CITATION: *Inquest into the death of* Xysz Tacdliwaazy @ Josh Ngalarina @ Mayinaj [2024] NTLC 3

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| TITLE OF COURT: | Coroners Court |
| JURISDICTION: | Darwin |
| FILE NO(s): | D0030/2022 |
| DELIVERED ON: | 5 April 2024 |
| DELIVERED AT: | Darwin |
| HEARING DATE(s): | 19 – 22 September 2023 |
| FINDING OF: | Judge Elisabeth Armitage |
| **CATCHWORDS:** | **Death in care, sudden death volatile substance inhalation (butane and propane) Volatile Substance Abuse (VSA), deodorant, mental health outliers, inadequate training of non-mental health staff** |

**REPRESENTATION:**

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| Counsel Assisting: | Chrissy McConnel |
| Counsel for Department of Health: | Tom Hutton |
| Counsel for the family of the deceased: | Avelina Tarrago |

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| Judgment category classification: | B |
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| Number of paragraphs: | 85 |
| Number of pages: | 29 |

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

No. D0030/2022

In the matter of an Inquest into the death of

**XYSZ TACDLIWAAZY @ JOSH NGALARINA @ MAYINAJ**

**ON: 31 JANUARY 2022**
**AT: ROYAL DARWIN HOSPITAL**

**FINDINGS**

Judge Elisabeth Armitage

## Introduction

1. On 19 January 2022 Ngalarina[1] was involuntarily admitted as a patient to the Royal Darwin Hospital (RDH), under s 39 of the *Mental Health and Related Services Act 1988 (NT)* (MHARS Act). On admission the On-Call Psychiatry Registrar documented an impression of: "*Behavioural disturbance in context of VSA [Volatile Substance Abuse] DDX [differential diagnosis] relapse schizoaffective disorder, requires admission to further assess and contain risk of harm to self and others, misadventure*".

2. Less than two weeks later Ngalarina was found unresponsive in a bathroom on a general ward. An empty can of deodorant was found next to them. Resuscitation attempts were unsuccessful and Ngalarina was declared deceased. The deodorant, a volatile substance, had been purchased earlier that day from the RDH pharmacy. The known risks of VSA and misadventure which had been identified on admission were, tragically, realised. Ngalarina was just 22 years of age when they passed away.

[1] As to the name and pronouns see [6] and [7] of these findings.

3. As Ngalarina was an involuntary patient when they passed away, they were a '*person held in care'* and an inquest was mandatory.[2]

4. The Department of Health (NT Health) considered that Ngalarina's passing was a '*sentinel event'*, that is, an event where something preventable goes wrong with a patient's care which causes the serious harm or death of a patient. NT Health acknowledge that there was an absence of clear procedures to guide staff in managing mental health patients in general wards. This omission was considered to be a *'root cause'* of their passing. NT Health frankly concede that Ngalarina's passing was preventable.

5. Ngalarina's parents are Jason Mayinaj from Wurruwi of the Yalama clan and Averly Wakuranhawuy from Milingimbi of the Gupapuyngu clan. Ngalarina referred to themselves as part Yolngu, they spoke Yolngu, and followed their father's clan. Ngalarina had a sister and two brothers. The family spent most of their lives residing between Milingimbi and Goulburn Island (Warruwi). When Ngalarina attended the Milingimbi School they lived with their grandparents in Milingimbi Community. When they were little they were healthy, eating bush foods, fruit and milk. At home, the family enjoyed camping on the beach and collecting mussels, spearing stingray, and cooking damper and kangaroo tail. The family made woomera and spears and told the stories of the old people and the song lines. Later Ngalarina attended school in Darwin as a boarder. Ngalarina spoke excellent English and was a bright student.

6. The history of Ngalarina's name and name changes is not entirely clear. I understand Ngalarina was called Josh Ngalarina at home. In about 2017 it seems they changed their name to Xysz when they came out as *yappa*, meaning sister not brother. The current birth certificate has Ngalarina registered as Xysz Yiyujaa Tacdliwaazy born 21 March 1997. The medical records from Miwatj Community Health Centre (Milingimbi Clinic) have Ngalarina

[2] *Coroner's Act (NT),* ss12, 15(1).

recorded as Xysz Mayinaj. Royal Darwin Hospital records have them recorded as Josh Ngalarina. Ngalarina's Facebook profile was Xysz Yiyujaa Tacdliwaazy which was registered to Josh Mayinaj.

7. Although born a biological male, sometimes Ngalarina wore feminine clothing. On those occasions they asked to be called *yappa* or sister. At other times Ngalarina wore masculine clothing and asked to be called *wawa* or brother. Some family members from the Yolngu side of the family considered Ngalarina a '*sistergirl*'. However, Ngalarina's mother generally considered Ngalarina male and called them Josh. In the absence of direct evidence concerning Ngalarina's gender or which pronouns might be most appropriate, in a genuine effort to respect both Ngalarina's mother's position and Ngalarina's apparent gender-fluidity, all the interested parties were consulted and agreed to use they/them pronouns throughout the inquest and to use the gender neutral and culturally acceptable name, Ngalarina.

**A history of mental health issues and Volatile Substance Abuse (VSA)**

8. Although Ngalarina enjoyed a happy family life, after they left school they started using substances and, according to the family, '*running amok'*. They became aggressive and caused trouble in community. At about the same time it also became evident that Ngalarina was experiencing challenging mental health issues. In October 2014, when Ngalarina was 17, a Milingimbi Clinic General Practitioner referred them to the East Arnhem Mental Health Service (EAMHS). Ngalarina was describing auditory hallucinations and held a fixated delusion they were pregnant. They were seen by a psychiatrist on 29 October 2024 and diagnosed with *"Cannabis induced psychosis on a background of multiple stressors"*. They were originally treated with BD Olanzapine and Risperidone, however, due to non-compliance, Depot Paliperidone was recommended, but refused. Ngalarina continued to be followed up in the community until about May 2015 when it was reported they

had shown a marked improvement. In June 2015 Ngalarina was removed from active follow up.

