CITATION: *Inquest into the death of Virginia (Kumanytjayi) Nabarula Brown* [2015] NTMC 015

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FINDING OF:	Mr Greg Cavanagh SM
CATCHWORDS:	**Death in Care, compulsory care and treatment in Alcohol rehabilitation centre, Death in mandatory detention**

REPRESENTATION:

Counsel:

Assisting:	Jodi Truman
Family of Deceased	Dr Ian Freckelton QC
NT Department of Health	Greg Macdonald
Central Australian Aboriginal Alcohol Programmes Unit	Andrew Harris QC

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IN THE CORONERS COURT
AT ALICE SPRINGS IN THE
NORTHERN TERRITORY
OF AUSTRALIA

No. A0046/2014

In the matter of an Inquest into the death of
VIRGINIA (KUMANYTJAYI) NABARULA BROWN
ON 31 OCTOBER 2014
AT CENTRAL AUSTRALIAN ABORIGINAL ALCOHOL PROGRAMMES UNIT, ALICE SPRINGS

FINDINGS

Mr Greg Cavanagh SM

Introduction

1. Virginia Nabarula Brown was found deceased on 31 October 2014 in her bed in room 5 of the residential facility of the Central Australian Aboriginal Alcohol Programmes Unit ("CAAAPU"), Alice Springs. The deceased was in the facility against her will and detained under an Alcohol Mandatory Treatment order made by the relevant Tribunal (*Alcohol Mandatory Treatment Act*). Sadly, nearly all of the detainees in Alice Springs under this legislation are aboriginal. Attempts were made to resuscitate her; however she was unable to be revived and was pronounced deceased at 9.48am. Out of respect for the family and the cultural practice of avoiding use of the Christian name of deceased, I will hereafter refer to the deceased as Kumanytjayi or Ms Brown, with the exception of the formal findings.

2. Kumanytjayi was an Aboriginal woman born on 25 December 1967 at Papunya, in the Northern Territory of Australia. She was 46 years of age at the time of her death. Evidence tendered before me shows that Kumanytjayi had a long history of alcohol abuse and this had significantly affected her health over the years. In 1997 she was recorded for the first time as suffering a tonic-clonic seizure (or what was previously known as a grand

mal seizure). It was diagnosed as having occurred as a result of her alcohol abuse. She suffered many such seizures thereafter in her lifetime.

3. In 1998 Kumanytjayi was admitted to the Alice Springs Hospital ("ASH") with severe abdominal pain. Her principle diagnosis was Chronic Pyelonephritis; which is a bacterial infection of the functional parts of a kidney and the lining of the renal pelvis. It was also recorded that her right kidney was not functioning properly. I note that as a result of his autopsy, it was the opinion of Dr Terence Sinton that Kumanytjayi's cause of death was Acute Suppurative Pyelonephritis. I will therefore return to this issue later in these findings.

4. At the time of her death, Kumanytjayi was subject to a Mandatory Residential Treatment order ("MRT order"). That MRT order had been made on 15 August 2014 and specified CAAAPU as the "Community Treatment Provider". It required Kumanytjayi be detained at CAAAPU against her will for a period of three months, i.e. until 14 November 2014. Although Kumanytjayi absconded from CAAAPU a number of times this was where she was detained at the time of her death.

5. As previously stated, at approximately 9.00am on Friday 31 October 2014 Kumanytjayi was found deceased in her bed in room 5 of the CAAAPU accommodation area. Attempts were made to resuscitate her but she was unable to be revived and was pronounced deceased at 9.48am.

Death in care or death in custody?

6. This death was reportable to me because at the time of her death, Kumanytjayi was a person subject to an MRT order. The *Coroners Act* ("the Act") defines at s12 a "person held in care" to include the following:

> "A person who is an assessable person, or a person in relation to whom a mandatory residential treatment order is in force under the *Alcohol Mandatory Treatment Act*"

7. I note that during the course of this inquest, submissions were made by Dr Freckelton QC on behalf of the family that it was open for me to find that this was both a death in custody and a death in care. Dr Freckelton QC appropriately conceded "*without reservation*" the submission made by Counsel Assisting that this was a death in care. However he submitted that the question of whether this was also a death in custody was "*not so straightforward*". Given that a finding of whether this is a death in custody or a death in care can impact on my ultimate powers under the *Coroners Act*, this is a submission that I consider appropriate to address from the outset.

8. I note that Dr Freckelton QC submitted that it was open to me to find that this was also a death in custody (tp.218.6):

> "…because under section 12(1)(a), it states that for the definition of a person held in custody, a person is taken to be held in custody if they are detained anywhere in the Territory by a person authorised to do so under any Act or law.

9. With respect to senior counsel, in my view, this is misconceived. The *Act* defines a "person held in custody" at s12 as follows:

> ***person held in custody*** means:
>
> (a) a person in the custody or control of:
>
> (i) a police officer; or
>
> (ii) a member of the Police Force of a State or another Territory of the Commonwealth or of the Australian Federal Police; or
>
> (iii) the Commissioner of Correctional Services; or
>
> (iv) a sheriff appointed under the *Sheriff Act*; or
>
> (b) a person detained in:
>
> (i) a custodial correctional facility (as defined in section 11(1)(a) of the *Correctional Services Act*); or

(ii) a detention centre approved under the *Youth Justice Act*;

and includes a person in the process of being taken into or escaping from:

(c) the custody or control of a person mentioned in paragraph (a); or

(d) detention in a place mentioned in paragraph (b).

10. Whilst it is may be suggested that Dr Freckelton QC's submission is a summary of what is provided for under the s.12 definition, I consider it is quite clear in its terms as to the circumstances in which a person is held in custody versus held in care. I therefore find that this was not a death in custody. It was a death in care and therefore, pursuant to s15(1) of the *Act*, this inquest is mandatory. The wider commentary powers given to me relating to "deaths in custody" are not available.

11. Pursuant to s34 of the *Act*, I am required to make the following findings if possible:

"(1) A Coroner investigating:

a. A death shall, if possible, find:

(i) The identity of the deceased person.

(ii) The time and place of death.

(iii) The cause of death.

(iv) Particulars required to register the death under the *Births Deaths and Marriages Registration Act*.

(v) Any relevant circumstances concerning the death"

12. Section 34(2) of the *Act* operates to extend my function such that I may comment on a matter including public health or safety connected with the

death being investigated. Additionally, I may make recommendations pursuant to section 35 as follows:

> "(1) A Coroner may report to the Attorney General on a death or disaster investigated by the Coroner.
>
> (2) A Coroner may make recommendations to the Attorney General on a matter, including public health or safety or the administration of justice connected with a death or disaster investigated by the Coroner.
>
> (3) A Coroner shall report to the Commissioner of police and Director of Public Prosecutions appointed under the *Director of Public Prosecutions Act* if the Coroner believes that a crime may have been committed in connection with a death or disaster investigated by the Coroner"

13. This inquest was held on 6, 7 and 8 July 2015. Ms Jodi Truman appeared as Counsel assisting. Mr Greg Macdonald appeared for the Northern Territory Department of Health. Dr Ian Freckelton QC appeared for the family. Mr Andrew Harris QC appeared for CAAAPU. I thank each counsel for their very helpful assistance. A total of nine (9) witnesses were called to give evidence at this inquest, namely; Detective Senior Constable Lewis Chown, Helen Dempsey, Ruchitabahen Panchal, Sabine Wedemeyer, Ron Miliado, Dr Jo Wright, Dr Derek Chong, Dr Terence Sinton and Phillip Allnutt.

