STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Tahlia Peden
Hearing dates:	12,13,14 March 2018
Date of findings:	30 April 2018
Place of findings:	State Coroner's Court, Glebe
Findings of:	Deputy State Coroner, Magistrate Teresa O'Sullivan
Catchwords:	CORONIAL LAW – Sexual Assault Services (SAS) Aboriginal Health Workers
File number:	2015/351554
Representation:	Ms Donna Ward, Counsel Assisting, instructed by Ms Kate McCrossin, the Crown Solicitor's Office Mr Jason Downing for the SNSWLHD and MLHD, instructed by Ms Roslyn Cooke Ms Melissa Humphreys instructed by Ms Scarlett Abernathy for the family
Non publication/access orders:	Publication of the proceedings is permitted under s.75(5) of the *Coroners Act 2009*. Pursuant to s.65 of the *Coroners Act 2009*, the evidence contained in Tab 14 of the coronial brief should not be supplied or copied to any person seeking access under this section.

Findings:	**The identity of the deceased** The person who died was Tahlia Peden. **Date of death** She died on 28 November 2015. **Place of death** She died at Goulburn TAFE, Goulburn, NSW. **Cause of death** Hanging. **Manner of death** Tahlia tied a rope around her neck and suspended herself from a railing with the intention of ending her life.
Recommendations:	1. That the Southern NSW Local Health District and Murrumbidgee Local Health District raise for discussion at the VAN Senior Executives Advisory Group Meeting procedures for SAS client referral from district to district and for that purpose, a copy of these findings be provided to attendees to facilitate discussion. 2. That a copy of these findings be provided to the NSW Health Team at the Joint Investigation Response Team (JIRT) Referral Unit (JRU) to consider clarification around reference to time frames in JRU documents that are referred to a NSW Health Service. 3. That a copy of these findings be provided to any committee overseeing the introduction of the Central Intake System and the audit of the use of the suicide risk assessment tool within the Southern NSW Local Health District with a view to ensuring that the proposed changes do not lead to any increased delay in client's accessing SAS or mental health services within the District.

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The Coroners Act 2009 in s.81(1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death. These are the findings of an inquest into the death of Tahlia Peden.

Introduction

1. This was the inquest into the death of Tahlia Peden. Tahlia was a young and proud Ngunnawal woman whose traditional land included the areas surrounding Canberra and Yass.

2. Tahlia was just 17 years old when she died, leaving behind a grieving family including her parents Tanya and Tim, her sisters Tiana, Taylor and Teagan, her grandparents, her cousins and wider family. Tahlia's mother describes her as a very caring person with a beautiful personality and so it is no surprise that this young woman also left behind many friends.

3. The death of a 17 year old understandably triggers a search for answers. Why did they die so young when, by rights, they should have been looking forward to all the excitement and all the challenges that lie ahead on the move from adolescence to adulthood? It is understandable that Tahlia's family ask such questions.

The Inquest

Section 81 of the *Coroners Act 2009*

4. Pursuant to s.81 of the *Coroners Act 2009*, the coroner holding an inquest touching upon the death of a person is required to make a finding as to whether the person the subject of the inquest died and, if so, findings as to the following:
   a) the identity of the deceased;
   b) the date of death;
   c) the place of death; and
   d) the manner and cause of death.

5. Under s.82 of the *Coroners Act 2009*, the coroner holding an inquest also has the power to make recommendations.

6. Tahlia's identity, date and place of death are already known.

7. The cause of death refers to the injuries that Tahlia sustained on 28 November 2015 which led her to die. On the evidence before me, Tahlia died as a result of hanging. So much is clear from the autopsy report. As to the manner of Tahlia's death, the evidence also suggests that Tahlia's death was self-inflicted as she spoke to and sent text messages to friends shortly prior to her death informing them of her intention to end her life and saying that she had a rope tied around her neck.

8. These friends, and the mother of one of them, drove to Tahlia's residence at the student accommodation associated with Goulburn TAFE to try and find

her [Tab 10.6 and 13.5]. They also contacted another resident and asked him to start looking for Tahlia [Tab 9.7 and 11.9].

9. Tragically, it was too late for Tahlia when they found her at her accommodation. It was the mother of one of her friends, along with another student resident at the TAFE (who responded to their calls for help) who tried to save Tahlia.

10. Police later found a note that Tahlia had written addressed to “Dear everyone” and which explained her decision to take her own life. This is not to suggest that Tahlia’s explanation makes sense but the note explains Tahlia’s thinking and, along with the other circumstantial evidence, establishes to the requisite standard that Tahlia intended to end her life.