9. In January 2017, Ngalarina was seen petrol sniffing in Warruwi. When police attempted to speak with Ngalarina they refused medical treatment, denied any substance abuse and are reported to have become abusive and irrational towards police, medical staff and their parents. Police applied for a VSA assessment under the *Volatile Substance Prevention Act 2005 (NT)* and family were reportedly very supportive of Ngalarina receiving education and treatment. It is not clear what VSA assistance was provided, if any.

10. On 25 January 2017, Ngalarina was brought to the Warruwi Clinic by police and assessed as suffering from an acute psychosis with associated VSA. They were involuntarily admitted to the Joan Ridley Unit (JRU) at RDH, accompanied by their grandmother. The JRU is a secure inpatient facility which accommodates adults with acute psychiatric problems.

11. On 30 January 2017, they were transferred to Cowdy Ward, a lower acuity mental health ward, and absconded that same day by jumping the fence. They returned to Warruwi Community where they were treated with anti-psychotics. On 21 February 2017, Ngalarina was assessed by a VSA Assessor in Warruwi with family present.

12. There followed several involvements between the Warruwi Clinic, the police and Ngalarina as a result of VSA and irrational behaviours. Sadly, Ngalarina was reportedly well known for '*sniffing*', and encouraging others (including children) to inhale volatile substances. Antipsychotic medication was recommended given Ngalarina's persistent VSA.

13. On 30 March 2017, a Remote Area Nurse attended Ngalarina's home for an unrelated medical matter and was informed by family members that Ngalarina had been sniffing aerosol cans. The nurse contacted police requesting a VSA

notification and the next day the police submitted an application for VSA treatment.

14. On 4 April 2017, a VSA Assessor spoke to Ngalarina's mother by phone and Averly reported her concerns for Ngalarina. The VSA assessor arranged for police to take Ngalarina to the clinic. Ngalarina was very unwell and involuntarily sectioned under the MHARS Act with an ongoing belief that people with magical powers wanted to suck their blood and kill them. They were evacuated to RDH, initially diagnosed as suffering from a drug induced psychosis, and admitted into JRU. During this period of hospitalisation Ngalarina was violent towards staff and engaged in serious self-harm by lacerating their throat with clinical scissors. Ngalarina was given a differential diagnosis of Schizophrenia/Schizoaffective Disorder and it was unclear whether this presentation was substance induced.

15. On 1 and 2 May 2017, Ngalarina was reportedly settled and engaging well with nursing staff. The family thought Ngalarina should go to rehabilitation and felt they lacked the knowledge to manage their mental illness. Even so, on 3 May 2017 Ngalarina was discharged and returned to community. They almost immediately re-engaged in VSA (petrol sniffing). Shockingly, in the early hours of the following day Ngalarina was brought to the clinic by distraught family members, having self-castrated one testicle during an episode of hallucinations. Ngalarina suffered significant blood loss and life threatening haemorrhagic shock. They were sectioned under s 34 of the MHARS Act and medically evacuated to RDH for emergency surgery resulting in the removal of a testicle. Ngalarina was then involuntarily admitted under s 42 of the MHARS Act. On 5 May 2017 they attempted to abscond from the hospital.

16. On 6 May 2017, they were admitted to JRU. On 10 May 2017, they asked a nurse for aerosol but a Senior Nurse on shift directed that it "*should never be given to them*". At 11.15am Ngalarina absconded JRU by climbing the fence.

They were found by their mother at Casuarina and returned to RDH by police. Over the next few days their behaviours were unpredictable and their medical records document their *"high potential to abuse deodorants"*. VSA rehabilitation was discussed on 16 May 2017, but Ngalarina was reportedly not interested in rehabilitation.

17. On 22 May 2017, Ngalarina again absconded from JRU. Their mother advised they were at an Aunt's place in Darwin. Police located them and returned them to JRU on 23 May 2017. They gradually improved with depot medication and on 31 May 2017, the Mental Health Tribunal placed Ngalarina on a Community Management Order (CMO) of 6 months duration[3] and discharged them from JRU. On discharge their diagnosis was Schizophrenia which was to be managed by 200mg Zuclopenthixol depot. They returned to Warruwi, with planned community follow-up. The family said they did not receive much education about their illness and just knew that Ngalarina needed their injections.

18. After returning to the community they experienced better health. Although they continued to use cannabis, there was a period of no reported VSA, and a VSA Treatment Order was no longer considered necessary.

19. This situation sadly changed when, on 15 March 2020, Averly told the Warruwi police that Ngalarina had located a jerry can of unleaded petrol and was sniffing it with children in the community. The next day police submitted an application for a VSA assessment. Due to COVID-19 related travel limitations the VSA assessor relied on clinic staff to follow up possible rehabilitation with Ngalarina. They were reportedly ambivalent towards rehabilitation. After collateral checks in the community suggested there were no ongoing VSA issues, on 25 May 2020 the VSA assessor found there was no severe risk of harm and a treatment order was refused.

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[3] The CMO was repeatedly extended and Ngalarina was still on a CMO as at 19 January 2022.

20. In early 2021 Ngalarina was living in Darwin and was largely compliant with their CMO. In September they travelled to Milingimbi with family for sorry business. On 2 December 2021, Ngalarina was found sniffing and taken to the Milingimbi clinic. A police officer submitted an application for a VSA assessment, the fourth volatile substance abuse report submitted since 2017.