14. A brief of evidence containing various statements, together with numerous other reports and police documentation was tendered at the inquest. Public confidence in Coronial investigations demands that when police (who act on behalf of the Coroner) investigate deaths that they do so to the highest standard. I thank Detective Senior Constable Lewis Chown for his investigation.

15. The focus of this inquest was upon the service providers that were caring for, and treating, Kumanytjayi in the period prior to her death, in order to:

15.1 ensure that the standard of care being provided to her as a person "detained" under the *Alcohol Mandatory Treatment Act* was appropriate;

15.2 ensure that such care was being provided in accordance with the stated objectives of the legislation; and

15.3 determine whether her health issues were being appropriately investigated during her detention.

16. It is important to make clear from the outset that the aim of these proceedings is not to lay blame for Kumanytjayi's death, but to identify whether, when a person is detained under this legislative regime and their rights are therefore limited, they receive appropriate care, supervision and treatment.

Background

17. Kumanytjayi was from a large family. She had a number of siblings, some of whom have passed away. However her sisters Elizabeth, Priscilla and Felicia were all in attendance at the inquest and I thank them for the respect they showed to the coronial process. Her mother was Anna Pultara and her father was Teddy Amananu, both of whom are now deceased. She was born and raised in Papunya; attending primary school there and then on to Yirara College until leaving school at about 15 years of age. Her sister, Ms Elizabeth Raggett, recalled that the deceased worked as a teacher's aide at Haasts Bluff School but stopped working when she divorced her first husband. She spoke English as well as Luritja (Papunya) and Western Arrernte (Ntaria) languages.

18. Kumanytjayi was married to Suparkra Jugadai when she was still quite young and the couple had a baby boy when Kumanytjayi was only 19 years

of age. Unfortunately the child passed away as an infant and the couple later separated. Later in life Kumanytjayi married Cedric Namatjira, to whom she was still married when she passed away. I also thank Mr Namatjira for attending at the inquest.

Medical history

19. As earlier identified Kumanytjayi had a long history of alcohol abuse which appears to have resulted in a number of admissions to hospital. On 21 February 1997, she was admitted to the ASH following referral from the Papunya Clinic after a seizure. Perusal of her medical records show that this admission was the first of forty seven (47) known hospital admissions as a result of seizures before becoming subject to the MRT order in 2014. Some attendances in fact related to the occurrence of multiple seizures. It was during this initial seizure-related admission, that it was identified that Kumanytjayi was ethyl-alcohol ("ETOH") dependant and that the seizure she had experienced was a tonic-clonic seizure as a result of her ETOH abuse.

20. On 7 April 1998, Kumanytjayi was admitted to the ASH as a result of severe abdominal pain. She was diagnosed as suffering Chronic Pyelonephritis, and her right kidney was not functioning. Following this admission and until June 2012, Kumanytjayi was admitted to hospital on another thirty two (32) separate occasions related to the occurrence of seizures. On 20 June 2012, she was admitted to ASH for a period of five (5) days as a result of seizures. According to the hospital records for that admission; Kumanytjayi was "restless" and exhibited "signs of ETOH withdrawal" with hallucinations and delirium being recorded.

21. During this admission, doctors attempted to investigate the cause of her continuing seizures. She underwent an electroencephalography ("EEG") test to measure the electrical activity of her brain and completed the Rowland Universal Dementia Assessment Scale ("RUDAS") to assess her basic cognitive ability. Although an EEG had been recommended in 2007, it appears that it was not until this 2012 admission that attempts were made to

investigate the actual cause/s of the seizures beyond reference to being related to alcohol abuse or alcohol withdrawal.

22. On 26 June 2012, a referral was made to Alcohol and Other Drug Services Central Australia ("ADSCA") to initiate rehabilitation with a view to addressing Kumanytjayi's long term alcohol abuse. Kumanytjayi made clear at that time however that she did not want to participate in any residential rehabilitation and it appears her referral did not progress much further.

23. According to the medical records, the EEG results were received on 3 July 2012 and were "abnormal". A recommendation was made for Kumanytjayi to have an MRI scan to determine/eliminate causes of her seizures; however this involved Kumanytjayi having to travel to Darwin. Although the referral was made by ASH and attempts were made by the Central Australian Aboriginal Congress medical staff to arrange for her travel, Kumanytjayi did not attend for the MRI scan.

24. In terms of any "treatment" provided to Kumanytjayi up to this point in time, other than the matters outlined above, and basic observations occurring each time, Kumanytjayi was usually administered medication such as Thiamine and Diazepam. The Thiamine was prescribed due to the prevalence of a Thiamine deficiency brought about by her alcoholism and right kidney failure. The Diazepam (also known as Valium) was prescribed to manage alcohol withdrawal symptoms. She was also prescribed Sodium Valproate from time to time which was to manage/reduce her seizures.

25. In relation to what was done to address her Chronic Pyelonephritis and non-functioning right kidney as discovered in 1998, the medical records do not set out any apparent medical intervention, beyond the prescription of Thiamine. It is important to recognise however that whilst medication was prescribed from time to time, Kumanytjayi did not comply with the requirements for the taking of her medication and this is likely to have contributed to her health issues.

The *Alcohol Mandatory Treatment Act* legislative regime

26. I received evidence that the *Alcohol Mandatory Treatment Act* ("the *AMT Act*") commenced on 1 July 2013. In its own review, the Department of Health reports the *Act* to be:

> "… a health based legislative framework for the mandated assessment, treatment and aftercare of people who chronically misuse alcohol and who are either unlikely or unable to voluntarily access treatment options. The Act aims to stabilise and improve the health and social functioning of people, restore their capacity to make decisions about their alcohol use and personal welfare, and improve their access to ongoing treatment".

27. The *AMT Act* itself sets out its "Objects" at section 3 as follows:

> "The objects of this Act are to assist and protect from harm misusers of alcohol, and other persons, by providing for the mandatory assessment, treatment and management of those misusers with the aim of:
>
> (a) stabilising and improving their health; and
>
> (b) improving their social functioning through appropriate therapeutic and other life and work skills interventions; and
>
> (c) restoring their capacity to make decisions about their alcohol use and personal welfare; and
>
> (d) improving their access to ongoing treatment to reduce the risk of relapse".

