IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 002333

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the ***Coroners Act 2008***

Findings of:	Judge John Cain, State Coroner
Deceased:	Madeline Howe
Date of birth:	29 November 1998
Date of death:	8 May 2019
Cause of death:	1(a) Complications of neck compression in the setting of partial suspension
Place of death:	80 Witt Street, Benalla, Victoria, 3672
Keywords:	Suicide; Family violence

Aboriginal and Torres Strait Islander readers are advised that this content contains the name of a deceased Aboriginal person.
Readers are warned that there may be words and descriptions that may be culturally distressing.

INTRODUCTION

1. Madeline Howe was a 20 year old Aboriginal woman who passed on 8 May 2019, when she was discovered hanging in a bedroom within her grandparent's residence in Benalla. At the time of her passing, Madeline was living with her maternal grandparents. Madeline was one of five children born to parents, Chantel Howe and Damien Howe. Madeline's siblings include Courtney Howe, Chelsea Howe, Lachlan Howe[1] and Joshua Howe[2].

2. Madeline enjoyed a close relationship with her siblings and spent time growing up in Violet Town before the family moved to Benalla.

3. Madeline's parents separated in early 2015 and Ms Howe took Madeline, Chelsea and Lachlan to live with their maternal grandmother. Following the separation, Madeline and her siblings initially remained with Ms Howe, although Lachlan then moved to live with his father from time to time.

4. The available evidence from services and family indicates that Madeline was adversely affected by the separation and after leaving high school Madeline moved to Queensland to reside with her sister, Chelsea.

5. Madeline returned to Victoria on the day of her younger brother Lachlan's passing as she was scheduled to attend her sister's debutante ball. Following Lachlan's passing, Madeline remained in Victoria and resided with her maternal grandparents. Madeline struggled with her brother's death and was referred to several mental health services and attended a private psychiatrist.

6. In the period leading up to the fatal incident Madeline was employed casually with a local business trading as '*Spray Line'* as part of an Aboriginal Employment Traineeship program with Victoria Police.

THE CORONIAL INVESTIGATION

7. Madeline's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

[1] Lachlan is the subject of a separate and recent coronial investigation COR 2018 2344.
[2] Joshua passed away shortly after birth due to a brain haemorrhage.

8. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

9. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

10. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Madeline's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

11. This finding draws on the totality of the coronial investigation into the death of Madeline Howe including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[3]

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

Circumstances in which the death occurred

12. On 8 May 2019, after work Madeline and her colleague Ms Laura O'Connor attended Madeline's grandparents' home where they made two recordings, the final recording was at 2.20pm which showed themselves laughing and jumping around Madeline's bedroom.

13. After Ms O'Connor departed sometime between 3.00-3.30pm, Madeline fashioned a ligature from two belts and hung herself from her wardrobe door. Madeline's grandparents discovered her at 3.50pm and called emergency services.

[3] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

14. Ambulance paramedics arrived at 4.41pm and an air ambulance helicopter was called in to transport Madeline to Benalla airport. At 6.33pm, paramedics at Benalla airport were unable to revive Madeline. Madeline was pronounced deceased at 6.35pm.

Identity of the deceased

15. On 8 May 2018, Madeline Howe, born 29 November 1998, was visually identified by her former employer, Senior Sergeant Mark Byers.

16. Identity is not in dispute and requires no further investigation.

Medical cause of death

17. Forensic Pathologist Dr Heinrich Bouwer from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on 9 May 2019 and provided a written report of her findings dated 18 June 2019.

18. The external examination revealed the following:

    a) There was an abraded mark about the upper neck with a suspension point situation on the left side behind the ear, consistent with partial suspension with a belt around her neck attached to a door knob; and

    b) Post-mortem CT scans showed marked brain swelling with loss of grey/white differentiation, consistent with hypoxic ischaemic encephalopathy. There was no intracranial haemorrhage or skull fracture. The hyoid bone was intact. There was a small right-side pneumothorax in the setting of post paramedic cardiopulmonary resuscitation.

19. Toxicological analysis of post-mortem samples identified the presence of morphine at low concentration level of 0.01 mg/L. All substances identified were not at concentration levels that impacted on the cause of death.

20. Dr Bouwer provided an opinion that the medical cause of death was 1 (a) Complications of neck compression in the setting of partial suspension.