21. On 9 December 2021, a VSA assessment was conducted. Ngalarina was identified as being at risk of severe harm from volatile substances due to their history of VSA induced psychosis and also at risk of accidental death or injury. The Chief Health Officer advised that they were to be monitored and supported by the Miwatj Health Aboriginal Corporation Mental Health /AOD/ VSA team in Milingimbi and recommended that they be referred for voluntary residential rehabilitation. There is no evidence that Ngalarina ever voluntarily attended residential rehabilitation and they were never mandated to attend under the *Volatile Substance Abuse Prevention Act*.

22. A final application for a VSA assessment was made by Milingimbi police on 12 January 2022, in response to fresh reports that Ngalarina continued to engage in volatile substance abuse.

23. It is against this lengthy and recent background of mental health and VSA issues, which were well documented, that I now consider Ngalarina's final involuntary admission into care.

**Circumstances surrounding the death**

24. At around 9am on 19 January 2022, Milingimbi police were tasked to attend the Milingimbi Clinic for an unrelated matter. Whilst at the health clinic, they were approached by the nursing staff who expressed concerns for Ngalarina who was present, aggressive and agitated. The staff advised that Ngalarina's mental health had been declining over the last few days (since the final application for VSA assessment) and a Duty Medical Officer (DMO) had authorised their transport to RDH for psychiatric examination. CareFlight was

to take Ngalarina to RDH and Police were asked to stay and monitor Ngalarina because of their agitated state. At 4.30pm, police assisted the health clinic staff to take Ngalarina to the airport for Careflight transfer to RDH. Ngalarina was sedated to manage their behaviour during the flight. The clinic hand-over notes documented *"VSA over the past few weeks"* which was *"denied"* by Ngalarina.

25. On arrival at RDH, Ngalarina was assessed by a nurse at 7.15pm who recorded *"volatile substances"* as part of their alcohol and drug history, and *"Psychosis-volatile substance"* in their past medical history. Ngalarina's vital signs were taken and recorded, and an ECG was performed. No physical illness was identified. Later that evening, Ngalarina was reviewed by the On-Call Psychiatry Registrar, who noted (amongst other things) the background history of VSA. It is documented that they presented as suffering from disorganised thought, religious themes and sexual delusions as well as reporting special powers. They were admitted to RDH as an involuntary patient under s 39 of the MHARS Act. The order was in place for a period of 14 days and was due to expire on 2 February 2022. In the Emergency Department (ED), the escalation in their behaviour was of such concern that a direct admission to the JRU was indicated but, as there was no bed immediately available in JRU, Ngalarina was managed in ED for a time.

26. On 20 January 2022, as they were now admitted as an involuntary patient, the Senior Psychiatry Registrar suspended Ngalarina's CMO. Ngalarina was considered sufficiently calm and settled, likely because of sedation, to be transferred to Cowdy Ward instead of JRU. Later that day a psychiatric assessment by the Consultant Psychiatrist and Psychiatry Registrar (clinicians from the treating Top End Mental Health Service (TEMHS) Purple Team) could not be completed because Ngalarina was still affected by sedation. The Purple Team provides mental health services to patients who normally reside in East Arnhem Land and they were familiar with Ngalarina and their history.

27. On Friday 21 January 2022, Ngalarina was reviewed in Cowdy Ward by the Purple Team clinicians who were accompanied by a female Aboriginal Mental Health Worker at Ngalarina's request. The impression formed by the Purple Team was that Ngalarina was psychotic and suffering from grandiose and persecutory delusions. They were considered to be at high risk of harm to self and violence to others, and of moderate '*absent without leave'* (AWOL) risk. It was strongly recommended that they be transferred to JRU for the weekend with no ground leave. This was agreed to by the Cowdy Ward team leaders and, as a bed had become available in JRU, Ngalarina was promptly transferred. Plans for their treatment included graduating *"back to Cowdy later this week"*, and *"clarification of VSA"* and a referral to the VSA service, if required.

28. On Tuesday 25 January 2022, a multidisciplinary meeting was held and the Purple Team determined that Ngalarina could be trialled in Cowdy Ward for a few hours that day. However, before the trial took place, two patients in Cowdy Ward tested positive for COVID-19. Cowdy Ward was declared a COVID-19 red zone[4] and could not receive admissions, so Ngalarina remained in JRU. Ngalarina requested, and was given, their mother's phone number.

29. By 27 January 2022, Ngalarina's condition had further improved and they were considered ready for transfer to a less restrictive ward. However, because Cowdy Ward remained a red zone they remained in the more restrictive ward of JRU.

30. On 29 January 2022, as Cowdy Ward was still unavailable, Ngalarina was moved from JRU to the Youth Inpatient Unit (YIP) as a step-down clinical placement to a less restrictive ward, consistent with the least restrictive care principle.[5]

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[4] In accordance with the *COVID-19 Inpatient Unit TEMH AOD Service Operational Procedure.*

[5] *Mental Health and Related Services Act 1998,* s8(a).

31. As it transpired, however, COVID-19 imperatives resulted in YIP needing to become a red zone so that acutely ill mental health patients with Covid-19 could be admitted. To facilitate this, on 30 January 2022, steps were taken to transfer current patients in YIP to other wards. Ngalarina was one of the patients found suitable to be transferred to a general ward as they were considered to be progressing well, with a possible anticipated discharge on about 2 February 2022.

32. At 11.11pm on Sunday 30 January 2022, Ngalarina was transferred to a general ward, Ward 3A, as an '*outlier*'. An outlier is a mental health patient who requires mental health inpatient services but is allocated a bed in the emergency department or in a general ward because no beds are available in the appropriate mental health inpatient unit.

33. As they were still an involuntary patient, Ngalarina remained under security guard to prevent escape from the ward and to prevent harm to self or others. The security guards were not informed of Ngalarina's mental health status nor of any risks particular to them, such as those associated with VSA or their history of successful absconding or serious self-harm.