11. The inquest was held in Goulburn and heard evidence from eight witnesses. Tahlia’s family attended each day and I thank them for their participation in this inquest. It must have been harrowing for them. They cared about Tahlia deeply and their love for her was obvious. I offer them my heartfelt condolences.

The evidence

Background

12. In Tahlia’s case one cannot try to understand her death without trying to understand some important events in her life. This will necessarily focus upon the trauma that she experienced in the final couple of weeks of her life. This inquest heard evidence that Tahlia made a complaint to police that she was sexually assaulted approximately 10 days before she died.

13. The man accused of sexually assaulting her has not faced court and so the allegations against him have not been tested nor found proven. This is not a reflection on Tahlia’s credibility. I make no finding with regard to the alleged sexual assault but I will refer to the events starting on the evening of 18 November 2015 as a sexual assault given Tahlia’s complaint.

14. The sexual assault on 18 November 2015 and its ramifications for Tahlia’s well-being need to be considered in context with her underlying mental health. Tahlia didn’t experience the assault as an isolated trauma to be dealt with as a discrete incident. She, like anyone, experienced that incident in context with all of the other incidents, both good and bad, that shaped her into the person she was. The Court cannot focus solely on the events following the sexual assault without also understanding the pre-existing vulnerabilities that Tahlia had.

15. Tahlia’s mother frankly concedes, and the contemporaneous evidence from the Department of Family and Community Services amply demonstrates, that Tahlia’s mental health and her relationships with her family fluctuated over time. Tanya Peden dates a change in Tahlia’s behaviour back to a serious car accident that occurred in 2008 when Tahlia was 10 years old. Tahlia was trapped in the car and had to be cut from the wreck and Tanya Peden

required long term rehabilitation to recover from her own injuries which was difficult for the whole family [Tab 7.7].

16. Separate to this incident, there was evidence before the Court of Tahlia's text messages back and forth with various friends in the weeks before her death, which included a message in which Tahlia tells a friend that she was sexually abused at 10 years of age. There is no way of now investigating Tahlia's disclosure and there is no way that I can make a finding about what happened to Tahlia at that age. However, if Tahlia's disclosure is true, it too would help explain the behavioural change that her family observed from about the age of 10.

17. Tahlia's behaviour deteriorated in adolescence. She did more than test boundaries as might be expected during teenage years. Tahlia ran away, she had poor attendance at school, there was erratic behaviour and Tahlia began to self-harm. Tanya Peden describes Tahlia as being a "picker" [Tab 7.9]. Tahlia would also cut herself in an attempt to relieve anxiety and distress. There was evidence of a text message sent by Tahlia where she explained "I get really depressed and shit then I cut and it calms me down then I'm all happy". She also said "it's like an addiction" [Tab 14.28-29].

18. This is consistent with observations at autopsy that Tahlia had superficial linear scratches on her right thigh, left arm and the word "worthless" scratched into her right leg [Tab 4]. The "worthless" mark was also something that Tanya had observed on 20 November 2015 when she took photos of Tahlia's bruising following the sexual assault.

19. In 2012, when she was aged about 14 or 15, Tahlia was placed under a temporary care arrangement with the Department of Family and Community Services and lived for a time in a refuge. This lasted only a few weeks or months and Tahlia then moved to live with her maternal grandparents, her godfather, a family friend and her family for various periods of time.

20. Whilst living with her maternal grandparents, Tahlia took an overdose of Panadol and Nurofen. Her mother Tanya says this was the only previous suicide attempt that she was aware of [Tab 7.12] and there are no further suicide attempts documented within the coronial brief.

21. What is clear from the evidence is that Tahlia thought about and talked about suicide in the weeks and months before her death, even before the sexual assault in Wagga.

22. For Tahlia, a level of suicidal thinking or suicidal ideation was not uncommon or unusual. This is something that she reported to one of the support workers she spoke to following the Wagga sexual assault [Tab 24.42] and is reflected in many of the text messages that preceded the assault.

23. It is important to note that despite this history, things were not always sad and serious for Tahlia. Tahlia was enrolled in Goulburn TAFE and lived in student accommodation on site. In her oral evidence, Tanya Peden said that she was

aware that there was security at the TAFE accommodation, which provided a level of safety for Tahlia and a level of reassurance for her parents. While in the TAFE accommodation Tahlia had her own bedroom but shared a kitchen and lounge area with the other students. She was responsible for preparing her own meals and her mother, Tanya, helped her with budgeting and by teaching her recipes. Tahlia would return frequently to her family in Taralga to do her washing. Her parents believed that things were starting to look up for Tahlia.

24. By November 2015, things had improved to a level where the family decided that Tahlia could slowly move back home. In her oral evidence Tanya Peden said that this was to be a staged transition because Tahlia had to re-adjust to living back in the family home and the family needed to re-adjust to that too.