FURTHER INVESTIGATIONS AND CORONER'S PREVENTION UNIT REVIEW

21. For the purposes of the *Family Violence Protection Act 2008*, the relationship between Madeline and her father was one that fell within the definition of '*family member*[4] under that Act. Moreover, Mr Howe's actions in perpetrating emotional abuse against Madeline in the lead up to the fatal incident constitutes '*family violence'*.[5]

22. In light of Madeline's death occurring under circumstances of proximate family violence, I requested that the Coroners' Prevention Unit (**CPU**)[6] examine the circumstances of Madeline's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[7]

Relevant family violence history

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

25. Child Protection were involved with Madeline's family on fifteen occasions following reports of family violence, welfare concerns and abuse. In response to most of these reports Child Protection closed their involvement with the family following little or no investigation of the allegations.

26. The most substantial involvement with the family occurred in April 2015, following allegations that Madeline, Lachlan and Chelsea were at significant risk of harm. At this time, Madeline was presenting as at high risk of self-harm. Investigations indicated that Lachlan had been placed into the care of his father, and that Madeline felt a heightened level of responsibility for his safety in Mr Howe's care. It was alleged that Mr Howe had perpetrated significant physical violence against Ms Howe, Chelsea, Madeline and Courtney in the past, including choking all

[4] Family Violence Protection Act 2008, section 8(1)(a)
[5] Family Violence Protection Act 2008, section 9
[6] The Coroners Prevention Unit is a specialist service for Coroners established to strengthen their prevention role and provide them with professional assistance on issues pertaining to public health and safety
[7] The VSRFVD provides assistance to Victorian Coroners to examine the circumstances in which family violence deaths occur. In addition the VSRFVD collects and analyses information on family violence-related deaths. Together this information assists with the identification of systemic prevention-focused recommendations aimed at reducing the incidence of family violence in the Victorian Community

of them, and that Madeline was afraid to return to Mr Howe's address for fear that he would '*hit her'*.[8]

27. As a result of the above allegations, Mr Howe was found responsible for harm and the allegations against him were substantiated. On 28 April 2015, an Interim Accommodation Order was issued placing Chelsea and Lachlan in the care of Ms Howe and noting conditions around Mr Howe's contact with them.

28. During Child Protection's involvement, they identified that Mr Howe '*could be contributing to some disrespect by Lachlan towards his mother and sisters'* and noted that Mr Howe showed '*no insight or accountability for the trauma his children have been exposed to'*.[9] Child Protection closed their involvement with the family on 30 November 2015 following their assessment that both Mr and Ms Howe and the children had formal and informal support networks that would reduce ongoing conflict, and that neither child had expressed feeling unsafe in either parents' care.

29. Child Protection were involved with the family on six occasions following this engagement. Most of these reports were closed without any significant investigation.

30. On the 9 March 2017, Child Protection received a report advising that unnecessary welfare checks had been conducted on Ms Howe at the request of Mr Howe. This report detailed concerns that Mr Howe '*continues to try to control the older children'*.[10] This report noted that Mr Howe had a history of perpetrating family violence towards Ms Howe and that Madeline's mental health was declining as a result of recent contact with her father. The notification also documented that Ms Howe was feeling '*stressed because the father is causing trouble'*.[11]

31. Following this report, Child Protection referred the family to ChildFIRST[12] and closed the matter, with practitioners noting that '*it is acknowledged that Lachlan's behavioural issues and lack of routine in schooling and Chelsea's lack of engagement with school may impact upon their well-being and development. Furthermore, the concerns raised for Mother's stress suggest that she may not be coping with the current stress of Father reportedly being*

[8] Department of Health and Human Services, Case Record of Lachlan Howe, 165
[9] Ibid, 298
[10] Ibid, 70
[11] Ibid, 71
[12] Child FIRST (Child and family information, referral and support teams) are an entry point into family services.

controlling.'[13] Child Protection concluded that it was hoped that the referral to ChildFIRST would reduce 'the likelihood of significant risk to their wellbeing'[14] in the future.

Proximate mental health treatment provided to Madeline in the lead up to the fatal incident

23. Madeline's mental health deteriorated from 2015 when her parents separated. Madeline engaged with North East Child Adolescent Mental Health Service (**NECAMHS**) Wangaratta from 2015–2017 in the context of suicidal ideation. Madeline briefly moved to Queensland before returning to Victoria in May 2018 just prior to her younger brother Lachlan's passing by suicide. Madeline saw a counsellor in October 2018 but declined further involvement.