34. Ngalarina was received in Ward 3A by Nurse 1 who completed a *'Risk Admission/Discharge Tool'* (RADT). Nurse 1 recorded VSA in their medical history, however elsewhere, recorded petrol sniffing and cannabis as the only explicitly listed substances used by Ngalarina.

35. During the morning of 31 January 2022, the Senior Psychiatry Registrar reviewed Ngalarina and considered that they were doing well. Ngalarina's presentation, their suitability for '*ground leave'* and the possibility of discharge towards the end of the week were discussed with the Psychiatric Registrar, Purple Team. Based on her clinical judgement, the Senior Psychiatry Registrar approved 6 x 30 minute periods of leave within the hospital grounds, under supervision, and on conditions of "*no alcohol or illicit drugs"*.

36. On 31 January 2022, Security Guard 1 was rostered to monitor Ngalarina from 8am – 9.20pm. During this shift, five leave passes were granted and Ngalarina was escorted to the RDH smoking area for cigarette breaks.

37. CCTV footage shows that at 12.32pm, Ngalarina attended the RDH public pharmacy located on the ground floor. While under the supervision of Security Guard 1, Ngalarina purchased two Rexona body sprays/deodorants and a pair of nail clippers, paid for them with a Basic Card and placed them into their backpack before returning to Ward 3A. They were further escorted for smoking breaks during the afternoon. Security Guard 1 finished work at 9.20pm and was replaced by Security Guard 2.

38. At 9.23pm, Ngalarina requested and was escorted to the smoking area for a smoke break which took about 30-35 minutes. On return to the ward Ngalarina requested a towel to take a shower. Security Guard 2 gave them a towel and Ngalarina walked into the shower at about 10.08pm. Security Guard 2 waited outside the shower door and listened to the running water. After about 10 minutes Security Guard 2 knocked on the door but there was no response. Security Guard 2 waited another couple of minutes before he knocked again.

39. When there was still no response Security Guard 2 tried to slide the shower door open, but it was locked from the inside. Two nurses walked past and Security Guard 2 explained that Ngalarina had been in the shower for around 12 minutes. One of the nurses knocked on the door and after getting no response opened the door with scissors. The nurse found Ngalarina lying unconscious on the ground. The nurse called a *'Code Blue'*. The Emergency Response Team (ERT) attended and commenced and maintained cardio pulmonary resuscitation (CPR) for about 50 to 60 minutes. Tragically, Ngalarina could not be revived and was pronounced deceased at 11.20pm.

40. A Coroner's Constable was notified and attended. Upon arrival at Ward 3A, one of the nurses said that they located a Rexona body spray/deodorant inside the shower room. The Constable entered the shower room and was able to

smell Rexona spray inside the room. Blood was located under the toilet seat inside the shower and Ngalarina was observed to have a small laceration to the forehead. It is believed they hit their head on the toilet seat during a fall to the ground as a result of inhaling the body spray/deodorant.

**The autopsy**

41. On 1 February 2022, Forensic Pathologist, Dr Marianne Tiemensma, conducted an autopsy. As part of the procedure Dr Tiemensma received the can of Rexona from the shower recess which she noted was nearly empty, and the wet t-shirt Ngalarina had been wearing which she reported had *"an overpowering strong smell of deodorant, and multiple white patches visible, in keeping with sprayed deodorant".* The autopsy revealed no evidence of underlying heart or lung disease. However, features of acute respiratory failure were identified and the toxicological analysis confirmed the presence of butane and propane in the blood. Dr Tiemensma considered the cause of death was *"sudden death associated with volatile substance inhalation (butane and propane)".* In her evidence, Dr Tiemensma explained that every incidence of VSA gives rise to a risk of sudden death due to the possibility of it inducing:

   ◦ Cardiac arrhythmia, likely sensitising the myocardium (heart muscle) to the action of catecholamines, which leads to sudden death;

   ◦ Central nervous respiratory depression;

   ◦ Chemical effects, such as hypoxia and hypercapnia caused by persistent rebreathing of the solvent; and/or

   ◦ Vomiting, with risk of aspiration of stomach contents.

**Formal findings**

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

(1) The identity of the deceased is Xysz Yiyujaa Tacdiwaazy, born on 21 March 1997 at Darwin in the Northern Territory.

(2) The time of passing was at 11.30pm on 31 January 2022. The place of death was Ward 3A, Royal Darwin Hospital at Darwin in the Northern Territory.

(3) The cause of death was sudden death associated with volatile substance inhalation (butane and propane).

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

**Issues for the inquest**

43. Following the passing of Ngalarina, NT Health commissioned a Root Cause Analysis (RCA) which identified a number of serious deficiencies in relation to the care provided to Ngalarina which contributed to their passing. They included:[6]

- a lack of clear, standard procedures or pathways to provide guidance to non-mental health staff to assist them to safely manage mental health patients as outliers in general wards;
- only a limited handover was provided to the non-mental health staff who received Ngalarina and insufficient information was provided concerning key risks associated with their care, including supervision requirements;
- there was no standard operating procedure for Security Guards or Patient Care Assistants (PCA's) responsible for supervising mental health patients; and

[6] Affidavit of Dr Luke Butcher, dated 4 September 2023, [9].

- volatile substances were readily available on RDH grounds.

*The impact of COVID-19*

44. At the time of Ngalarina's admission, NT Health were responding to the COVID-19 (Omicron variant) wave of infections. In an effort to minimise the spread of the infection RDH was divided into zones which were continuously monitored and updated, as follows:

    - green zones for no COVID risk;
    - orange zones for close contacts of COVID positive persons; and
    - red zones for COVID positive patients.