28. The process undertaken when someone is referred under the *AMT Act* is that they are clinically assessed and then an independent Tribunal determines the best treatment option. It has been stated that the AMT system:

> "… is aimed at those chronic drinkers who are publicly intoxicated. … Adults who are taken into protective custody at least three times in two months for being intoxicated in public are referred to the Alcohol Mandatory Treatment (AMT) system".

29. When a person is referred to the AMT system the treatment that may be proposed can include detention for up to three months in a secure residential treatment facility, treatment in a community residential treatment facility or

other form of community management (including income management). CAAAPU is one of the secure residential treatment centres under the regime.

Kumanytjayi's referral to the Alcohol Mandatory Treatment (AMT) system

30. As set out above, adults who are taken into protective custody on at least three occasions in two months for being intoxicated in public are to be referred to the AMT system. On Saturday 19 July 2014 Kumanytjayi was taken into protective custody by police, pursuant to section 128 of the *Police Administration Act*, (first protective custody). Then on Monday 21 July 2014 she was again taken into protective custody by police (second protective custody) and on Friday 8 August 2014 she was taken into protective custody for the third time, therefore meeting the criteria of at least three occasions in two months.

31. When this criteria is met and the person is not the subject of any other specified order and is not going to be charged with an offence carrying a penalty of imprisonment; section 128A of the *Police Administration Act* sets out certain obligations upon police members. Amongst those obligations is the requirement that the member must contact a senior assessment clinician to ascertain whether a suitable assessment facility has capacity to conduct an assessment and to treat the person. If the police member is advised there is such a suitable assessment facility then the member must arrange for the person to be taken to that facility "as soon as practicable after the person is no longer intoxicated".

32. In terms of Kumanytjayi, police made a notification for assessment at approximately 5.00am on Saturday 9 August 2014. As a result of that notification and advice of a suitable assessment facility, Kumanytjayi was transported by police to the Alice Springs Alcohol Assessment Service ("ASAAS"). This is a facility located at the secure care facility adjacent to the Alice Springs gaol. The ASAAS records reveal that upon her arrival Kumanytjayi was subject to a health screen utilising patient information

from the Primary Care Information System ("PCIS") which is the online health system utilised by the Department of Health. It is supposed to enable care providers to gain shared access to a patient's medical information, including their medical conditions, medical background and current medications.

33. Following that initial assessment the *AMT Act* places certain obligations upon a senior assessment clinician as to notices and timing of an assessment. Pursuant to section 17 the assessment must be conducted "as soon as practicable" but "not later than 96 hours after the assessable person is admitted to the assessment facility".

34. Once the assessment has been completed, section 20 of the *AMT Act* requires that the senior assessment clinician take certain action "within 24 hours" of completion. One of the actions available to be undertaken is an application to the Tribunal pursuant to section 22 of the *AMT Act* if the senior assessment clinician is of the opinion that the person is not likely to fulfil the criteria for involuntary admission under the *Mental Health Act* and meets the criteria for admission under the *AMT Act*.

35. This is the process that was undertaken in relation to Kumanytjayi. Her Assessment Report records that she reported to the senior clinician that she had started drinking at the age of 20 with her friends and family and may have "possibly" had a period of two months when she was abstinent whilst at Papunya but she was "not sure". She reported usually drinking up to 16 standard drink units of beer and wine in a sitting which usually took place at least once a week around payday and that sometimes she got "the grog shakes". The Assessment Report was stated to include details as to her medical history, however it did not include any reference whatsoever to her history of Chronic Pyelonephritis.

36. After the assessment was undertaken at ASAAS, application was made to the AMT Tribunal and heard on Friday 15 August 2014. Kumanytjayi participated in that hearing via video-link and was legally represented.

After hearing the application, the Tribunal determined that Kumanytjayi met the criteria for a mandatory treatment order as set out within section 10 of the *AMT Act* and made orders requiring that she attend mandatory treatment and be income managed. The orders provided, inter alia, that Kumanytjayi was to be admitted to and detained at CAAAPU for a period of three months from 15 August to 14 November 2014 and she was subsequently transferred to CAAAPU on 15 August 2014.

37. CAAAPU is a not for profit organisation that was formed in 1991. I visited the premises during the inquest and it is an impressive facility. Its stated primary objective is the provision of Aboriginal controlled and culturally appropriate alcohol counselling and treatment services. It is also now one of the secure residential treatment centres offering treatment under the AMT scheme.

Events following the making of the orders and detention at CAAAPU

38. Shortly after arriving at CAAAPU on 15 August 2014 Kumanytjayi suffered a seizure and was conveyed by St John Ambulance to the ASH where she remained overnight for treatment and observation. Unfortunately she absconded from the hospital and a report was made to police at 2.39pm on Saturday 16 August 2014. As a result of this notification, police kept a look out for Kumanytjayi and on 23 August 2014 she was located by police in an intoxicated state and transported to the hospital where she remained for a number of hours before absconding again.

39. Kumanytjayi was not located again by police until 3 September 2014. Again she was intoxicated. On this occasion she was kept at the police watch house for a number of hours in order to sober up and was then transferred to the ASAAS where she stayed until 8 September 2014. During her time at ASAAS she was reported as suffering a 45 second seizure and was taken to the ASH for observations, but was then returned to ASAAS.

40. On Monday 8 September 2014 Kumanytjayi was seen by Dr Milnes at ASAAS who assessed that she was finally fit for transfer back to CAAAPU. Kumanytjayi was returned to CAAAPU that day and it appears that her condition was relatively settled for a period of time. On 10 September 2014 she was seen again by Dr Milnes who recorded she was "currently well" and noted as follows:

> "NOTE MUST HAVE BLOODS TAKEN EARLY OCTOBER (FORM WRITTEN) FOR Sod Valproate & TSH (has previously been on higher dose of Valproate but may have been compliance issue therefore 200mg bd may be sufficient"

41. Unfortunately however, on Monday 15 September 2014 Kumanytjayi suffered another seizure in her accommodation at CAAAPU. As a result she was taken by ambulance to the ASH for treatment and observation. She was seen by Dr Kyaw who formed the opinion that her sodium valproate levels were "sub-therapeutic" and recommended they be increased with a review to be conducted in a week. The records note that Kumanytjayi was subsequently released into the care of CAAAPU staff at 8.00am on Tuesday 16 September 2014. She was seen by a doctor at CAAAPU that day upon her return.

42. On Saturday 20 September 2014 Kumanytjayi again absconded from CAAAPU. Police were advised at about 1.56pm and an alert was placed upon the system. She was located by police on 22 September 2014 and the CAAAPU progress notes show that an attempt was made by police to return Kumanytjayi to CAAAPU at 12.30am, but she was required to be taken to the watch house first before she could return. Upon returning to CAAAPU later that morning, Kumanytjayi indicated that the reason she had absconded on that occasion was because "she went to watch a footy game". Later that evening, Kumanytjayi suffered another seizure at CAAAPU. It is recorded as only lasting "a few seconds" and no ambulance was called with Kumanytjayi stating she was "feeling okay".