24. On 21 January 2019 Madeline contacted North East and Border Mental Health Service (**NEBMHS**) Psychiatric Triage and was referred for an intake assessment. This was conducted on 4 February 2019 by Clinicians Tony North and Melina Gale[15]. Madeline reported that her mood had deteriorated over the eight months since Lachlan's passing. She reported poor sleep and appetite, feelings of hopelessness and helplessness, and ongoing suicidal thoughts with a plan and intent. Madeline reported having made suicide attempts in the previous weeks via overdose, hanging and running a car off the road. Madeline engaged in safety planning and agreed to call the mental health crisis line, emergency services or attended an emergency department if she felt unsafe. Madeline planned to continue paid employment and gave her medications to a friend named Rachel.[16] In addition, she agreed to self-refer to the Centre Against Violence (**CAV**),[17] obtain a psychologist referral via a General Practitioner (**GP**) Mental Health Care Plan (**MHCP**) and attend a psychiatrist review and ongoing weekly case manager reviews with NEBMHS.

25. On 6 February 2019 Clinician Gale called Madeline confirming her psychiatrist appointment for 11 February 2019. Madeline continued to adhere to the plan and gave her medications to Rachel and agreed to the appointment, later rescheduling to 18 February 2019 due to work. Madeline denied risk to herself and continued to partake in the safety plan.

---

[13] Department of Health and Human Services, Case Record of Lachlan Howe, 64

[14] Ibid, 64-65

[15] Northeast Border Mental Health Service community mental health records, pg.25.

[16] It was unclear if the plan documented during the intake assessment to surrender medication to Rachel was current/ongoing or once off to eliminate access to means by reducing the supply she had at that time.

[17] The Centre Against Violence offers free, specialist family violence crisis intervention services and short-term case management to all people, including LGBTQIA+ people and children, who are experiencing current family violence crisis.

26. On 18 February 2019 Psychiatrist Dr Pralay Mazumdar assessed Madeline with Clinician Gale and Rachel present. Madeline was assessed as reluctant to help-seek based on past experiences with mental health services. Her responses were monosyllabic with downcast gaze, and Rachel did most of the talking. Dr Mazumdar was aware of Madeline's trauma history and assessed that her functioning was disturbed with anhedonia,[18] social withdrawal and that she was crying during most of her appointments. Madeline reported feeling continually suicidal and guilty that she wasn't present when Lachlan passed. Dr Pralay Mazumdar made a plan to review Madeline again in one week and to consider commencing an antidepressant.

27. On 25 February 2019 Madeline was reviewed by Dr Mazumdar and reluctantly agreed to commence the antidepressant fluoxetine. She reported anger outbursts from minimal triggers. Dr Mazumdar wanted this monitored due to the family history of bipolar affective disorder.[19] Dr Mazumdar ceased the fluoxetine on 6 March 2019 due to side effects. Clinician Gale discussed possible antidepressant withdrawal symptoms with Madeline. Madeline denied any thoughts, plans, or intent to harm herself and remained in agreement with the safety plan and to see Dr Mazumdar in two weeks.

28. On 25 March 2019 Madeline called Clinician Gale and rescheduled her appointment with Dr Mazumdar to 1 April 2019. During the call Madeline reported ongoing low mood and suicidal thoughts with no plan or intent. She continued working, spent time with Rachel and remained engaged in her safety plan. Since ceasing fluoxetine she no longer had side effects of acute anger or irritability.

29. On 27 March 2019 Clinician Gale spoke to Rachel who reported her belief that Madeline was struggling with Lachlan's upcoming birthday on 31 March 2019. Clinician Gale attempted to contact Madeline, who did not answer or return her calls, then documented that Clinician Sue Hill would contact Madeline to assess risk in her absence.[20] There was nothing in the available records to suggest Clinician Hill followed up in Clinician Gale's absence.

30. On 1 April 2019 Madeline was reviewed by Dr Mazumdar. She was depressed, sad, and irritable following Lachlan's birthday. Madeline reported marked irritability and anger outbursts with suicidal thoughts on fluoxetine. Dr Mazumdar opined Madeline may have experienced a fluoxetine-induced hypomania and discussed with her the need for antidepressant therapy to

[18] The inability to experience pleasure from activities usually found enjoyable.

[19] Northeast Border Mental Health Service community mental health records, pg. 36.

[20] North East and Border Mental Health Service medical record pg.41.

treat her depression and a mood stabiliser to prevent a further episode. Madeline was commenced on the antidepressant mirtazapine and mood stabiliser sodium valproate.

