can recommend to see similar deaths do not happen. That is important, but not the most important thing. Let us find out the truth of what happened. So, the Coroner is concerned with investigating reportable deaths or unexpected violent, suspicious death.

We get, in the Northern Territory, on average over the last few years, about 350 to 375 reportable deaths to the Coroner. That is where there is no death certificate signed by a medical practitioner and my little office - it has three police constables - three Coroner's constables - a sergeant, a receptionist/secretary, it has a clerk, a Deputy Coroner, and me and that is it. We have not had a staff increase in the 15 years I have been a Coroner. Let me hasten to say, fortunately, the level of reportable deaths has not gone up that much - maybe from about 300 when I first started to around 375 now. However, dare I say it, the level of public expectation of what I do has increased and increased and increased.

You never saw much of what the Coroner did or heard much of what the Coroner did 15 years ago, but what I do seems to be in the news more over the last several years. What I do is investigate death. I react. I am not proactive, and some of the submissions you have are about: 'Oh, we can help the Coroner'. I am not proactive, that is for the Health Department, for government, for other agencies. I react. My job is to find out how it happened, when it happened, who it happened to, where it happened, and the circumstances of how it happened so that I can report to the family, the senior next of kin.

Now I must do an investigation. Some people, especially the press, get mixed up about what an inquest is about. An inquest is a public examination towards the end of my investigation. I am mandated to do a coronial investigation. For every reportable death there is a coronial investigation. Of the 370 a year, every one of them is investigated by the coroner. There is a brief of evidence done; there are statements taken; the family are reported to; autopsies are mostly done; medical reasons for the death are ascertained as well as other reasons – not just the medical reason but all the circumstances of death.

We might, at the end of the day, do only about 15 inquests a year. That is the public end of it. For some reason people seem to think that I have to do an inquest on every reportable death; I do not. What I do for most of them is, at the end of the day when you have finished the investigation there will be a two or three page summary done of the circumstances of the death for the family, the cause of death, the time and date of death, and what happened. We say to the family: 'We do not need an inquest is going to take the matter any further.'

The exception to all of that is death in custody. I must do a public examination. There are good public policy reasons for that which we all know about.

Suicides: I went to our records and said to Vicky, the receptionist, to go to the - because we input all our records into the National Coroners Information System – NCIS. Each state pays money towards it; it was set up by SCAG, the Standing Committee of Attorneys-General. Each week my staff input autopsy results and statistics and all the other reports into that system - something that one of your submissions, from the academic institution we know about, failed to mention. So I said to Vicky: 'Tell me about the suicides over the last five years in the Northern Territory: 2007, 2008, 2009, 2010 and 2011'. In 2007 there were 51; in 2008, 41; in 2009, 43; in 2010, 47; and in 2011, 43. I said: 'Break them up into over 18, under 18, Indigenous over 18, Indigenous under 18, Caucasian over 18, Caucasian under 18'. She was able to do that all within an hour and a half. I am going to give you these figures in a moment.

They code into that system the name of the person, the age, the date of birth, date of death, country of birth, Indigenous origin, race, sex, marital status, date the coroner was notified, the address, external cause, intentional suicide, location, school, home, playing sports - the whole thing.

And then (inaudible) identified that one of the great concerns for all of the state coroners is privacy and confidentiality. Your wife dies and she has hung herself; she has suicided. Lots of times there are confidential and embarrassing family secrets in most families behind suicides. We want the family to tell us the truth so that we know the truth. Sometimes, the truth has to come out publicly, but a lot of times it does not. I did not think so in the Northern Territory for the suicides of, for example, Senator Bob Collins and Neville Walker. Most of the suicides, I do not have an inquest on. Some I do, and I will tell you about that. I do not think that the family - I am searching for a word - all of the family emotion, history, likes and dislikes, behind suicides in the family should be the subject of the prurient interest of the press or the public. If families thought they were going to be subject of such public interest, I do not think I would get all of the truth that is necessary to fulfil my job.