43. On Wednesday 24 September 2014 at approximately 2.45pm Kumanytjayi absconded again. She was located by police on Thursday 25 September 2014 in a highly intoxicated state. Because of her level of intoxication she was taken into protective custody at the Alice Springs Watch House at 10.51pm. A breath test was conducted at 11.30pm which showed that Kumanytjayi had a reading at that time of 0.225% breath alcohol concentration. She was subsequently released from the watch house at 8.17am on Friday 26 September 2014 and transported back to CAAAPU. There was no further absconding after that date.

44. After returning to CAAAPU on 26 September 2014, Kumanytjayi was witnessed by a number of other clients to have another seizure that lasted approximately 30 seconds. She was seen by the doctor at CAAAPU who noted the seizure was probably caused by the fact that she had been non-compliant with her medication during her absconding period and also drinking. A plan was therefore reached to recommence her on her sodium valproate and commence diazepam in order to stabilise her.

Medical treatment at CAAAPU

45. Dr Derek Chong was one of the doctors to provide care and treatment to Kumanytjayi during her detention at CAAAPU and was her treating doctor at the time of her death. Dr Chong had been employed by the Department of Health on a locum basis for 5 and half weeks ending on 2 November 2014. Although he could not recall his starting date, I find he commenced sometime towards the end of September 2014. Dr Chong gave evidence that he was employed to provide services at ASAAS, as well as CAAAPU and at Alcohol and Other Drug Services Central Australia. He would attend at CAAAPU at least two days per week, normally Tuesday and Friday, usually between 1.00pm and 5.00pm.

46. These times were set by him with the intention of seeing patients at the beginning of the week and then reviewing any management strategies on the

Friday. Dr Chong stated that on Tuesdays he would only see the patients that

> "support workers would triage and prioritise what patients I needed to see in consultation with the registered nurse that was at CAAAPU". Then on Fridays he would review "not only those (seen) on Tuesday, but also any new patients that needed to be seen. … Or new conditions … for the other patients I hadn't seen".

47. Although Dr Chong was not the doctor to conduct the initial medical assessment of Kumanytjayi or in fact any of her assessments at ASAAS, he was subsequently involved in her care at CAAAPU. Dr Chong recalled to police that his first significant involvement with Kumanytjayi was on a Tuesday when she was referred to him by CAAAPU staff who advised that she had suffered a seizure a "*day or so*" before. He gave evidence that after seeing Kumanytjayi that first time, he was told that she absconded. Having considered carefully the information contained in the CAAAPU progress records, I find that the date that Dr Chong first saw Kumanytjayi was on or about Tuesday 23 September 2014. I make this finding despite the fact that there is no attendance record made by Dr Chong on that date. I do this in light of his evidence that he had difficulties initially accessing the progress note system at CAAAPU known as ARNI and because it is clear that he recalled being informed that Kumanytjayi had just returned from absconding and then absconded once more during the time that he treated her. Given that the last time she absconded was 24 September 2014, this leads me to the conclusion that he must have seen her for the first time on 23 September 2014, i.e. the day before her last abscond on 24 September 2014.

48. The next time that Dr Chong is recorded as seeing Kumanytjayi was on Friday 26 September 2014. Again, this was after an occasion of absconding on 24 September 2014 and is the occasion where she was found "highly intoxicated" by police. Dr Chong agreed that he was advised that Kumanytjayi had experienced a seizure that had lasted approximately 30 seconds and had been witnessed by staff. Given Kumanytjayi had been non-compliant again with her medication and had been drinking; his plan was to

recommence her Sodium Valproate (i.e. Epilim) medication and start her on Diazepam (i.e. Valium) to try and reduce the risk of seizure. Dr Chong also ordered blood tests to be taken. He agreed in his oral evidence that his focus at this time was on dealing with Kumanytjayi's seizures.

49. There is then a reference in the ARNI records to Kumanytjayi having "medical appointments" on Tuesday 30 September 2014. However there is no accompanying medical attendance record. I am therefore not able to determine if Kumanytjayi did in fact see a doctor on that day. The next time that Dr Chong is recorded as seeing Kumanytjayi is Tuesday 14 October 2014, almost 3 weeks after his noted plan to retest Kumanytjayi's sodium valproate levels. I do note however that the ARNI progress notes record that on Monday 6 October 2014 Kumanytjayi was taken for blood tests. The progress notes also record that the medical attendance on 14 October 2014 was two days after what was described as a "micro-fit" having occurred on 12 October 2014.

50. Dr Chong agreed that he had recorded in his notes for the attendance on 14 October 2014 that Kumanytjayi expressed concerns about having a fit again and that she had been "worrying about this constantly". Dr Chong also noted that support staff had advised him that Kumanytjayi had experienced "two episodes where she has lost consciousness momentarily and they have assumed it may have been a fit". Dr Chong's notes recorded as follows:

> "Full work up needed and further symptoms need to be clarified to ascertain the urgency of review".

51. Dr Chong stated in his evidence that he recalled this attendance and that (tp.136.6):

> "Kumanytjayi was very sincere, as she always was, that she was worried about - she really wanted the medication. She really wanted the seizures to be fixed. And we explored it further, and as I - it's in my statement to the police that it was the shame factor that when she came out of the seizure people watching her and looking at her made her feel very shameful, and that's the experience that she didn't like the most. So the seizures that - like you said, micro seizure, were

> more likely actual seizures showing that there was some focal seizures, partial seizures, that were occurring. So that's where - that's where I increased the sodium valproate".

52. Dr Chong stated that he did not recall Kumanytjayi ever complaining or indicating she was unwell beyond her seizures and that "*seizure was the most concerning factor for her*". Dr Chong arranged for a pathology script to be written for the "full work up" to be undertaken. I did not receive any documentary evidence that these were ever done however Dr Chong recalled an occasion where he received results from the registered nurse at CAAPU. He stated that he was required to obtain these via the nurse as he was not an employee of the ASH. Dr Chong stated that this made treating Kumanytjayi "*very difficult because I couldn't see her past history and what the emergency department had noted*". Dr Chong gave evidence that in his opinion it was "*definitely*" important that a medical practitioner at CAAAPU providing treatment under the AMT system have access to such records.

53. In addition to difficulties in accessing some records, Dr Chong stated it was his recollection that there were also "difficulties" at this time in having patients transported to the hospital. These included staffing resources but also Kumanytjayi not being available because she was attending cultural excursions. Dr Chong was unable to recall specifically the results for the "full work up". As a result he stated that perhaps Kumanytjayi had not attended because of transportation issues. This is of concern given that within the progress notes Kumanytjayi is recorded as continuing to be "unwell", "shaky" and "unaware". This included Friday 17 October 2014 which was a day when Dr Chong was in attendance at CAAAPU and yet he is not recorded as seeing her on that day despite her continuing difficulties.