45. On 25 January 2022, COVID positive patients were identified in Cowdy Ward, consequently, it became a red zone and could not accept patients. On 30 January 2022, although Cowdy Ward had transitioned to an orange zone, it still could not accept patients. The YIP and JRU were green zones but they were at maximum capacity and could not accept patients. When there are no mental health wards available to take patients, this is known as '*bed-block*'. Two COVID positive mental health patients required urgent admission and it was decided to activate YIP as a red zone for the TEMHS Inpatient Unit so that the acutely ill COVID positive patients could be accepted. However, to facilitate this the adult COVID negative patients located in YIP (as an alternative to Cowdy Ward which had not been accepting patients) needed to be relocated as outliers to general wards. Each of these patients, including Ngalarina, were considered to be low risk from a mental health perspective and were due for discharge within the next week.

46. In an effort to reduce the risk of COVID transmission, it was also decided that all the TEMHS outlier patients would be managed by one set of clinicians (Dr Lehmann-Waldau and Dr Shakelaar) rather than by their usual treating team (which in Ngalarina's case was the Purple Team). In hindsight, NT Health

identified that the COVID motivated change in the treating team likely contributed to the failure to recognise and manage Ngalarina's ongoing VSA risk.

***Management of mental health outliers in general wards***

47. Although COVID was the catalyst for Ngalarina becoming an outlier, the evidence established that it is common[7] for mental health patients to be cared for in general wards. Whenever the demand for mental health inpatient beds exceeds capacity, mental health patients are accommodated in ED and in general wards. I was disturbed to learn that demand almost always exceeds mental health inpatient bed capacity. On occasions I understand there have been upwards of 14 patients requiring a bed in a TEMHS Inpatient Unit, who were unable to be accommodated (no beds available) and so, like Ngalarina, were managed as outliers in ED or general wards. In the 2022/2023 financial year, shockingly the total number of days that RDH mental health patients spent as outliers was 1,392.[8]

48. As at 30 January 2022, the relevant guideline for nursing staff caring for outliers was the *Mental Health Outlier Patients in RDH General Wards Guideline*. NT Health frankly conceded that this guideline was deficient. Given the ongoing heavy reliance on outlier beds, and a history of issues of concern being raised by nursing staff[9], it is difficult to understand how there was an absence of clear and adequate guidelines for the safe management of TEMHS outliers.[10] NT Health considered that this failing was a root cause which contributed to Ngalarina's passing.

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[7] See for example Community Visitor Program Annual Report 2020/2021 p 26, Top End Inpatient Units are running at 120% capacity and there was an occasion when 18 people were waiting in the Emergency Department for admission.
[8] Affidavit of Dr Luke Butcher, dated 4 September 2023, [149].
[9] Transcript pp70-71
[10] Root Cause Analysis (RCA), NT Health Report, date approved 6 April 2023, para 1.4, p6.

***A failure to document, plan for, and mitigate the VSA risk***

49. As noted earlier, in the context of COVID-19 exigencies, during the afternoon of Sunday 30 January 2022 Ngalarina was identified as appropriate to be moved to a general ward. At 3.53pm the Operations Manager sent an email to Dr Luke Butcher, General Manager Top End Mental Health, Alcohol and Other Drugs Service, noting that Ngalarina's involuntary status would expire on 3 February 2022 and they were due for discharge on Tuesday or Wednesday. Although they were considered "*currently settled*" they remained a "*potential AWOL risk*" and *"would need a good PCA with excellent communication skills"*. However, their ongoing VSA risk was not mentioned in the email.

50. Later that afternoon the TEHMS On-Call Psychiatry Registrar prepared Ngalarina's *Management Plan for Mental Health Outliers* (Management Plan). The Registrar had a large case load, and did not have a comprehensive knowledge of Ngalarina's clinical condition so relied on medical records to complete the Management Plan. Accepting those circumstances, while the Management Plan continued leave restrictions and documented the requirement for a 1:1 Patient Care Assistant (PCA), it was incomplete, and failed to document or address any of the other known risks, such as VSA, the serious history of self-harm or the history of successful absconding. On its face the Management Plan, which is extracted below, appears cursory.

MANAGEMENT PLAN FOR MENTAL HEALTH OUTLIERS

M 24Y21/03/1997 1014715
IP H HD JRU
DR: WOOD DA
E10660463

PART A: INITIAL MANAGEMENT

Initial Registrar Review: [illegible] Consultant: Wood

**Status Under the Mental Health Act following Section 38 Review**

Voluntary: Section 25 ☐

Involuntary: Section 39 (Mental Illness) 39.1 ☐ 39.2 ☐ Date/Time:...............

Section 42 (Mental Disturbance) 42.1 ☐ 39.2 ☐ Date/Time:...............

Forensic: Section 80A (Voluntary) ☐ Section 81 (Involuntary) ☐

Adult Guardian:............... Other Guardian:...............

| | |
|---|---|
| **Management** | t/f back to RDH tower on 30/01/22 |
| **Anticipated Risk:** | |
| **Required Support:** | ☐ Nursing ☑ PCA ☐ Security ☐ PCA and Security |
| **Management Plan** (including behaviour): | 1. 1:1 PCA in RDH tower<br>2. no leave.<br>3. NRT |
| **Medication** (charted on EMMA): | as per EMMA |

**FOR FURTHER ADVICE CONTACT:**

- TEMHS After Hours Bed Manager on 0408 102 828 (Mon, Thurs, Fri 1400- 2200, Sat, Sun 0800-1630)

or

- TEMHS MHET Registrar and /or Consultant during working hours (0800- 1630 )

or

- TEMHS On Call Registrar and / or Consultant after hours VIA RDH Switch

MANAGEMENT PLAN MENTAL HEALTH OUTLIERS

51. It seems that problems with Management Plans were not isolated. A *Mental Health Outliers Audit Report* (the Mental Health Outliers Audit) was completed in December 2021. Of the 11 patients considered in the audit, two were identified as not having a Management Plan at all and there was a further instance where a Management Plan did not record patient risks.[11]

52. By 30 January 2022, the only time Ngalarina's use of deodorants as an inhalant was documented in the 2022 RDH medical records was on the night they were admitted into ED, although petrol sniffing and cannabis use was

[11] *Mental Health Outliers Audit Report, 6 December 2021 version 1*

documented several times thereafter. Had the medical records and risk assessment forms contained consistent and accurate information concerning their VSA, Ngalarina's use of deodorants as inhalants would more likely have been identified as a risk by the On-Call Psychiatry Registrar, and then should have been listed and addressed in the Management Plan. Identification of the risks in the Management Plan, together with documented planning to mitigate and guard against those risks, may have prevented Ngalarina accessing deodorant.