25. It was clear that all the family were excited at the prospect of being able to live together again. Before Tahlia did move home, she planned a trip to Wagga to visit a friend [Tab 7.15].

The trip to Wagga Wagga

26. Tahlia travelled to Wagga Wagga on or around 14 November 2015.

27. Tanya Peden described the trip as a holiday for Tahlia to visit her friend Jess in Wagga before moving back to the family at Taralga.

28. In a text message, Tahlia described the trip as follows, “I did a bad thing now, I jumped a train to run away from it I don’t know how long I’ll be gone but so someone knows I’m going to Wagga. Don’t tell my parents” [Tab 14.47].

29. It’s hard to know from this distance what it was that Tahlia was running away from, but the other messages around this time suggest she was about to be “kicked out” of TAFE accommodation [Tab 14.41]. Tanya Peden said in her oral evidence that neither she nor Mr Peden were aware of that at the time.

30. Upon arrival in Wagga it seems Tahlia stayed with her friend Jess, but things did not run smoothly, at least as far as Tahlia reported in her text messages. On 15 November 2015 she said to a friend “Hahaha Wagga Day 2 got someone arrested…he beat me…around” [Tab 14.51]. The next day Tahlia received a message from the Women’s Domestic Violence Court Advocacy Service which said “our role is to offer support and information to women referred to us by police” [Tab 14.55] which suggests Tahlia had made some kind of complaint that prompted the intervention of that service.

The sexual assault

31. On the evening of 18 November 2015 into the early hours of 19 November 2015, Tahlia was sexually assaulted, as set out in her statement at Tab 18. She was eventually able to sneak to the womens toilets at the hotel where she had been taken and once there she rang her mother, Tanya. She then rang 000 while her mother also rang 000 from Taralga. [Tab 7.16].

32. Tahlia ran out of the hotel and hid at a nearby McDonald's while she waited for police to come and find her. She was in a strange town, far from family, fearful that her attacker would follow her. This would have been a terrifying wait for anyone, let alone for a vulnerable 17 year old woman who had just survived a sexual assault.

The sexual assault services

33. Once police found Tahlia, she was taken to Wagga Base Hospital and shortly thereafter met Ms Natasha Spokes from the Wagga Sexual Assault Service ("Wagga SAS") who provided immediate support and commenced arrangements for a referral to the Goulburn Sexual Assault Service ("Goulburn SAS") once Tahlia returned home.

34. Ms Spokes encountered some initial difficulty when trying to reach the Goulburn SAS via a phone call to the Emergency Department of Goulburn Hospital. In her oral evidence, Ms Catrina Richens, Clinical Lead for the Sexual Assault Services in the Southern NSW Local Health District ("SNSWLHD") said that the on call worker was at home but out of reach of the mobile phone service used by Goulburn SAS at the time. The Wagga SAS notes suggest that the Goulburn Hospital Emergency Department had put the call through to the Goulburn SAS worker's personal mobile (which she did not have with her) rather than the on call mobile [Tab 24.14].

35. It is an alarming prospect to think that something so simple could prevent workers from being contacted about urgent matters after hours. This problem seems to have been rectified by the later provision of upgraded phones for use after hours.

36. Ms Spokes was eventually able to speak to the Goulburn SAS on call worker and indicated that Tahlia would return to the Goulburn area and later require the help of that service. At that stage it was likely that any forensic medical examination would need to be organised by Goulburn SAS [Tab 24.14].

37. In 2015 a forensic examination organised by the Goulburn SAS would actually have been conducted in Canberra because of a lack of suitably trained doctors in Goulburn. This situation has since changed and there is now some limited opportunity for a forensic medical procedure to be conducted at Goulburn Hospital depending upon the location and availability of a female doctor who has been recruited to perform such work.

38. Ms Spokes did not immediately complete file notes of her involvement with Tahlia in the early hours of 19 November 2015 and so when the next SAS worker, Ms Rachel Harmer, commenced work with Tahlia later that morning, she did not have the benefit of Ms Spokes' notes. There had been an oral handover but not all details obtained overnight were conveyed during that discussion. Whilst Ms Spokes had earlier obtained a history that allowed her to report to the Goulburn SAS that Tahlia "was assaulted when Tahlia was 15 yrs, has self-harm scars on arms" [Tab 25.2], according to Ms Harmer the information about Tahlia self-harming was not relayed to her during her oral handover from Ms Spokes.

39. Ms Spokes must have been tired at the end of a long overnight shift but it is sensible that the Wagga SAS now requires on call workers to complete notes prior to finishing their shift. This means that workers who follow on later shifts have available to them all of the contemporaneous information that was obtained during the earlier shift and they can revert to those notes if they need to double check any relevant history.