54. On Tuesday 21 October 2014 CAAAPU staff again record Kumanytjayi as "not stable … not feeling good and wanted to see the doctor". Dr Chong's notes record her as "complaining of feeling funny in the head" and again being "concerned about another seizure". In his evidence he recalled that because Kumanytjayi was "*only a slight person*" and the Diazepam had a 30

hour half-life, he thought this may have been causing her lethargy, grogginess and unsteadiness, rather than a warning sign related to her seizures. As a result Dr Chong recorded a plan to reduce the Diazepam with a "review on Tuesday".

55. Kumanytjayi's condition however did not improve. She is described by staff on 22 and 23 October 2014 as feeling "weak and unstable" and having "a very mild turn". Dr Chong is recorded as seeing Kumanytjayi on Friday 24 October 2014. In his evidence he stated that again Kumanytjayi's main concern was having another seizure. As a result he increased her sodium valproate levels and made a plan to "re-evaluate her serum levels on Friday" (i.e. 31 October 2014).

56. On Monday 27 October 2014, one of the case workers, Ms Ruchitabahan Panchal recorded in the CAAAPU progress notes that Kumanytjayi appeared "unstable, her eyes flips lot as well" and that she was "feeling very sick". Despite these notes, Ms Panchal gave evidence that she did not arrange for Kumanytjayi to see the doctor because "she (Kumanytjayi) did not want to". There is however no record of this conversation or statement by Kumanytjayi in the notes. In addition, there is no record of Kumanytjayi seeing Dr Chong on Tuesday 28 October 2014 when he was next attending at CAAAPU despite the observations made by Ms Panchal. In fact, despite previously recording a plan to review on Tuesday 28 October 2014, Dr Chong did not see Kumanytjayi again before she died.

57. As to ensuring that planned reviews of patients actually occurred, Dr Chong stated that every week he would "*read and revise the plans I wrote before*" to ensure their compliance, however he conceded that this "*system fell down if there was a lack of support staff or that the patient wasn't in the facility at the time*".

58. Dr Chong stated that Kumanytjayi's death was unexpected and he was "*surprised and saddened*" when he heard. Initially his evidence was that he did not think he could have done anything differently in relation to his

treatment of Kumanytjayi, save for a full blood work up, and that his focus had been on her seizures. However during cross examination by Dr Freckelton QC, he stated there were things he had learnt from the death and that he believed he could improve, particularly in relation to taking a better medical history and ensuring access to all relevant documentation.

Events of evening of 30 and morning of 31 October 2014

59. I had tendered as part of the coronial brief a statement from Ms Rhonda Karpa who was a fellow client at CAAAPU and had known Kumanytjayi her entire life, referring to her as "young sister". Ms Karpa stated that she played cards with Kumanytjayi and Ms Malthouse in room 5 during the evening of Thursday 30 October 2014 and whilst she had heard that Kumanytjayi was a "sick woman", she appeared "happy" that night and "didn't seem sick".

60. A statement from Ms Levina Letchford was also tendered into evidence. She was one of the support workers employed at CAAAPU. She commenced her usual shift at 3.30pm on 30 October 2014 and was scheduled to finish at 11.30pm. She stated that on 30 October 2014 Kumanytjayi appeared happy and was in fact happier "than usual"; forming this opinion because Kumanytjayi "normally" went to bed early but "stayed up later than usual and she was playing cards in her bedroom". Ms Letchford recalled Kumanytjayi went to bed about 10.30pm and that she was already asleep when she did her hourly check upon her at 11.00pm.

61. Ms Letchford stated that she was well aware of Kumanytjayi's health problems, especially "epilepsy and diabetes", and that if she had noticed anything "out of the ordinary" she would have sought assistance. Ms Letchford recalled that "sometimes" she was able to tell if Kumanytjayi was "having a fit" because she would "start getting shaky" and "you'll just notice the way she talks and she'll forget things", however on 30 October 2014 she believed that Kumanytjayi "was fine".

62. Ms Helen Dempsey gave evidence before me. She had been employed at CAAAPU since March 2014 as the "night watch" person and was familiar with Kumanytjayi. Her shift generally commenced at 11.30pm and ended at 7.30am the following day. She recalled commencing her shift at 11.30pm on Thursday 30 October 2014 and stated that at that time "all of the ladies" were already asleep. Ms Dempsey performed checks during that shift every hour as required by shining a torch through the curtain of the windows to the rooms. She would not enter the room unless she could not see through the curtain and would shine the torch to see if the client was present and that they were "okay". The only time she would enter the room was at the 7.00am check at which time she would knock on the door, say words to the effect of; "it's time to wake up, it's 7 o'clock" and then leave the clients to get up on their own.

63. Ms Dempsey recalled that there was usually another female client that shared the room with Kumanytjayi and that this was a practice developed by the female clients as they were aware of Kumanytjayi's seizures and wanted to have another person with her should "something" occur. Ms Dempsey stated that during each of the hourly checks on that shift she did not recall anything "out of the ordinary" and had assumed that Kumanytjayi was asleep. Ms Dempsey stated that she did not consider it unusual when Kumanytjayi did not immediately get out of bed at 7.00am because it wasn't unusual for her to sleep in.

64. I had tendered into evidence the statement of Ms Cynthia Malthouse who was sharing room 5 with Kumanytjayi on the evening of 30 October 2014. She referred to Kumanytjayi as "aunty". She recalled attending a cultural outing on 30 October 2014 and stated that "Aunty was happy during this outing", ate and was "communicating". She recalled playing cards with her and Ms Karpa that evening and that Kumanytjayi told her that "she was not feeling well; she told me she was tired". Ms Malthouse stated that she and Kumanytjayi went to sleep "at about 11pm" and she slept on the floor whilst

Kumanytjayi slept on the bed. She "did not hear or see any problems with aunty during the night".

65. Ms Malthouse set out within her statement that the next morning she woke at 7am and went about having breakfast, her medication and a shower. She stated that when she returned to room 5 she:

> "… saw aunty sleeping on her bed. Aunty was laying face down with her face in the pillow. Both arms were by her side.
>
> "I then rubbed aunty's back to get a response. I didn't see any signs of breathing so I went and informed case worker Ruchita. Aunty's left arm felt cold to touch."

66. Ms Ruchitabahen Panchal was the worker that Ms Malthouse spoke to. Ms Panchal gave evidence before me. She commenced employment at CAAAPU in the Alcohol Mandatory Treatment Program on 3 July 2013. She had known Kumanytjayi since she was detained on 15 August 2014 but she had gone on leave a number of times during that period. She described being aware that Kumanytjayi was "sick". She recalled that when she returned from leave in October 2014 that Kumanytjayi was well on some days but not on others.

67. Ms Panchal also recalled the cultural outing on 30 October 2014 and Kumanytjayi being in the car, listening to music and appearing "really good". After the outing, Kumanytjayi told her she was tired, but so too were a number of clients and so she allowed them time off. She did not see Kumanytjayi again before finishing her shift at 4.00pm that day.