***Inadequate handover and training of nursing staff caring for outliers***

53. It is unknown why Ngalarina was transferred to Ward 3A in the middle of the night.[12] However, that decision, in conjunction with inadequate guidelines and procedures, likely contributed to the unsatisfactory handover to the general ward nursing staff, who were assuming responsibility for Ngalarina's ongoing care and safety.

54. The *Mental Health Outlier Patients RDH Checklist for Admission*[13] (the Checklist) is intended to ensure that the initial handover includes information concerning the patients "*risk assessment to self/others/from others/absconding*". It also contains a physical checklist with the intention of reducing risks by directing the nurse assuming responsibility ensures:

    - that the ward environment is checked for common sources of risk to mental health patients (for example, glass or electrical cords) are removed; and
    - the belongings of the patient are inspected and sources of risk (for example, charging cords, sharps, glass and lighters) are removed and stored safely.

[12] Affidavit of Dr Luke Butcher, 4 September 2023, [160].
[13] Affidavit of Dr Luke Butcher, 4 September 2023, [112].

55. However, when Ngalarina was admitted onto Ward 3A the Checklist was not completed and these safety measures were not implemented. Again, this failing appears widespread. The Mental Health Outliers Audit revealed that of the 11 patients audited, none had the Checklist completed.

56. Additionally, NT Health conceded that the checklist itself was deficient in that the items identified for risk management did not include volatile substances.

57. Nurse 1 received Ngalarina into Ward 3A at 11.11pm. Although she could not precisely recall what information was provided during the handover, she did not recall VSA being discussed. The *Nursing Clinical Bedside Handover Sticker* was not completed but she did complete the *Risk Admission/Discharge Tool* (RADT) at 1.25am on 31 January 2021 (extracted below). Unfortunately the risk of Ngalarina sniffing volatile substances other than petrol was not documented or identified.

**RISK ADMISSION / DISCHARGE TOOL (RADT)**

Sex 68

IP H HD ORT
DR: WOOD DA
E10660463

Address must be documented if patient details hand written

**ASSESSMENT on Admission** (Discharge planning on admission cont')

| | |
|---|---|
| Provisional Medical Diagnosis | Relapse of schizophrenia Disorder |
| Relevant Medical History | *Circle:* HTN / CCF/ IHD / AF / MI / T1DM / T2DM / TIA / CVA / CKD / GORD / DVT / PE / Asthma / COPD / ETOH excess / CLD / Obesity / Dementia / OA / Hypercholesterolaemia / Fluid Restriction<br>Other: VSA, Cannabis use disorder, Cluster B personality traits |
| IV Access on Admission | ☐ AVF ☐ Tenckhoff Catheter<br>☐ PICC or other central line ☐ Port-a-cath<br>☐ IVC site checked ☐ IVC inserted outside of hospital? ☐ No ☐ Yes – remove IVC, re-site (if still needed) |

| | |
|---|---|
| **Other Drugs** | List substance/s: Petrol sniffing, Cannabis<br>Route: Declined to answer. Last taken: __/__/__ at __:__ hrs<br>Has the patient been referred to AOD for counselling? ☐ Yes ☑ Patient declined |

58. Although Nurse 1 correctly transcribed information from other medical records into this document, some of it meant very little to her. In her evidence Nurse 1 frankly admitted that she had a limited understanding of mental health diagnoses such as schizophrenia and had received no specific mental health

training since she commenced working in RDH. She said she did not feel equipped to look after mental health patients and, although she had previously raised concerns with her team leader, nothing had changed and she believed her concerns were unlikely to be addressed.[14] It was apparent from the evidence of Nurse 1 that the level of support available on the ward was variable and that she found working with mental health patients in such an environment extremely stressful.[15] She had since taken matters into her own hands and reduced her working hours to manage her stress.

59. Nurse 1 also frankly admitted that she did not understand what was meant by VSA (or the kinds of substances that might be used)[16] and had received no specific training about it. Since Ngalarina's passing, Nurse 1 knew that VSA training had been provided in '*Grand Rounds*'. However, she had been unable to attend the presentation which was held during a lunch hour. She had accessed the training on-line, at home, in her own time, and was able to see the slides but had been unable to access the audio presentation.[17] Nurse 1 thought that mandatory training should occur during work hours set aside for the purpose. She did not think that nursing staff should be expected to complete training in the midst of a shift when they are busy attending to patients or during their lunch breaks. Those views appear to be reasonable.