In a closed session I will tell you about some of the suicides and I am sure that you will agree that it is not necessary for things to come out. Do mum and dad have to know that he had some sexual issues? Does the public have to know, when they look at an autopsy report, that particular person had a penile implant, for example - a pathetic thing to say, but there are things and facts to do with all of us that are not necessary to be in the public arena. Often, they are to be found in the files of people who have committed suicide. For that reason, I am very concerned - as are all the other state Coroners - to see there is privacy and confidentiality on these files.

We often have researchers who want to come in and look through them - and there are good research reasons in the trends of suicides to know lots of things. However, it is a balancing act - there is a balance there to be achieved.

Though I had a few more things to say, I will shut up. I have waxed lyrical, I am sorry about that. It appears to me, in all my work, there are things that have struck home to me personally. For instance, people do not know how easy it is to hang yourself. I had this strange idea before I became Coroner that when you hung yourself - you had the idea of what you saw on TV or the movies that you hung yourself up and your legs had to be gesticulating and you had to have a broken neck before you could hang yourself - it is so darn easy - that is wrong. You can gently go to sleep with a little bit of loosely tied noose against the door handle. It is just that pressure on the main artery there - there is no pain, you go to sleep and you never wake up. I have had instances of people suiciding with their bra on a single bed frame - lying down and putting the bra around their neck.

It is very easy to kill yourself, which is one of the reasons, when I look at the stats, I am not sure they are completely right about the level of suicide. We get about 40 or 50 a year. I have no doubt there are probably another half dozen of single vehicle road accidents where people have ended their life intentionally. But, you cannot be sure. Our law system is you do not call it an intentional death unless you are fairly sure. But, I reckon there are probably another half dozen at least.

Then of the ones we call it suicide - the ones where the kid has put the noose around his neck - I have a feeling in some of those they are more a call for attention; they do not really intend to kill themselves, they just do not wake up. Or, 'Please, someone stop me doing this. I am unloved. No one pays attention to me'.

Of the 40 or 50, you could add another half dozen and then subtract two or three. I had a good talk to my former deputy, Elizabeth Morris, about that and she agrees with those figures. She was with me for several years.

Now, of those - this is the other big furphy out there - there is this feeling that people who commit suicide are mentally ill; they are mad. Why would you do it? That is what well-adjusted happy people think. There certainly is a selection, off the top of my head maybe a third, a quarter, who commit suicide who are mentally ill or mentally fragile, have had suicide ideation for years, have been in mental health institutions, in and out, who end their lives. However, the rest are not psychotic, are not particularly mentally ill, may be unhappy, and make what they consider to be a rational decision - it is just not worth living. 'Life is pretty shitty. I am going nowhere. My girlfriend has left me. Mum is an alcoholic. Dad bashes her up all the time. I am 16 or 17. I was fiddled with when I was 9. I thought I got over that. Life is just not worth living'.

We can go to the other extreme. You have the 70-year old who is really sick with three or four kinds of cancer and just wants to end it. Many people, as far as they are concerned, make a rational decision that it is just not worth it any longer. I was surprised to realise that after I became Coroner. How unhappy must people be?

Then there is a small proportion – and this is the other strange quirk I have picked up – to commit suicide can be the ultimate selfish act. 'You do not love me enough. I will make you wear that guilt the rest of your life, mum and dad. You have not given me the new car. You have not given me enough'. To use an old adage, it is the ultimate cut-off-your-nose-to-spite-your-face.

Then I see the grief of families. You would never get over it, would you? If my child suicided I would never get over it. You would have tears every morning.

I did a public inquest in that regard into the death of a Nicholas Edward Spring who died at the Royal Darwin Hospital on 30 May 2010 from hanging. He had been mentally ill and looked at treatment and care, aftercare and counselling for the bereaved family. That family, a very nice Darwin family, was concerned about what happened afterwards. They were grieving, they needed counselling, they needed attention, they needed help. They did not get it. At the inquest they were very sensible. They said that that should be looked at.

I know that almost all the other coronial offices around Australia have dedicated grief counsellors. Counselling families over death is a very specialised thing to do and we do not have any. The Coroner's constables, who are police, do what they can but it is not a speciality of theirs. There was a response from the Attorney-General's Department - and I respect that - tabled in parliament to my recommendation which said, in effect that: 'There are not enough suicides to really have a full-time grief counsellor. We will outsource it, and you can continue to give your little booklet. So sad, so sorry'.