31. On 2 April 2019, Rachel contacted Clinician Gale reporting Madeline had sent her a message saying she had overdosed. Madeline had one week's supply of sodium valproate and unknown amount of fluoxetine. Clinician Gale discussed the report from Madeline with Dr Mazumdar who suggested ongoing phone contact with Madeline as previously arranged without further follow-up or changes to her management plan.[21]

32. At 1.30pm on 3 April 2019, Madeline returned Clinician Gale's call and reported taking an unspecified amount of fluoxetine and sodium valproate. She denied any adverse effects and reported it had been her plan all along and "*I knew I wasn't going to be able to overdose properly on that medication*".[22] Madeline was unable to articulate the reason for overdosing and denied current plans or intent to act further. The safety plan was reviewed including escalation pathways and crisis contacts. The plan was further discussed and agreed with Dr Mazumdar. Madeline agreed to initiate contact with the team if required.[23]

33. On 8 April 2019, Clinician Gale called Madeline who reported ongoing suicidal thoughts with no plan or intent and stated she was safe because she was too tired to act on the thoughts. Distraction techniques were discussed and agreed upon. Madeline stated that she was picking up her medication that day and denied having access to any other medication or future plans to overdose. It was unclear if Madeline was picking up the medication from Rachel or the pharmacy.

34. On 15 April 2019, Madeline was physically unwell so she was reviewed telephonically by Clinician Gale. Her mood was reported as not improving despite taking medication as prescribed. Madeline did not report suicidal thoughts, plans or intent and discussed plans for the Easter holidays. She remained engaged in her safety plan and was reportedly aware that Clinician Gale was going on leave and that Registered Nurse (RN) Emma Morris, reportedly also aware of the arrangement, would follow up in her absence.[24]

35. On 23 April 2019 Madeline was reviewed by Dr Mazumdar and Clinician North. Dr Mazumdar assessed that Madeline looked better and was forthcoming and reactive when describing a

[21] North East and Border Mental Health Service medical record pg.43.
[22] North East and Border Mental Health Service medical record pg.43.
[23] North East and Border Mental Health Service medical record pg.43.
[24] North East and Border Mental Health Service medical record pg.48.

recent camping trip. Madeline reported less anger and fewer suicidal thoughts. She was adherent with medication, and her sleep and appetite had improved. The sodium valproate prescription was increased and a review with Dr Mazumadar was set for five weeks. This was the final contact NEBMHS had with Madeline.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

Adequacy of proximate mental health treatment provided to Madeline

36. Madeline had a significant history of trauma including childhood abuse, family violence and her brother's passing by suicide. Madeline was diagnosed with depression and was being monitored for signs of bipolar affective disorder. Madeline had a long history of involvement with mental health services for chronic suicidal thoughts with fleeting plans and intent that she had acted on.

37. Madeline's access to psychological counselling beyond that provided by NEBMHS is unlikely to be a source of any prevention opportunity. Access to further psychological counselling may not have had a preventative impact in this case as NEBMHS engaged Madeline in appropriate safety planning during their engagement with her.

38. Madeline's treatment plan included weekly engagement with her case manager that facilitated monitoring and continued assessment of her engagement in safety planning, allowing for Madeline to remain in the community with the ability to identify the need for escalation of care.

39. The available evidence suggests that the treatment plan was not followed in Madeline's case manager's leave of absence for unknown reasons. This was a time when it would be reasonable to expect support in the lead-up to the anniversary of Lachlan's passing. Madeline's treating clinicians did not document a change in the treatment plan or rationale for this change or to monitor the commencement of new medications for side effects, efficacy and potential antidepressant induced hypomania.

40. NEBMHS have reviewed the care provided to Madeline in the lead up to her passing and made reasonable changes to facilitate better continuity of care for their patients. In the circumstances

of this case, I make no adverse finding in relation to the treatment provided by NEBMHS to Madeline.

The significant impact of family violence on children and young adults

41. Madeline and her siblings were alleged to have witnessed incidents of violence perpetrated by Mr Howe against Ms Howe as noted above. Mr Howe is also alleged to have perpetrated emotional and physical abuse against Madeline and her siblings. In a statement to police, Lachlan's eldest sibling advised that Mr Howe was '*always verbal'* towards the children and would '*belittle'* and make the children '*feel worthless'*.[25]

42. There has been significant research into the impacts of childhood exposure to family violence. The Royal Commission into Family Violence (RCFV) report outlined the serious short and long term effects that family violence can have on the health and wellbeing of children and young people, noting that the effects may be '*acute and chronic, immediate and accumulative, direct and indirect, seen and unseen'*.[26]

43. In their report, the RCFV advised that children exposed directly or indirectly to violence '*can suffer from a variety of physical, emotional and mental health effects including depression, anxiety, low self-esteem, impaired cognitive functioning and mood problems'*[27] and are more likely to suffer '*learning difficulties, trauma symptoms and behavioural problems'*.[28]

44. Research has indicated that even when a child is not directly exposed to violence, they can still experience significant impacts on their health and wellbeing and exhibit behavioural, mental health and social problems.[29] Young people exposed either indirectly or directly to family violence were also found to experience similar consequences, with correlations found between exposure to family violence and unemployment, mental health issues and homelessness in adolescence and adulthood.