60. Similarly, Nurse 2, who was very experienced and had worked in Ward 3A for many years, had not received any training in VSA and as at 31 January 2022 was not aware that VSA could include deodorants.[18]

61. Nurse 2 had cared for many outlier patients in Ward 3A over the 4 to 5 years prior to Ngalarina's death. Similarly to Nurse 1, she too had raised her concerns about not being sufficiently trained to care for such patients and had become accustomed to her concerns seemingly falling on deaf ears. She

[14] Transcript pp 65-67, 70
[15] Transcript pp 70-71.
[16] Transcript pp 65-66, 70
[17] Transcript p 85, Nurse 2 also said that she could only watch the slides.
[18] Transcript p 79.

described experiencing instances where the behaviour of outlier patients had deteriorated in Ward 3A and of her being exposed to abusive and aggressive behaviour. She said that having outlier patients in the ward made her anxious and at times she felt unsafe, *"because you don't know what is going to happen next".*[19]

62. I thank both nurses for their temerity to speak frankly about their experiences and concerns. While there may be no quick solution to the need to accommodate outliers on general wards, the nursing staff who are regularly rostered to those wards deserve to receive the additional training and support they have identified is necessary, so they are better equipped to, and have the confidence to care for, their vulnerable outlier patients. This is consistent with the findings of the RCA in which it was identified that the general ward nursing staff had "*limited mental health education and knowledge*" and the panel considered it "*unreasonable to expect nursing staff to provide safe care to mental health outliers without adequate support and resources".*

***Inadequate handover to security guards caring for outliers***

63. Shortly before midnight, Ngalarina was transferred from the YIP to Ward 3A under security guard escort instead of a PCA as specified in the Management Plan. It is unclear why a PCA was replaced by a security guard[20], but it was likely a staffing issue.

64. Security guards are predominantly used to prevent patients from absconding.[21] Although their presence addressed Ngalarina's flight risk, they did not have any mental health training and they were not informed of any other risks associated with their care, in particular, they were not told of the VSA and serious self-harm risks. In his statement, Security Guard 1 said that he had not been given any instructions limiting purchases from the pharmacy and he

[19] Transcript pp 80-81.
[20] RCA, page 19.
[21] See for example, Statement of Security Guard 1 dated 19 September 2021 at [2], "I was tasked by my supervisor to monitor a patient and ensure that he didn't run away from the hospital".

said that nursing staff saw the Rexona body sprays when they returned to the ward but did not do anything about them.[22]

65. The policy at the time was lacking and did not require that information about identified risks be provided to security officers.[23] Without this vital information it was difficult for security staff to discharge their responsibilities, manage risk and keep Ngalarina and others safe. Had the security guards known of these risks it is unlikely that Ngalarina would have been permitted to purchase deodorant and nail clippers. Tragically, the failure to provide information regarding the potential risks of VSA to the security guards responsible for the safety of Ngalarina likely directly contributed to this preventable death.

66. Additionally, although the Inpatient policy provided that a "*Special is to be no more than arms-length from the consumer with no physical barriers in between the Special and the patient*" [24] , the security guards were not told or aware that they were expected to maintain visual contact with Ngalarina at all times, including whilst showering. This failing also likely contributed to the passing.

***Access to aerosol deodorants and other volatile substances***

67. When Ngalarina passed away, aerosol deodorants were freely available from the two publicly accessible pharmacies located on RDH grounds. This was a further contributing factor to the death. Those products have since been removed from the shelves and are now placed behind the counter.

68. However, even with that added precaution, a sale would likely only be refused in circumstances where an adult patient is accompanied by a Special who informs pharmacy staff that the patient is not permitted to purchase the item.

[22] Statement of Security Guard 1, 19 September 2021, [7]
[23] Affidavit of Dr Luke Butcher, 13 September 2022, [80]; Statement of Security Guard 1, 19 September 2021, [5]
[24] RCA, page 22; though this was specified for Inpatients (see Category of Observations TEMHS Procedure Version Number 19.0 p2.9) there was no equivalent requirement for Outliers.

It seems a fairly flimsy safeguard in circumstances where patients could arrange for visitors, or perhaps even other patients, to make purchases on their behalf.

69. In the mental health inpatient wards (Cowdy and JRU) the personal belongings of patients are checked by staff every time a patient enters the ward and risky items are removed, but that procedure was not in place for outliers.

70. However, even with such a procedure, as Nurse 2 commented, there are 32 patients on Ward 3A, most of whom are medical patients, not mental health patients. There are no restrictions on medical patients bringing deodorants (or scissors/razors) onto the ward and there is little in place (other than astute supervision) to prevent outliers sneaking access to such items from bedside tables, bags or shared bathrooms. In my view, the risk that outliers (and other patients with VSA issues) have relatively easy access to aerosols at RDH has not been adequately addressed by removing these items from the shelves of the pharmacy.

**Institutional Response - Department of Health**

***Mental Health Outliers***

71. Following this incident, the *Mental Health Outlier Patients in RDH General Wards Guideline* has been updated by NT Health. A new policy outlining the Model of Care for outliers was approved on 4 July 2023[25] and a new Outlier Procedure was approved on 4 August 2023.[26]

72. The Outlier Procedure now sets out the process for supervision to be followed for outliers on general wards. The procedure now provides that:

  - A Management Plan must be completed by the admitting Authorised Psychiatric Practitioner (which includes a risk assessment and

[25] Model of Care Outlier Management Top End Mental Health Services
[26] Mental Health Outlier Patients in RDH General Wards Procedure

identification of risks) and an environmental checklist (Part B of the Management Plan) must be completed by the admitting nurse.

- The allocated nurse is responsible for the care of the outlier patient and the direction of any 1:1 supervisory staff (PCA or security guard).
- A new *Outlier Constant Supervision Instructions Form* must be completed by the allocated nurse and signed by each supervisory staff member. It itemises issues to be addressed at each handover which include level of supervision, risks and safety. Supervisory staff must advise the nurse when taking the patient off the ward and on their return, and report the receipt or purchase of any items by the patient to the nurse.

***Training in VSA***

73. On 24 July 2023, training on VSA was delivered in the Grand Rounds education program. I understand the training was well attended, which likely reflects the level of concern RDH staff felt over the passing of Ngalarina. Although I was told that an audio of the presentation was available to staff who could not attend Grand Rounds, as discussed earlier, Nurses 1 and 2 were unable to access that audio recording though could access the slides.

74. By letter dated 8 February 2024 Dr Butcher advises that:

    - a VSA online course is now available to all NT Health staff on the Mylearning platform, and that 108 staff members had already completed the course.
    - The VSA Grand Rounds video forms part of the nursing and midwifery orientations and new staff are directed to enrol in the online VSA course.
    - The VSA posters have been updated and are displayed in the RDH and Palmerston Hospital wards.