I am not so sure. I would request of the committee, and I would follow this up *in camera*, that if we had an additional Coroner's clerk who was a dedicated grief counsellor, specialising - it is a trained social worker/psychologist - who also had other duties to deal with keeping on top of the suicide records in my office, liaising with Health Department and other academic institutions which wanted to access them for research purposes, this is after passing ethics committee votes of yes or no which the National Coronial Information Service have, then that could be made into a full-time job. For instance, we allowed a PhD student from the university some years ago, who wanted to do what we thought was a worthwhile project on suicides, access to the records. We did not have staff to look over her shoulder as to what she was actually getting out of the files, and we were not too happy in the end to find out what was going on.

Anyway, I have been rambling for the last five minutes, so I will shut up.

Madam CHAIR: You have not been rambling. It has been interesting to listen to you and I thank you for sharing your view. I will go to committee questions.

Mr GUNNER: I thought that was quite compelling. As you spoke, I crossed off a lot of the questions I was intending to ask. Something you spoke about and you finished on was about that period after a suicide and talking with the families. We have heard a lot of evidence around the importance of postvention, to use a common expression, of working with them to stop contagion or those other ...

Mr CAVANAGH: First of all, there is the working with the family to get them to come to grips with this thing which is going to be with them for the rest of their life: why did my child die? It must be my fault. And often it is not. Often it is never their fault. Fault has to be put out of the equation.

There is the other side of things afterwards, especially in remote communities. There are going to have to be people on the ground because kids copycat. When I did the big inquest into the suicides on Tiwi Islands several years ago, I was quite concerned about publicising all this because of copycat reasons, but of course the community is so small they knew anyway.

One of the sad things coming out of that, Marion, was the kids would see the funerals that went on for three, or four or five days, saw that the most attention that that deceased ever got was in the funeral period. I thought that was pretty good; it was almost an incentive for them do it. You need people out, especially in the more remote communities, where we do not have a lot of social shoulders by way of mentoring and counselling - in small communities when someone suicides, especially the youth. That is my view.

It gets back to what I recommended in the big inquest into petrol sniffing in the Centre. Put youth counsellors out on the communities. 'Mum is getting bashed, dad is an alcoholic, and I need someone to talk to'. Actually I explained to Marion that my own background is such that it could be called disadvantaged. I had a great mentor in my football coach at 15 or 16. The football club and sport dragged me to places that I would not have got to. There you go.

Mr GUNNER: Just one more question on some of the evidence. I thought it was fascinating when you spoke about some of the people who committed suicide, who might have not intended to commit suicide - it might have been a cry for help. We heard a lot of evidence, mainly from the Centre, about the increased use of suicide as a threat. Almost in any argument you might have with a family member, you would threaten to kill yourself. I was wondering if you have noticed, through any of those investigations you have done, whether there had been an increase – the boy who cries wolf, in a sense – in the threats to do it, which meant that no one was ever actually sure where that youth was standing.

Mr CAVANAGH: I must say my impression is most kids, if we are talking about youths, it is not entirely completely surprising when they end their life. There is usually some indication, even in retrospect. You think: 'Oh, God, why didn't I pick that up?' That is an answer, I would say.

Mr GUNNER: It was concerning that they were saying it so often that no one was sure if they were meaning it or not. That was right, wasn't it Marion? You remember that the hearings we heard in Alice about the increased use of the threat, which got to the point where they were not sure when to help or not help, and left mothers, particularly, distressed ...

Madam CHAIR: That was of cry wolf. Because it had happened so many times, people had become immune to staying vigilant with a lot of those kids. So, it was, yes ...

Mr CAVANAGH: Oh yes. I agree, yes. Any death, especially of a young person who has all their life in front of them, is awful and is sad. As a member of our community, it ought to be as sad to us and to the family. I do not think it is necessary to overstate the matters. In 2011, there were 43 suicides, seven were under 18. In 2010, there were 41, six were under 18. In 2009, there were only two under 18. In 2008, five; and in 2007, 8. The majority are Aboriginal - most of them are Aboriginal kids - as compared to suicides averaging around 40 per year. Did you have a question, Mr Styles?