40. Ms Harmer took over from Ms Spokes and started work on Tahlia's case. This involved numerous telephone conversations with Tanya Peden, Wagga Base Hospital (Tahlia having later decided to have a forensic medical examination conducted in Wagga), the Joint Investigation Response Unit, Wagga Police and community organisations who might be able to transport Tahlia home or help fund the cost of her transport home.

41. Tanya Peden and Ms Harmer had their first discussion at 11.30am on 19 November 2015. They each have genuinely held, but conflicting, recollections of this discussion. Tanya Peden says that during this discussion she was assured that Tahlia would receive counselling within 24 hours from the Goulburn SAS and that she was told this was SAS policy. She also recalls Ms Harmer saying that Tahlia had been assessed as "high risk" of suicide or self-harm.

42. Ms Harmer denied giving any such assurance or guarantee of counselling within 24 hours by Goulburn SAS or that she had assessed Tahlia as being "high risk".

43. Given the passage of time since that discussion and the understandable emotional strain that Tanya Peden was experiencing at the time, the contemporaneous file notes of Ms Harmer provide the most reliable record of the discussion.

44. This record reads [Tab 24.22]:

    P/C from Tanya Peden…Tanya advised she was calling to try and organise transport for Tahlia to Canberra. Tanya said that she works in Canberra but she lives 2 hours away from Canberra and was currently exhausted and did not think it was safe to drive to Wagga. Tanya informed Wagga SAS worker that she was Ngunawal and that Tahlia also identified as Aboriginal and there may be resources available via the TAFE Aboriginal Liaison Officer or Community Services.

Plan [numbering as on the original]

2. Wagga SAS worker Natasha Spokes to explore transport options for Tahlia and contact Tanya with outcome.

3. Wagga SAS worker Natasha Spokes to contact FACS Helpline and make a report .

1. Wagga SAS worker Rachel Harmer to provide support during FME to Tahlia.

2. Wagga SAS Rachel Harmer to make referral to Joanne (Goulburn SAS) after confirming Tahlia would like counselling.

3. Wagga SAS worker Rachel Harmer to make IIMS report regarding difficulty in locating room.

45. The only policy referring to a 24 hour turn around was the Sexual Assault Services Policy and Procedure Manual (Adult) which provided "all clients presenting in crisis following a recent sexual assault should be seen by a sexual assault counsellor within one hour of presentation. All adults who have been sexually assaulted within the past four days should be seen by a counsellor as soon as possible and no later than 24 hours after first contacting the services" [Exhibit 5].

46. The Wagga SAS had already complied with this timeframe by the time of Ms Harmer's conversation with Tanya Peden because Tahlia had met with Ms Spokes shortly after being taken to hospital.

47. The file note from Ms Harmer also refers to difficulties in finding a suitable room in which the forensic medical examination was to be conducted at Wagga Base Hospital. Ultimately, the procedure was conducted in the midwifery department in a twin room with a spare bed and when the other occupant of the room was absent having an ultrasound. This was a less than ideal arrangement but Ms McMahon, Coordinator of the Wagga SAS, confirmed in her oral evidence that there is now a dedicated suite for forensic medical examinations at the newly opened Wagga Base Hospital.

The "risk assessment" conducted by Wagga SAS

48. The Court received into evidence the "NSW Health Framework for Suicide Risk Assessment and Management for NSW Health Staff" dated September 2004 [Exhibit 7 at Annexure "B"]. That document carries within it a suicide risk assessment guide which, as the title suggests, is to guide but cannot supplant a thoughtful and comprehensive clinical assessment as to suicide risk.

49. Whilst the document existed in 2015 it was not then in use within the Sexual Assault Services in either the Murrumbidgee or the Southern NSW Local Health Districts.

50. This does not mean that no suicide risk assessment was undertaken in Tahlia's case. For instance the contemporaneous notes of Ms Harmer following the forensic medical examination detail "risk assessment conducted, Tahlia denied any risk to self or others."

51. There is nothing in the contemporaneous records from Ms Harmer recording Tahlia as being at high risk of suicide or self-harm and I accept the evidence of Ms Harmer that she did not make any assessment that Tahlia was at high risk.

52. A further risk assessment was conducted during the detailed telephone discussion between Tahlia and Ms McMahon on 24 November 2015 [Tab 24.41]. While Tahlia reported some suicidal ideation and self-harming thoughts these reports needed to be considered in context of Tahlia's history. She reported to Ms McMahon and it is confirmed elsewhere within the coronial brief (as highlighted above) that this was not unusual for Tahlia. Ms McMahon in her evidence said that this was not unusual for clients of the service if they have experienced earlier trauma in their life, as Tahlia had.