68. On 31 October 2014, Ms Panchal started at approximately 8.00am. She conducted a hand over at about 8.20am and was advised that a wakeup call had already been done but some clients were still asleep. At about 9.00am Ms Panchal started knocking on the doors to wake up the remaining clients. She reached room 5 which was occupied by Kumanytjayi and Ms Malthouse and noted Kumanytjayi was still in bed, but Ms Malthouse was awake. She saw that Kumanytjayi had the covers over her but did not think this was

unusual for her and therefore gave her no cause for concern. She said to Kumanytjayi words to the effect that she needed to "wake up", have her breakfast and medication and that it was nearly 9 o'clock, but Kumanytjayi did not respond.

69. When there was no response, Ms Panchal asked Ms Malthouse to wake Kumanytjayi. This was because she did not normally touch the clients to wake them. She saw Ms Malthouse touch Kumanytjayi and at the same time Ms Panchal moved the bed covers and noticed Kumanytjayi was face down with her face on the pillow. She noticed that Ms Malthouse appeared shocked and as a result she touched Kumanytjayi and noticed she felt "very cold". Ms Panchal stated she immediately knew that "something" was wrong and called for help from fellow worker Ms Yasmine Watts and then subsequently raised the alarm with other staff.

70. Ms Watts' statement to police was tendered in evidence and confirmed in large part the events as recalled by Ms Panchal. She too recalled that Kumanytjayi had appeared "a lot better" on 30 October 2014 than the previous week and in fact described her as "chirpy". Ms Watts also confirmed that Kumanytjayi usually slept until about 9.00am and so she was not concerned when she did not wake at the first wake up call.

71. Mr Ron Miliado gave evidence before me. He had been employed at CAAAPU since July 2013 and was the Quality Assurance Officer and, on occasions, Acting Manager. He recalled seeing Kumanytjayi at CAAAPU but was not involved with her directly in any way. He recalled that on 31 October 2014 at about 9.15am he was in a meeting with Mr Brett Taylor and Ms Sabine Wedemeyer when he heard Ms Panchal calling for help. Mr Miliado stated that as soon as this was occurred he immediately ran to Kumanytjayi's room and attempted CPR with Ms Wedemeyer until paramedics arrived.

72. Ms Wedemeyer also gave evidence before me. She was employed as the manager of the Alcohol Mandatory Treatment section at CAAAPU and had

held that position since July 2013. She largely confirmed the events as described by Mr Miliado as to when the alarm was raised.

73. I received statements from each of the St John Ambulance officers who attended CAAAPU that morning. They described the events upon their arrival and recalled their opinion, together with Dr Malcolm Johnson who subsequently arrived, that Kumanytjayi had been dead for some time. They undertook a Recognition of Life Extinct ("ROLE") procedure and Kumanytjayi was declared deceased on arrival ("DOA") with Dr Johnson pronouncing her death at approximately 9.48am on 31 October 2014.

Cause of death

74. Given Kumanytjayi's death was sudden and unexpected, it was particularly important that an autopsy be carried out. This was done by Dr Terence Sinton on 5 November 2014. Dr Sinton also gave evidence before me and noted that upon examination of the body he found no injuries to Kumanytjayi's body and therefore no evidence to indicate foul play or any suspicious circumstances surrounding her death.

75. Blood samples were taken by him and subsequent toxicological analysis showed the presence of anticonvulsive drug valproate and of the sedative drugs diazepam and nordiazepam; but at therapeutic levels with no causal connection to the death. Importantly there was also no alcohol detected. Dr Sinton stated in his report that the significant findings at autopsy included the following:

> "(i) A severely atrophic right kidney, with frank pus, and kidney stone formation (acute suppurative pyelonephritis with nephrocalcinosis).
>
> (ii) Evidence of severe chronic inflammatory damage to both kidneys (chronic glomerulonephritis).
>
> (iii) Evidence of past contusional brain damage, along with acute but mild congestion of the surface of the brain (acute cortical hyperaemia).

(iv) Microscopic evidence of mild but chronic inflammatory disease of the liver (hepatitis)."

76. Dr Sinton stated:

> "Given the history and autopsy findings, she died from severe acute on chronic kidney failure, the effects of this compounded by both acute and chronic brain damage".

77. Dr Sinton expressed his opinion within the autopsy report that the cause of death was Acute Suppurative Pyelonephritis with conditions contributing to her death being Acute and Chronic Brain damage and Chronic Glomerulonephritis. In his evidence he explained that Acute Suppurative Pyelonephritis was in basic terms a sudden or rapid infection in a kidney with pus present. He considered the infection likely to have happened over a period of "*some days to weeks, to have that appearance*".

78. I note that the Department of Health called evidence from Dr Anthony Joseph ("Jo") Wright which also sought to address the issue of cause of death. Dr Wright is a physician and was not present during the autopsy of Kumanytjayi. I note that Dr Wright's evidence was given based on his consideration of Dr Sinton's autopsy report, Kumanytjayi's medical records and observations made in witness statements in the lead up to her death.

79. Dr Wright set out his opinion that the autopsy findings did not in fact support a finding that Kumanytjayi's death was due to acute infection. He noted in his affidavit (and confirmed during his evidence) that death due to acute infection generally included signs associated with low blood pressure and haemorrhagic changes. He stated that in his opinion, deaths due to acute pyelonephritis also only occurred after the kidney had become obstructed, which then usually resulted in the patient being in great pain and becoming sick over several days with "profound disturbance to bodily functions". Dr Wright noted that none of this was evident in Kumanytjayi's records or the witness accounts prior to her death. In his evidence he stated that such an infection did not occur "*silently*" and that (tp.110.7):

> "A renal infection is a major life-threatening illness and people are in pain, they're sick, they're not able to get out of bed. They're quite unwell and it's not something that's mistaken."

80. It was therefore Dr Wright's opinion that Kumanytjayi's death was "more likely" due to a cardiac event which he considered was "almost certainly triggered by one or more epileptic seizures. Dr Wright confirmed in his oral evidence that it was his opinion there was (tp.123.10):

> "…a compelling case that she had a cardiac death as a result of changes in her blood chemistry that occurred during a fit. And we have evidence that she actually was occasionally incontinent of urine during – during a fit and she had been incontinent when she was found in bed. So I think a fit was certainly involved and I think it likely that even in the absence of abnormalities in the coronary arteries or any severe abnormalities in the coronary arteries, we have enough evidence to show that both her potassium goes up and she had developed bradycardia in an unexplained way, that both of those things probably conspired to lead to her having a fatal cardiac event.

81. Dr Wright's opinion and report was provided to Dr Sinton who confirmed that during the course of his autopsy he also considered other potential causes of death. He stated (tp.179.1):

> "… this woman was chronically, and almost irremediably ill in my opinion. There were a number of things that could have caused her death for which there is pathological evidence which I believe I demonstrated at autopsy."