Mr STYLES: I did, Mr Cavanagh. I would like to put a story to you and, then, see what you think about that. I might struggle with some of it because it is a personal story. I just find when we look at the figures of 43 in 2011, and you add, roughly, perhaps another six to that, that is roughly 50; that is almost one a week. I would have thought that, having been through a counselling process that you describe, with me and my kids after the loss of their mother, that one a week would be a fairly heavy workload for a trained counsellor. I would just like to put this to you that after my wife died, I had three little kids and we just, basically, fell apart. Since then I have been in the role of a school-based police officer and have seen families literally fall

part. We were very fortunate because we got some quality counselling through Anglicare. We went to counselling for 18 months to pull us back together again.

Now, I do not propose to go through the details of that. We were there basically once a week for the first month, then we were there every two weeks. After a year we were down to about one a month, and then we went every three months. After 18 months we saw the counsellor and took a cake down and had a bit of a celebration because we were over the worst of it. I say 'over the worst of it' because there is an ongoing process which continues for the rest of your life.

What I see here is other Coroners have dedicated grief counsellors and we do not. It may be put out to private enterprise, but I see the absolute necessity of a full-time counsellor attached to your office. I repeat, because it is important, it took us 18 months of counselling to get over the basics.

Mr CAVANAGH: Okay.

Mr STYLES: As a result of that, we now have in our community a very experienced counsellor - my daughter. She is now a counsellor and it is that process we went through that was able to give us the ability to sell counselling not only to women, because women will take counselling much easier than blokes will. However, having gone through that process of quality counselling, in my time as a school-based police officer I was able to talk to men. They are the hardest people to get to counselling, but if you can demonstrate you have been through it, and if we have people in the community who go through quality counselling and are at barbecues, at functions, selling the advantages to other men of counselling - and we also have to do that on Aboriginal communities. We need to sell that so people do not have a fear of counselling.

Our role would be to try to put you out of business in relation to suicide. Our ultimate goal would be to have zero suicides. I do not know whether we will get to that, but we need to put in quality counselling and quality procedures to reduce counselling.

You said it but I ask you again, do you really need a dedicated grief counsellor attached to your office?

Mr CAVANAGH: I will answer this in full. I delivered, on 29 July 2011, a report into a suicide. I made the following recommendation:

The family of the deceased have understandably been shocked and upset by the loss of their loved one. They expressed on many occasions the frustration of the lack of education and assistance and counselling.

Paragraph 77: As indicated during the course of proceedings, every other Coroner's Office in Australia has grief counsellors. The Office of the Coroner of the Northern Territory does not provide this service. This must be addressed. Grief counsellors are trained social workers/psychologists who are experienced in meeting and talking with bereaved parents and relatives. This is a very important and necessary function. I recommend the Northern Territory government give consideration to the merits of funding such a service here in the Northern Territory.

If other jurisdictions in the country can recognise the vital need for such persons and such a service, I suggest the Department of Justice consider it.

There has to be a response now under the coronial legislation tabled in parliament through the Attorney-General from the department. A written response was received from the Department of Justice:

Due to the limited number of matters dealt with in the Northern Territory Coroner's jurisdiction, the establishment of a dedicated counselling unit within the Coroner's Office is not considered the best option for addressing this issue and the preferred approach is to refer grieving family members to external organisations that specialise in grief counselling as the need arises.

I agree with everything you said, Mr Styles. I agree with you. I see the grief; I see the tears. I share the grief and I share the tears. If it is said there is not quite enough work for a grief counsellor, I am suggesting I can make more work. Just a newly renovated office in my suite of offices and we can say to that person: 'Not only will you be the grief counsellor specialising in looking after people who need that – especially after suicides – but you will also look after the records of the coroner's office to do with suicides and the confidentiality and privacy needs of families in that regard'. So that when we get the odd researcher who

comes in and we allow in, we will be able to oversight things such that identification is not to the fore and privacy is. My answer is that I agree with you.

Mr STYLES: Would you see that that person's role as possibly someone who can go into the community from time to time and present ...