53. Ms McMahon explored these matters with Tahlia. In her evidence she referred to discussions about strategies to help Tahlia cope and distract herself from these thoughts and discussion about where Tahlia's supports were. Tahlia identified her family, particularly her mother and father, as strong supports, checking in on her and doing things like making sure she was eating properly.

54. Ms McMahon did not identify Tahlia as being at such a level of risk as to warrant referral to the Mental Health Access Line or another service. Nor was she at such risk as to warrant immediate attention from ambulance or police. I accept that if Ms McMahon had identified such a risk, she would have acted on it.

55. Further, suicide risk assessments are not instruments of precision. The vast majority of people who experience suicidal ideation will not go on to complete suicide and medical science has not yet determined a way to reliably predict who amongst us will commit suicide.

56. But regardless of any suicide risk, Tahlia's case needed to be referred to the Goulburn SAS and Tahlia needed to receive a follow up call from that service offering their specialised counselling. Wagga SAS considered that such contact needed to be made by Goulburn SAS as a matter of priority.

A breakdown in the referral pathway

57. The evidence before me indicates that on the evening of 18 November 2015 into the early hours of 19 November 2015, Tahlia was sexually assaulted. At approximately 2.45 am, on 19 November 2015, Tahlia met with Ms Natasha Spokes from the Wagga SAS at Wagga Base Hospital. On 28 November 2015, Tahlia passed away without Goulburn SAS having contacted her.

58. At the close of evidence it is clear that the following matters contributed to the situation where Tahlia was left without professional support as she grappled with the repercussions of her sexual assault and trauma background:
    - Tahlia's mother and father were treating her with "kid gloves" and assumed she was receiving counselling but did not intrude by asking Tahlia about it;
    - Rachel Harmer at Wagga SAS knew that there was no one available at Goulburn SAS on Friday 20 November 2015 because Joanne Long had said she would not be available. Ms Long had court commitments with another client that day;
    - Rachel Harmer was attending training in Sydney from Monday 23 November 2015 until Friday 27 November 2015 and therefore provided a hand over to Shannon McMahon on Friday 20 November 2015. Although Ms McMahon was not at work that day, the handover still took place [Tab 26.52]. There were several intake clients to discuss, not just Tahlia's case [Tab 26.54] and Ms Harmer told Ms McMahon that the service would need to formally refer Tahlia to Goulburn SAS the next week [Tab 26.54];
    - Ms McMahon then reviewed the records when she returned to the Wagga SAS offices on Monday 23 November 2015 and believed that "sufficient referral information had been provided to Goulburn SAS to establish a referral and follow up with the client" [Tab 27.19] although further clinical details from Wagga SAS would need to be provided in due course. Wagga SAS did not require written referrals from another SAS before taking action and Ms McMahon assumed that Goulburn operated under the same system; and
    - Ms Long at Goulburn SAS on the other hand was waiting for a written referral form or handover documents. That was the process in place at Goulburn SAS and she assumed other services operated in the same manner [Tab 28.25 and 27].

59. Into this mix came a document from the Joint Investigation Response Team Referral Unit [Tab 24.36], prompted by an earlier report that Wagga SAS made to the FACS Child Protection Helpline. This JIRT Referral Unit document seemed to introduce further confusion.

60. The form included in a prominent position on the front page a JRU Referral Date of 24 November 2015 and JRU Referral ID and a Response Time marked in bold as "<10 days".

61. Ms Long understood this time frame to apply to her response to the referral from the JRU. She said in her statement "…because the JRU document indicated a response time of less than ten days, there was nothing in the JRU document to indicate any suicidality or any other acute risk and I knew that Tahlia was receiving phone support from WWSAS. I was unaware that I needed to contact WWSAS in order to facilitate a transfer and counselling as a matter of urgency. My intention was to contact WWSAS within the less than 10 day timeframe as prescribed in the JRU referral. I also expected that I would be [sic] receive a written referral form for Tahlia from WWSAS within the less than 10 day timeframe as per JRU referral" [Tab 28.39].

62. This understanding that the JRU document imposed a timeframe upon the SAS was not limited to Ms Long. In their oral evidence, Ms McMahon, Ms Harmer and Ms Richens all understood that was the way in which to interpret the time reference included in the JIRT Referral Unit form.