82. In relation to other potential causes of death he stated (tp.179.2):

> "In relation to the infective disease of the kidney, this has the potential to produce a kind of complication called septicaemia and this is when the bacteria in the kidney actually starts spreading through the body and the toxic products of this bacteria also spread through and they can produce quite profound and very rapid changes in the body and there was some evidence for that inasmuch as she had some inflammatory – mild but acute inflammatory damage over the surface of her brain. The other thing is, the damage to the brain itself – I know this woman had a long history of epileptic disease and seizures and I believe it is a point of contention but certainly that could have caused her death as well, had she had another seizure. And then the third way in which she might have died, as a general

> concomitant to all this, is under the general heading, if you like, a biochemical or metabolic…"

And further (tp.179.5):

> "And this happens as a result of the chronic disease affecting both kidneys. Over a period of time, various changes take place in the body and these can produce chemical changes which can have a very profound and very acute and very dangerous effect, particularly on the heart and it can cause cardiac arrest. So the three groups are the septicaemic disease from the kidney, the disease in the brain which has been there for some time, or thirdly, the metabolic effects perhaps of both these conditions."

83. Dr Sinton also noted that there was in fact evidence of obstructive damage to both kidneys where the tubes coming away from both kidneys were dilated and inflamed providing evidence of past obstructions to the urine going from the kidneys down into the bladder. He agreed that generally Acute Suppurative Pyelonephritis was an "*unbelievably painful condition from time to time*" however he stated that pain was "*subjective*" and there was evidence of chronic brain disease which may have altered Kumanytjayi's perception of pain.

84. Dr Sinton stated that he *certainly* did not rule out a cardiac event as opined by Dr Wright and went on to state (tp.180.5):

> "I think she did die a cardiac death, related to the changes – as I say, the kidney disease, in my mind, was a starting point, if you like, for her final decline, and it culminated in my opinion in the cardiac arrest and my – if I can offer my pathological evidence for that is that she died pretty quickly and we know that because there is no fluid build-up in her lungs which is a very common finding. As people go into that terminal heart failure event, their lungs tend to fill up with fluid, hers had not done so. So I think she has died a rapid death. By no means do I exclude a further epileptic seizure, but again, my rationale for that as a pathologist is that I am looking for a causal link between defined and identified pathology rather than necessarily a supposition of pathology."

As to the opinion of Dr Marcus Ilton, Dr Sinton stated (tp.180.8):

> "I think – and this is complex stuff, sir, with lots of side tracks on it and people get confused – but basically, in my opinion, she has had this chronic disease, she has had an acute episode on the top of chronic illness over many years. There has been an event – the evidence would suggest that it's cardiac. The evidence is perhaps less defined as to what produced the cardiac event – either a neurological one from her brain or an acute infective and metabolic one from her kidney. I can only say that in my opinion that the kidney disease was more affinitive at this time.

85. I have considered carefully the evidence of the experts surrounding the possible causes of Kumanytjayi's death. It is clear that Kumanytjayi suffered a constellation of comorbidities and ill health. As such, any one of the identified possible causes of death such as acute on chronic pyelonephritis, a seizure, the onset of septicaemia, or even a combination of other potential causes, may have caused her cardiac arrest. Whilst I am able to find that Kumanytjayi died from a cardiac arrest, I am unable to find with any degree of certainty what caused that cardiac arrest. I therefore find her cause of death to be cardiac arrest resulting from one or more of the chronic and acute illnesses possessed by the deceased.

Issues for consideration

86. As stated at the commencement of these findings, my focus during this inquest was to:

86.1 ensure that the standard of care being provided to Kumanytjayi as a person "detained" under the *Alcohol Mandatory Treatment Act* was appropriate;

86.2 ensure that such care was being provided in accordance with the stated objectives of the legislation; and

86.3 determine whether her health issues were being appropriately investigated during her detention.

87. I intend to deal with these issues under the following headings:

87.1 The standard of care and supervision provided by CAAAPU staff during Kumanytjayi's MRT order and detention at the facility;

87.2 The standard of medical treatment provided to Kumanytjayi by medical professionals employed by the Department of Health during the period of her MRT order.

The standard of care and supervision provided by CAAAPU staff during Kumanytjayi's MRT order and detention at the facility

88. As previously noted the *AMT Act* is a health based legislative framework. It is therefore implemented by the Northern Territory Government via the Department of Health and that Department therefore bears ultimate responsibility for persons made the subject of a MRT order. CAAAPU is however the secure residential treatment centre whilst the person is subject to the MRT order. On this basis, I consider it appropriate to carefully analyse the evidence as to the standard of care and treatment provided by CAAAPU to Kumanytjayi during her period of detention there.

Supervision

89. As to the issue of supervision, whilst Kumanytjayi absconded from CAAAPU on 15 August and 20 and 24 September 2014, I consider that overall CAAAPU staff provided an adequate level of supervision to her. It is important to recall that CAAAPU (and other secure residential treatment centres) are not prisons, nor are they intended to, nor should they, be prisons. Having said that, every effort should be made once a person is subject to an MRT order to ensure that they remain at the facility for the entire period of that order if they are to have any hope of being able to meet the objects of the *AMT Act*.

90. The persons targeted by this legislation are persons recognised to be "some of the most chronic abusers of alcohol in our community". It is therefore of little surprise that they would be, at the very least, reluctant to remain in facilities where they are prevented from accessing alcohol. It appears

however that appropriate processes are in place for preventing as much as possible people from simply leaving, and also for ensuring persons are returned to the facility should they abscond.

91. I note that during the evenings all clients at CAAAPU, including Kumanytjayi, were checked every hour. Such checks do not involve any physical contact with the client. On each occasion that Kumanytjayi was checked it was considered, even at the wakeup call at approximately 7.00am, that she was asleep and staff were not concerned about her on those checks. I did initially therefore have some concerns about the adequacy of these "checks" and their purpose. I also note that during the night shift, there is only one case worker for every 10 residents. Whilst the case worker is trained in first aid; they are not nurses or health professionals. It was identified during the course of the evidence however that the purpose of the hourly checks was to ensure that the client was still at the facility and that they were behaving appropriately.

92. I have now sat as the Coroner during a number of inquests where questions have been raised as to the adequacy of checks which do not involve direct physical contact with the person. I am well aware that the significant reason for not making physical contact with a person during such checks is to avoid interfering in that person's sleep. Obviously sleep is important for any human being and particularly where that person is suffering health problems and attempting recovery, as was the case here, from chronic alcohol abuse.

93. I also note the evidence that the manner of "checks" had been changed from those undertaken initially because CAAAPU staff had received a number of complaints from clients being frightened by someone coming into their room and others not wanting to be woken every hour. As a result changes were made and the purpose of the checks was only to ensure clients were present and behaving appropriately. This being their purpose; it is clearly fulfilled by the manner in which the checks are presently conducted.

94. Whilst I cannot be satisfied about when precisely Kumanytjayi passed away, given that she was cold to the touch at the time of her discovery, it appears likely that she had been deceased for some time. I do find however that it appears more likely than not that even if it had been discovered quickly that she was not breathing, this is not likely to have made any significant impact upon the unfortunate outcome of her death given its likely cause and the evidence of Dr Sinton that Kumanytjayi "*was chronically, and almost irremediably ill*".