45. Additionally, research undertaken by Lifeline found that people who experience family violence are 4.5 times more likely to attempt suicide than the general population. The desire of a victim survivor to find a "*way out*" reduced coping capacities, isolation and the far reaching

[25] Coronial Brief, Statement of C Howe, 74
[26] North and West Regional Children's Resource Program, '*Through a Child's Eyes: Children's Experiences of Family Violence and Homelessness'* (2013) 4.
[27] The Royal Commission into Family Violence, *Children and young people's experience of family violence,* 107.
[28] Ibid.
[29] Family Court, *Exposure to family violence and its effect on children,* < http://www.familycourt.gov.au/wps/wcm/connect/fcoaweb/reports-and-publications/publications/family+violence/exposure-to-family-violence-and-its-effect-on-children>.

psychological and emotional effects of family violence have been identified as factors contributing to the heightened level of suicidal behaviour amongst individuals who have experienced family violence.[30]

46. Western Australia's Ombudsman recently reported that of the 124 women and children who passed by suicide in Western Australia between 1 January 2017 and 31 December 2017 68 were identified as having experienced family violence.[31] While the report acknowledged that the link between family violence and suicide is under-researched, a systemic review of available research found that '*irrespective of method, sample and measurement of [intimate partner violence/abuse] and suicidality'* there is a '*degree of consistency in findings across these studies confirm[ing] a strong relationship between [intimate partner violence/abuse] and suicidality*'[32] and noted that '*intimate partner abuse [is] a significant risk factor for suicidal thoughts and behaviours'*.[33]

FINDINGS AND CONCLUSION

47. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Madeline Howe, born 29 November 1998;

    b) the passing occurred on 8 May 2019 at 80 Witt Street, Benalla, Victoria, 3672, from 1(a) Complications of neck compression in the setting of partial suspension; and

    c) the passing occurred in the circumstances described above.

48. A finding of suicide can impact upon the memory of a deceased person and can reverberate throughout a family for generations. Such a finding should only be made on compelling evidence, not indirect inferences or speculation. It is often difficult to determine what may have precipitated a decision to end one's own life. There are sometimes issues known only to the deceased person and sometimes events in the person's life suggest a reason.

[30] Lifeline, *Submission to the RCFV into Family Violence* (Australia; 29 May 2015).
[31] Western Australian Ombudsman, *Investigation into family and domestic violence and suicide*, (October 2022), < chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.ombudsman.wa.gov.au/Publications/Reports/FDV-Suicide-2022-Volume-1-Ombudsman-Foreword-and-Executive-Summary.pdf>.
[32] Ibid, 24
[33] Ibid, 30

49. The available evidence suggests that Madeline was significantly affected by the family violence that resulted in her parents' separation and the recent passing of her younger brother. Any suicide is a tragedy, suicide of a young adult is particularly devastating because they have such enormous untapped potential.

50. I find that in circumstances suggesting significant emotional trauma, Madeline intended to end her life.

51. I convey my sincere condolences to Madeline's family for their loss. I acknowledge the grief and devastation that you have endured as a result of your loss.

52. Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

53. I direct that a copy of this finding be provided to the following:

Ms Chantal Howe, Senior Next of Kin

Mr Damian Howe, Senior Next of Kin

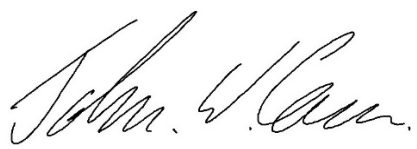
Mrs Jenny Ellix, Albury Wodonga Health North East & Border Mental Health Service

Ms Lisa Waite, Executive Director of Clinical Services, Benalla Health

Dr Neil Coventry, Chief Psychiatrist, Office of the Chief Psychiatrist

Detective Senior Constable Yvette Taylor, Coroner's Investigator

Signature:



Judge John Cain
STATE CORONER
Date:11 January 2024

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an

investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.