Mr CAVANAGH: I think they should. We often get requests to go and talk to a community. I gave a presentation – who are those lovely elderly people? The retired Rotarians. They meet at the Casuarina Club. I was so interested and interesting. I often get asked, and so does Cathy, to go and address the doctors at the hospital, a whole lot of community organisations. I do not have the time. I would expect, if I got the person you are talking about, would give community education.

There is a lot of interest in what I do. There is some need for the public to know exactly what I do and they do not. They watch American television programs and they think that I have to actually open up a body and do an autopsy myself. My wife has had to say to a lot of people in her trade: 'No, no, he does not actually attend the autopsy. No. He is not a doctor'.

So, yes, I am 100% with everything you have had to say, Mr Styles.

Mr STYLES: Thank you.

Mr GUNNER: Just an important point you made earlier: suicide should not be seen as a mental illness but people who ...

Mr CAVANAGH: It often is not a sign of mental illness. It often is not. I was surprised.

Mr GUNNER: One thing we are looking at is prevention, obviously, and trying to find points of intervention where you can make a difference to someone who might be heading down that track. Often the problem is that they distance themselves from friends and family; they are not involved in the local sporting club; they are not a member of a community group; 70% of them, I think that was the statistic, do not present to medical professionals – not necessarily as, as we say, mentally unwell, but not even to a counsellor or anyone. I was wondering if, through your investigations you have ever seen a common point or a common expression of help that maybe we misread, where there could be a point of intervention that we are missing?

Mr CAVANAGH: Look, the problem is too large. People who commit suicide are unhappy. There is a lot of unhappiness out there. In my view, especially the younger people, there is a need – if you are going to really want to stop people, young people, suiciding, then youth workers and youth counsellors attached to schools – where they have to go - or within a small community, in the smaller the community the more you can define the problem. Mentoring, youth counsellors and advisors need to be there on the ground – and I am not being facetious – to hold the hands of unhappy people. You only have to go to yourself - I do not know about you, Michael, but at 13 years of age I did not know if I was Arthur or Martha. If you are getting some wrong advice, or dad is drunk and mum is being bashed up, there is no food on the table, you need a mentor. You need: 'Hey, hard times. Harden up prince, princess. Come on, hold my hand, we will go forward'. If it is not your mum, dad, or your uncle, you need someone else.

Mr GUNNER: I think that accords with a lot of our thinking around schools are, perhaps, the most evident point of communal interest where people go.

Mr CAVANAGH: Didn't I say that in the Tiwi Islands inquest about education? It all starts - and education is more than just reading and writing, etcetera. Education is being taught how to mature, how to grow up, how to handle the tough times. As teachers know, it is much more.

Mr GUNNER: The communities we saw where they had really good programs is where the community themselves identified the problem, and provided their own local mentors, and took a real lead role.

Mr CAVANAGH: Yes. Marion?

Madam CHAIR: Greg, if I can be so bold, I am actually going to go to the heart of two ...

Mr CAVANAGH: You be as bold as you like.

Madam CHAIR: … coronials which I am sure are going to trigger some response - one in the Top End and one in Central Australia.

Mr CAVANAGH: Yes.

Madam CHAIR: The Central Australian one is in relation to a hanging of a young person, petrol sniffing, sexual abuse, remote communities - and you looked at the effectiveness of FACS ...

Mr CAVANAGH: Did I do an inquest or was it a …

Madam CHAIR: It was a coronial that you did.

Mr CAVANAGH: A coronial inquest. So, do we know the name, or for Aboriginal cultural reasons, we did not know?

Madam CHAIR: No, you did the inquest into the death of Kumina Forbes.

Mr CAVANAGH: Forbes, yes, that young girl out near Yulara?

Madam CHAIR: Yes. Your conclusion was:

There was some irony in the fact that her physical and mental health continued to deteriorate despite the spotlight which was being shone upon her community … by NT government agencies, the Australian government, and the media.

Mr CAVANAGH: She fell through the cracks, didn't she?

Madam CHAIR: When I picked up the coronial and looked through it, it just seems to be the same. I must say this coronial was in 2009. She was 15; she died in 2006 ...

Mr CAVANAGH: I must say that is the one where the former Attorney-General, McClelland, asked me to Sydney and address him and Macklin and a whole lot of other people about how these kids fall through the cracks when we are spending so much money. Isn't that the one?