63. Yet the evidence of Ms Erin Brazenall, Senior Health Clinician with the Joint Investigation Response Team Referral Unit explained that the timeframe of "< 10 days" was a timeframe to prioritise the JRU response, not the SAS response [Tab 30.19.ii]. She explained "the response timeframe was applied to this report by the FACS Child Protection Helpline, however, the Police and Wagga SAS had already responded in a shorter timeframe when the JRU actions occurred. Information sent to the Goulburn SAS by the JRU included, as per standard format, that the original Helpline timeframe had been <10 days." [Tab 30.19.xi]

64. This misunderstanding contributed to the delay in Tahlia being offered counselling by Goulburn SAS. Ms Long relied upon an assessment of "<10 days", imposed by the Child Protection Helpline who had neither seen nor spoken with Tahlia (because that was not their job). On the other hand the SAS workers at Wagga had spoken to Tahlia and were better informed than anyone at the Helpline about Tahlia's need for specialised counselling. None of the SAS workers wanted Tahlia to wait up until 10 days before being offered support from her local service in Goulburn.

65. A statement from Ms Emma Field (Manager – Priority Populations for the Murrumbidgee LHD) annexed a new version of the JIRT Referral Unit form, issued in 2017 [Tab 29A at "C"]. This form includes a 'tick a box' section to highlight what "action/s requested from the Health Service receiving this information."

66. The new form also continues to refer to a timeframe described as "Priority this case was given at the JRU." On the face of the document it is not clear what this means. Does it, for instance, mean a timeframe for the JRU to respond or does it mean a timeframe that the JRU is giving to a NSW Health Service for action?

67. Ms Field says that the new form is an improvement on the previous form and the Court has received submissions that the timeframe referred to in the form is a timeframe to guide the JRU response and is not a timeframe for the LHD to apply to their response.

68. Even accepting this is the case, the potential for confusion arising from the face of the document persists. It is said that the additional part of the form referring to "Immediate/Urgent Health response required, in addition to JRU priority" removes any confusion about the role of the timeframes that are also included on the form, but it is difficult to know why the timeframes are included at all if they are irrelevant to the "provision of information to a NSW Health Service for action."

69. Without wanting to prescribe how this potential confusion might be clarified, it is appropriate to bring this issue to the attention of the JIRT Referral Unit for consideration and amendment if they decide that amendment is necessary in practice. The Crown Solicitor, at my request, contacted NSW Health to bring this matter to their attention.

70. On 27 March 2018, Ms Tadros, Senior Legal Officer, of Legal and Regulatory Services, NSW Health, advised the Crown Solicitor as follows:

"This matter provides evidence that some clinicians in Health's Sexual Assault services may be less clear about how the stated JRU/JIRT timeframe should be interpreted when planning their clinical response. Given the misinterpretation of the timeframe information the Director of the Child Wellbeing Unit [at NSW Health] will seek to establish a working group to review how timeframe information is provided by the JRU to all health services in Guidelines and Forms and will accept a recommendation by the Coroner to that effect.

Any work will need to be directly linked to any policy review of NSW Health's Sexual Assault Services Guidelines for determining the urgency of a Sexual Assault Service response and for transfer of referrals. The Ministry of Health's Prevention and Response to Violence Abuse and Neglect Unit has advised that they will also include guidance on this issue in the new JIRT Health Clinical Practice Guidelines which are being developed this year".

71. This seems a sensible approach and I am grateful that NSW Health were able to quickly respond to this issue.

Events in Tahlia's life after her return from Wagga

72. Upon return to Goulburn, Tahlia had the support of her family and her friends but no contact from Goulburn SAS and no face to face counselling.

73. Tahlia did have telephone counselling from Ms McMahon on 24 November 2015 as outlined above. Some of the advice Ms McMahon gave about distracting herself from unwelcome thoughts mirrored the advice that Tahlia also received from her mother. The text messages include a text from Tahlia saying "I can't sleep, I can't stop thinking about it. I don't know what to do" to which her mother replied "Breathe. Have a warm milk. Read until u drift off. Distract ur thoughts" [Tab 14.76]

74. As well as dealing with the emotions triggered by the sexual assault, other matters related to her accommodation also had an impact upon Tahlia in the final days of her life. On 24 November 2015, she sent a text stating, amongst other matters, "I've completely ruined my life" [Tab 14.93].

75. With the benefit of adult reasoning and hindsight it is easy to see that Tahlia's life wasn't ruined in that moment. But from Tahlia's perspective these matters were distressing, as was a trial separation of her parents. At times of acute distress these problems assumed great significance for Tahlia and her functioning fluctuated accordingly.

Events in the final hours of Tahlia's life

76. Even having read and heard all the evidence the Court cannot know what triggered Tahlia's final actions on the evening of 28 November 2015. Her conduct earlier that day gave little indication that things would later change so quickly and so finally for Tahlia.

77. Tahlia spent time with her cousin and paternal grandfather. She made plans to spend the next day with her friend Kirilee. She arranged to come home to Taralga to do her washing and sent excited texts to her mother about the ripple cake she was baking.

78. Later in the evening Tahlia was in the common room watching movies with other students and nobody noticed anything amiss.