***Additional mental health training and supervision***

75. A *Mental Health Intensive/Upskilling Program* was developed and trialled with 5 participants between September 2021 and February of 2022. A Pilot Report in March 2022 discussed the strengths and weaknesses of the training package. It was reportedly overall well received and the small number of participants reported that they had developed *"confidence, in identifying and responding to presentations of mental illness"* and *"they are able to identify signs and symptoms, and or changes indicating preventable deterioration"*. On the available evidence it is unclear whether this program is to be continued.

76. There is currently no evidence that time has been set aside for self-directed on-line training outside rostered shifts. In my view this is required. However, in his letter dated 8 February 2024 Dr Butcher advised the following:

    - A M*ental Health Deterioration Simulation Workshop* has been developed by the Clinical Education and Research Service (CLEaRS) for a target audience including nurses and PCAs and security staff. 22 staff have since completed the training provided in 3 workshops and further 10 are scheduled up to June 2024.

    - A self-directed online *Introduction to Mental Health* course is currently under development which will provide education on common mental health disorders. The course will be available for all NT Health staff providing services to the public commencing in June 2024.

    - A *Pharmacology and Mental Health Education* self-directed on-line course is being developed as a resource for NT Health clinicians to learn/refresh their knowledge of medications commonly prescribed for mental health disorders, commencing in August 2024.

    - A *Mental Health Outlier Nurse/Midwife Poster* now reminds nursing staff to: confirm the patient is classified as a mental health outlier,

check the management plan and how to seek assistance from the MHAOD Mental Health Outlier Nurse.

- A *Mental Health After Hours Nurse Coordinator* role was established immediately after Ngalarina's passing. The role provides leadership for mental health services after hours, attends the ward where outliers are present, and reviews review the Security Constant Supervision Instruction form. The role is under review and continuing to evolve.

***Restricting Access to volatile substances***

77. As previously discussed, aerosols are now placed behind the counter in the public pharmacies and the *Top End Mental Health Service Inpatient Unit, Patient and Carer Information Booklet* has been amended to make it clear that all aerosol cans are banned from inpatient units.

78. However, given the number and frequency of outliers in general wards, and in light of the fact that the risk of VSA is not limited to mental health patients but extends to medical patients (and all visitors), in my view NT Health should consider either introducing a whole of hospital ban, a requirement that aerosols be handed to a staff member for safe keeping, or similar precautions.

**Family Concerns**

79. In spite of challenging behaviours, from VSA or when they were unwell, Ngalarina retained the support of their family. Both directly and through their lawyers, family members raised many concerns with NT Health which were addressed in letters and meetings with the family. One particular concern that persisted during the inquest was about communication. The family thought there should have been better communication between Ngalarina's treating team and themselves. They would have liked to receive more education about schizophrenia and how they could best support Ngalarina in the community, and they would have liked more thorough and timely communication when Ngalarina was moved between wards and when their release from hospital was

being planned. Family members told me that, *"…family is very important to our clan and our community. As family we should always be involved in the discussion. The treating team need to respect how the family are responsible for our children when they come back home".*[27]

80. From time to time Ngalarina requested privacy be maintained over their personal information, which limited or prevented communication with family members. As an adult they were entitled to have their request for privacy respected. However, NT Health acknowledged that communication with Ngalarina's family during this admission was unsatisfactory. In a letter to the family dated 8 September 2023, the failures in communication were largely attributed to the additional burdens placed on staff who were also dealing with COVID-19 exigencies. However, it was acknowledged that, even so, family should have been informed of the transfer to the general ward and been consulted in respect of any discharge planning. In that letter, Dr Butcher concluded by saying:

*"It would have been better for [Ngalarina] if they were able to stay and complete their treatment within the Inpatient Unit. They had been recovering well in that setting since their arrival approximately 11 days earlier and was progressing towards discharge in the coming days. It is deeply saddening that did not occur.*

*I wish to take this opportunity again to convey my sincere condolences to…[Ngalarina's] family for their loss."*

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[27] Joint statement of Averly Wakuranhawuy and Judith Madupinyin dated 19 September 2023, [30]

## Conclusion

81. It was well documented that Ngalarina's history of VSA and mental ill health were linked. In this instance, their mental health deterioration and hospitalisation came just days after a final VSA assessment was requested by Milingimbi police. The risk posed by VSA was not simply historical, it was current, and likely the precipitating cause of their ill health and involuntary admission into RDH. Both the link and the risks were documented in the admission notes and those risks should not have been overlooked or minimised during their stay in RDH.

82. It has been frankly admitted by NT Health that their policies and procedures were inadequate. The risk posed by VSA was not consistently or clearly documented, and insufficient steps were taken to alert staff to the risk, or to address and mitigate the risk. The risk crystallised when Ngalarina accessed deodorants. Tragically, staff did not recognise the risk this posed, they failed to intervene, and Ngalarina passed away.

83. NT Health responded promptly and diligently to this sentinel event. They reviewed and revised their policies and procedures. They introduced (and are continuing to introduce) new training programs to educate their staff about VSA and, more generally, about mental health patient care. They met with the family, apologised for their failings in Ngalarina's care, and expressed sincere sorrow for their passing. They participated fully and openly with the inquest process.

84. In light of the changes that have already been, or are in the process of being, implemented it is unnecessary for me to make recommendations concerning staff training and outlier ward policies. However the availability of aerosols in general wards remains a concern.

**Recommendation**

85. **I recommend** that the Department of Health consider extending the ban on aerosol cans to apply hospital wide and, where that is not possible, for example on medical grounds, they be kept safely secured.

Dated this Friday 5 day of April 2024.

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ELISABETH ARMITAGE
TERRITORY CORONER