Madam CHAIR: That is the one. When I did some research and pulled up some of the coronials and inquests that you did – much of the evidence the committee has compiled when we have gone out to some of these areas … It was 2006 and we are still hearing it in 2012. I was listening to you saying that you put a recommendation to the Attorney-General's Department of having grief counselling. There are recommendations, both in this coronial - and one of them was the reporting and investigation in a timely way. In your opinion, since this time, has it become better? Has the reporting …

Mr CAVANAGH: One of the things I criticised in that particular coronial inquest was the tardiness, the slowness in the police investigation. Yes, and I have to say that I am pretty happy with the response over the last few years in the police investigations of those kinds of things. That has improved.

But, that whole coronial is an example of what I am about. My job is to identify the problems. I do not have a staff to fix them. I do not even have staff to be proactive to see what you done about my recommendations. I do not know how many staff the Ombudsman has. I have told you how big mine is. I have about three and that has stayed the same for 15 years. There is this expectation that - I have a personal interest - I have a work interest in being proactive. My jurisdiction is to be reactive. This is what happens, this is how it happened, and these are the problems I have identified. Government, fix them. I will tell you again if they are not fixed and I find another death. I will criticise you, but there you go.

Madam CHAIR: One of the recommendations in that report was the Coronial Investigation Unit in Alice Springs is appropriately staffed and resourced in order that members of the unit are able to ...

Mr CAVANAGH: That was the police constables unit.

Madam CHAIR: Is that placed in your office?

Mr CAVANAGH: With the police.

Madam CHAIR: Police, okay.

Mr CAVANAGH: We have this - and every state has it – there is an issue about police investigating on behalf of the Coroner, especially investigating deaths in custody. However, every state Coroner has the police do their coronial investigations. Within my office just across the road, there is the civilian staff I have told you about and, on the third floor of the Magistrates Court, there are also three police constables, not in uniform, who are answerable to the police for their discipline but work for my deputy and me on a daily basis discussing coronials every morning and during the day. Their job is to go out with the body bag, be the first point of reference, and start the investigation. What I said in that particular case, because I do not have - all the Alice Springs coronials are run out of my office - is I want a dedicated police officer or two in Alice and I got it.

Madam CHAIR: You have staff in Alice Springs and you have staff in Darwin. If you say in 2011 there were 43 completed suicides, are you able to tell me how many of that 43 were in remote communities?

Mr CAVANAGH: I can tell you but I will have to take it on notice. My statistics today - 37 were over 18, seven were under 18, 21 were Indigenous over 18, and of the seven under 18, five were Indigenous. It would not take me more than an hour or two to tell you what communities those five came from, but I have not brought that today.

Madam CHAIR: Can we get that on notice?

Mr CAVANAGH: I will ring you this afternoon. I will give you this, it is an IQ test. That can form part of the committee records. I am not going to take up your kind invitation for lunch. I am going to go back and I will ring it through over lunch.

Mr GUNNER: Is it possible, when you are doing that, if we could also get the breakdown slightly different. Our terms of reference is 25 and under. Is it possible to get that?

Mr CAVANAGH: That might take more than an hour or two; you are making it a little hard. All this suggests to me I should have given you more time and attention at the start. I am sorry, I apologise that I did not. One of the reasons is I do not work full time as a Coroner, I still do magisterial work. Okay, go on.

Madam CHAIR: The other coronial I do want to – and I suppose this is one of the areas when we wrote to you because information or evidence that was given to the committee was in relation to establishing a suicide register.

Mr CAVANAGH: Yes.

Madam CHAIR: I just want to go to the heart, I suppose, of another coronial which was not suicide, but certainly led towards quite a strong recommendation from you. That is towards the reporting, or mandatory reporting, of domestic violence. That was a coronial of a young Aboriginal woman at the hands of her de facto spouse. That death led to multiple incidences and visitations to hospitals as well as clinics, and despite, I suppose, this alarming and increasing or escalating pattern, the warning bells did not go off amongst all these agencies, which unfortunately then led to her death.

You called for mandatory reporting as part of …

Mr CAVANAGH: I called for the government to consider it.

Madam CHAIR: To consider mandatory reporting.