79. At about 9.22pm Tahlia rang her friend Kirilee (who she had planned to see the next day) but Kirilee could not hear properly and said she would call back later.

80. At 9.23pm Tahlia sent a message "Kiraa there is no minute, I'm going for good thank you for everything I love you" [Tab 11.7].

81. Kirilee then sent a message to a mutual friend who lived on the TAFE campus and asked him to search for Tahlia [Tab 11.9].

82. At 9.30pm Tahlia rang the Police Assistance Line. The audio of that call is in evidence at Exhibit 2. She asked to be put through to Detective Senior Constable Cooper at Wagga Wagga Police Station.

83. DSC Cooper was the officer investigating Tahlia's sexual assault. She had met Tahlia on 19 November 2015 and had rung Tahlia on 25 November 2015 to check on her welfare and discuss the case. Tahlia must have developed a level of trust and rapport with DSC Cooper (which reflects well on DSC Cooper) as reflected in the later phone call on 28 November 2015. Unfortunately this was a busy night at Wagga Police Station. DSC Cooper was patrolling in uniform and Tahlia's two attempts to contact DSC Cooper at Wagga Police Station via the Police Assistance Line went unanswered.

84. The inquest has also investigated whether Tahlia called either the Mental Health Access Line or Rape & Domestic Violence Services Australia but neither organisation has any record of Tahlia contacting them that year [Exhibits 3, 4 and 10]. It remains possible that Tahlia made an anonymous call to either service but there is no record of this in her mobile phone.

85. At 9.35pm Tahlia received a telephone call from another friend and then checked her voicemail.

86. At 9.41pm Kirilee received a text from Tahlia saying "I can't keep living like this" and in a telephone call that followed, Tahlia was crying and very upset. She said she had a rope tied around her neck and also tied to the balcony.

Kirilee, another friend Kerry and Kirilee's mum drove straight to the TAFE to look for Tahlia but unfortunately they were too late.

Self-inflicted death

87. Tahlia's history of suicidal ideation, her telephone call and texts to Kirilee and a letter later found in her room by police support the finding that Tahlia's actions were accompanied by an intent to end her life.

The importance of Aboriginal Health Workers

88. Tahlia was a young Ngunnawal woman yet she was not offered the assistance of an Aboriginal Health Worker because that service was not available to the Sexual Assault Service at Wagga in 2015. It must be frustrating, at the least, for Aboriginal clients to have to wait until a 'policy' permits or prompts non-Aboriginal workers to offer such referrals.

89. Non-Aboriginal people can probably never understand the importance of offering the help of Aboriginal Health Workers to Aboriginal clients. The health bureaucracy can be difficult to navigate for any client who is ill, anxious and unfamiliar with the terminology, the process and the health professionals themselves. This is often compounded for Aboriginal clients, particularly for a 17 year old young woman like Tahlia with a background of trauma and the recent ordeal of having endured sexual assault.

90. Aboriginal Health Workers have the potential to provide an invaluable service to their community and to the health professionals working with Aboriginal clients. Whilst Aboriginal Health Workers do not provide counselling, they help target referrals and follow up to other services; they help clients negotiate the system and they provide support in a way that is culturally appropriate.

91. As Ms Jackie Jackson (Manager for Aboriginal Health Services for SNSWLHD) emphasised in her oral evidence, Aboriginal clients should be offered the support of an Aboriginal Health Worker but may chose not to take up the offer.

92. The Court cannot know in Tahlia's case whether offering an Aboriginal Health Worker would have changed the ultimate outcome. It is a significant and welcome development that such workers are now able to be called in by SAS workers when an Aboriginal client wants an Aboriginal Health Worker involved (typically and understandably, a female Aboriginal Health Worker is preferred by female clients). This is now available in each of the Local Health Districts previously involved in Tahlia's case.

Other changes since Tahlia's death

93. Wagga SAS and Goulburn SAS have each amended their procedures for referring clients to, or receiving clients from, another SAS. This is a sensible development that has arisen from the Clinical Review conducted after Tahlia's death.

94. Wagga SAS now provides referrals/handovers orally and via email. They have adopted the practice of requiring a delivery and read receipt when referring a

client to another SAS and in the email referral ask the other service to confirm that the referral has been accepted. They also ask for details of the current plan for follow up with the client [Tab 27.46].

95. Goulburn SAS has developed a compliance procedure to apply to the receipt of a referral from another SAS. This document contemplates that referrals might be made orally, but Ms Richens said in oral evidence as a matter of practice SAS workers usually request follow up in writing. The procedure provides that "The SAS will inform the referring agency when contact has been made with the client and this will end any formal contact between the referring agency and the SAS unless there is an ongoing clinical reason to continue maintaining contact" [Exhibit 7, Annexure "D", page 2].

96. These changes to practice in Wagga and Goulburn will hopefully prevent any repetition of the problems in Tahlia's case, at least within those districts. Query though, how other Local Health Districts within New South Wales manage their own local procedures for referrals between SAS and across Local Health District lines. To this end it seems sensible for these coronial findings to be used in an appropriate state wide forum to prompt discussion about how individual SAS manage referrals. In oral evidence Ms Louise Fox (General Manager of Ambulatory and Integrated Care for SNSWLHD) identified a quarterly meeting (known as the the VAN Senior Executives Advisory Group Meeting) which would provide an appropriate forum to discuss referral practices between all SAS within the state.

97. As outlined above, since Tahlia's death each of the relevant SAS have introduced the use of a Suicide Risk Assessment Guide contained within "NSW Health Framework for Suicide Risk Assessment and Management for NSW Health Staff."

98. Within the SNSWLHD governing the Goulburn SAS, this "tool" was introduced in February 2018 and its use will be reviewed after a three month trial [Exhibit 8.19].

99. Staff at Wagga SAS who are now using the tool or guide have reported that the threshold for referring clients to mental health services for assessment has been lowered. A similar result might be anticipated in Goulburn. Should this eventuate it is foreseeable that an increase in the number of clients being referred to the Mental Health Access Line for assessment, and possible follow up in the community, will have a commensurate effect on resources within those services. This potential flow on effect needs to be included in any review undertaken at the end of the three month trial period.

100. The SNSWLHD also expect to trial a Central Intake System to provide "a 24 hour 1800 number that clients across sexual assault services, domestic violence services and child protection services, can call" [Tab 29.8].It is said that "the idea is that in crisis situations, the 1800 number will be staffed 24 hours, so that there is an immediate crisis response" [Tab 29.8].

101. It will be observed that an immediate crisis response was already part of the SAS at Wagga (where Natasha Spokes was called in during the early hours of the morning) and Goulburn (where Natasha Spokes attempted to speak to the on-call worker via contact with the Emergency Department at Goulburn Hospital).

102. The Central Intake System will have wider responsibilities than the on-call workers with the SAS. The Central Intake System worker will have responsibility for domestic violence and child protection services as well as sexual assault services. There is the potential this might lead to a delay in clients, or services such as Police or other SAS, speaking to a local SAS worker if their call has to proceed via the Central Intake System. This potential unwanted effect should be kept in mind as the Central Intake System is introduced and monitored. I will make a recommendation to that effect.

103. In closing I would like to thank my counsel assisting, Ms Donna Ward and her instructing solicitor, Ms Kate McCrossin for the enormous effort they have put into this case. I would like to thank the officer in charge, Senior Constable Mick Flynn.

Conclusion

104. Tahlia's death was a tragedy. She came from a close and loving family and there could be no doubt that Tahlia knew that she was loved. This knowledge, I hope, gives her family some comfort.

105. Tahlia's father, Tim, spoke on behalf of the family when he said, "the world has lost a beautiful soul". After hearing from Tahlia's parents, I believe that to be true. I am so sorry.

Findings required by s.81(1)

As a result of considering all of the documentary evidence and the oral evidence given at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

The identity of the deceased

The person who died was Tahlia Peden.

Date of death

She died on 28 November 2015.

Place of death

She died at Goulburn TAFE, Goulburn, NSW.

Cause of death

Hanging.

Manner of death

Tahlia tied a rope around her neck and suspended herself from a railing with the intention of ending her life.

Recommendations

Pursuant to s.82 of the *Coroners Act 2009*, Coroners may make recommendations connected with a death. The Clinical Review following Tahlia's death, with input from Mrs Peden, identified and led to change in important areas. Thus, the scope of recommendations is narrowed because of the sensible amendments to practice that have already been made as outlined above.

Three areas remain for consideration and recommendations will be made as follows:

1. That the Southern NSW Local Health District and Murrumbidgee Local Health District raise for discussion at the VAN Senior Executives Advisory Group Meeting procedures for SAS client referral from district to district and for that purpose, a copy of these findings be provided to attendees to facilitate discussion.

2. That a copy of the coronial findings be provided to the NSW Health Team at the Joint Investigation Response Team (JIRT) Referral Unit (JRU) to consider clarification around reference to time frames in JRU documents that are referred to a NSW Health Service.

3. That a copy of the coronial findings be provided to any committee overseeing the introduction of the Central Intake System and the audit of the use of the suicide risk assessment tool within the Southern NSW Local Health District with a view to ensuring that the proposed changes do not lead to any increased delay in client's accessing SAS or mental health services within the District.

I close this inquest.

Teresa O'Sullivan
Deputy State Coroner
Glebe

Date: 30 April 2018