Mr CAVANAGH: Because I know there are pros and cons. It just occurred to me, though, at the time, if there is a mandatory reporting from a doctor or nurse of a sexual nature and that is seen to be necessary, I do not see much difference to daughter or mum attending the local clinic with a broken nose, broken this, that and the other, bleeding, hopelessly bashed to within an inch of her life, and that is not supposed to be reported to the police. Yet if the girl or mum has been – and it is serious – sexually assaulted to any degree, it has to be. I remember thinking that at the time.

I know that the media reporting was that I recommended that there be mandatory reporting. I stepped back half a step and I said: 'I want you to consider it'. Because the other side of the coin is, if there is mandatory reporting they are not going to get their wounds attended because they do not want their husband going to gaol, so they do not go to the clinic and it gets worse.

Madam CHAIR: Well, I suppose where we have been compiling and taking the evidence, so I will go to the numbers we have for attempted suicides over a five year period. There were around 419 in the Northern Territory. If we look at attempted suicides, then we look at completed, and I have not had time to add these numbers you gave me, but if we were to then add between 2007 and 2011 the numbers that you gave us in terms of completed and then extrapolate from the completed versus attempted, you would then – what is, I suppose, a big gap in all of that, is no one really knows whether the people who have actually attempted suicide have then completed, so they have gone from this cohort to that cohort.

Mr CAVANAGH: The big problem is: what is an attempted suicide? Is it fair dinkum or not? I am not sure at all that you can get some realistic outcomes out of trying to define what attempted suicides are, because it can just be a joke by someone, or it can be really serious on the other extreme, and then get a whole lot in the middle.

More to the point, I think you ought to define it as self-harm, attempted self-harm. Remember after the Tiwi ones and during the Tiwi inquest the number of kids who were going up the light poles threatening to throw themselves off? There were lots of them. Even if they were serious, it was more about attempted self-harm than killing themselves.

My response is I am just not sure what realistic achievements you can get out of such a wide area of attempted suicides. It could encompass so many things. I do not know where you get the figures from. For someone to come along and say there were 400 attempted suicides, I am not sure how accurate that data is at all. In fact, I am pretty sure it would not be really accurate. It is a bit of a guess, isn't it?

Madam CHAIR: I should say that they are actual incidents that police attend to …

Mr CAVANAGH: So, they think it is fairly serious.

Madam CHAIR: Something has happened and police attended those incidents. If you are saying it should not be attempted suicide, it should be self-harm, should the categories - or should we be saying let us look at the number of self-harm incidents in the Northern Territory, whether they be attended to by police or reported to clinics?

Mr CAVANAGH: Call them that and, out of that, you can then say: 'Yes, there is just the increased need of what Cavanagh is talking about; people on the ground - counsellors, youth workers. If you say, 'Oh, well, there are only about half a dozen youth suicides a year; we do not need people on the ground'. No, no, the problem can be better explained by saying there are also 400 or 600 self-harm; many of them are would-be suicides. As to what extent, we are not sure, but that is enough of a problem. So, do not just focus on the half-dozen completed. Yes, we know they were suicides. You have a weighty argument for more resources.

Mr GUNNER: It is a way of measuring wellbeing of a community.

Mr CAVANAGH: Health and wellbeing - it happens.

Mr STYLES: Prevention is better than cure!

Mr CAVANAGH: Prevention is better than the death. Prevention is the cure.

I do not want to be recorded anymore.

It is so bloody sad, and it will always be so bloody sad. The people I deal with - as I say to the police constables: you are not dealing with people from the criminal classes here, these are usually really nice people who have never been in criminal trouble, and they want to be looked after. You have to treat them a bit differently than looking at it in terms of your policing.

Madam CHAIR: Do you want to go *in-camera* for this session?

Mr CAVANAGH: Yes.

Madam CHAIR: We might just take a break for a minute and I will just ask. We could pass, if you wanted to. Did you want this, or we could make that ...

Mr CAVANAGH: You can make that available to the press if you want.

Madam CHAIR: Yes, okay.

Mr CAVANAGH: It is not confidential.

The Committee resolved to take the remainder of Mr Cavanagh's evidence 'in camera'