Treatment

95. As for the "treatment" provided by CAAAPU staff within the facility; I note that whilst the case workers were responsible for ensuring that persons received their prescribed medication, they were not involved in any other way besides dispensing the medication from a Webster pack and ensuring that it was taken. The responsibility for the medical management rested with the attending medical officers employed by the Department of Health.

96. As to the provision of treatment for clients to improve their social functioning, restore their capacity to make decisions and reduce their risk of relapse (i.e. part of the stated objects of the legislative scheme), I was concerned by the lack of clear evidence provided as to what precisely was being done at CAAAPU. In relation to Kumanytjayi; it does not appear that a formal case treatment plan was prepared for a significant period of time following her detention. According to the evidence of Ms Wedemeyer it appears there was not even a formal pro-forma document in existence at the time known as a case treatment plan. It is also apparent that there was a six (6) week period during Kumanytjayi's 13 week order where there was no Senior Treatment Clinician employed at CAAAPU to even prepare such care treatment plans. This is of real concern given such plans assist in providing direction, and attributing identified responsibility, for the care and treatment of a person subject to a MRT order.

97. It does however appear that this situation has changed at CAAAPU and that there has been a Senior Treatment Clinician employed at CAAAPU since at least 7 October 2014. Further, case treatment plans are now prepared promptly upon a client's arrival at CAAAPU. It also appears that whilst a formal care treatment plan in documentary form may not have been prepared for Kumanytjayi for a significant period of time; this did not mean that she was not receiving any "treatment" during her detention at CAAAPU. I note that she was participating in rehabilitation programs, outings and receiving medical treatment and monitoring for her continued seizures throughout her detention when she had not absconded. I also note that whilst there were delays in the treatment approaches taken with respect to Kumanytjayi, these delays were because of her numerous absconding episodes and the fact that she drank during such episodes. This resulted in additional time being taken to get her physically stable and during such times there was the additional focus upon her seizures which were clearly a major concern to Kumanytjayi.

98. After considering the evidence carefully; I am of the opinion that staff at CAAAPU provided an adequate level of care and treatment to Kumanytjayi prior to her death commensurate with their qualifications. As I stated during the course of the evidence however, attempting to rehabilitate chronic alcoholics requires great skill and expertise. It is an extremely difficult exercise and not easily achievable *even* when the person has a strong desire to rehabilitate. Clearly such a desire is not often the case with respect to people compulsorily detained, rather than voluntarily admitted, into rehabilitation. Appropriately qualified professionals are therefore needed to be employed to ensure that this very difficult and complex task has prospects of being able to be achieved.

99. I was therefore particularly pleased to hear the evidence provided by the Chief Executive Officer of CAAAPU, namely Mr Phillip Allnutt that he recognised and accepted there is a need for a medically trained addiction specialist and/or clinical psychologist to be employed at CAAAPU to assess the treatment being provided to clients at CAAAPU and that he is making

endeavours to ensure this occurs with the assistance of the Department of Health. I was also impressed by his evidence as to CAAAPU's own efforts to increase the qualifications and skill base of even its Life Skills workers and case managers to improve the care provided to its clients.

100. I should also note at this juncture that I was impressed by the evidence received from Mr Allnutt and his senior members of staff as to what they did following this death. It is clear that CAAAPU took this death very seriously. I note that CAAAPU undertook a number of culturally appropriate steps and Mr Allnutt also reviewed CAAAPU processes and policies, resulting in changes being made should such an event occur in future. Whilst CAAAPU did not conduct its own independent review on this occasion, I note that they have ensured that one would occur in future and that they intend to undertake their own independent review, audit and evaluation of their program along with individual client cases. CAAAPU is to be commended for its proactive approach in this regard.

Protocols and procedures

101. I was however concerned about the lack of robust protocols as to the preparation of case treatment plans at the time of Kumanytjayi's detention. These are clearly important documents. I agree with the submission of Dr Freckelton QC that individual case treatment plans provide the platform for a coordinated approach to the provision of care and treatment to a person and therefore they should be a priority in terms of their preparation and access. I note however that there now exists an "Alcohol Mandatory Treatment Clinical Practice Guideline" ("the Guideline") and this forms part of the Operational Protocol between CAAAPU and the Department of Health (exhibit 11). I was pleased to see that the Guideline makes clear that an individual treatment plan should be established "preferably within 24 hours of admission" (clause 7.4) and that they are to be "continuously reviewed and revised" and to be "placed on client files and a copy … provided to the

client" (clause 7.8). These are important improvements and changes to the system in place since Kumanytjayi's passing.

102. I do however consider that there should also be a method of recording any amendments that are made to those plans as and when they occur. This is particularly so given such plans are required to be "continuously reviewed and revised". There should be some method available to record when those changes are made and the reasons for such changes, i.e. what "risk and need" has been identified to prompt such amendments to the care treatment plan. Given the preparation and review of care treatment plans forms part of the Guideline produced by the Department of Health, I intend to make a recommendation directed to the Minister to ensure protocols are instituted to formally record any changes made to a person's care treatment plan and the bases for such changes.

103. I am also concerned about the impact that lengthy staff absences had upon the care and treatment of Kumanytjayi. Kumanytjayi was detained for 13 weeks from 15 August 2014. Ms Wedemeyer gave evidence that there was no Senior Treatment Clinician completing case treatment plans for 6 weeks until one commenced on 7 October 2014. This means that when Kumanytjayi returned after absconding on 8 September 2014 there was no Senior Treatment Clinician at CAAAPU. One of Kumanytjayi's case workers (Ms Panchal) was then away for numerous periods, including a lengthy period from 26 September to 13 October 2014.

104. It is important that when someone is detained for a period of three (3) months and individual staff members integral to their treatment are to be absent for lengthy periods, that there be documented and detailed handovers between workers for that period and a formal acceptance of responsibility for that client. I was not comforted to hear evidence that placed doubt as to precisely who were Kumanytjayi's case workers at all relevant times. I therefore intend to make recommendations directed to the Department of

Health to ensure that outside providers to the AMT program (like CAAAPU) have sufficiently robust protocols in place that require this to occur.

105. I also note that there were many times during the course of evidence where there was reference to information being provided "verbally". I have said many times now as the Coroner that it is extremely important that detailed notes are taken as to events involving persons whose care is placed in the hands of another. When this is not done, it makes it very difficult for a family who is still grieving the loss of their loved one to accept evidence that certain things were said or done when they are not contemporaneously documented, furthermore, it is essential for proper care and treatment. I hope that by making such comments in these findings that CAAAPU quickly adopts changes to ensure better record keeping in relation to decisions and responsibilities for clients.

<u>The standard of medical treatment provided to Kumanytjayi by medical professionals employed by the Department of Health during the period of her MRT order</u>

106. As previously noted the Department of Health bears ultimate responsibility for persons who are the subject of a MRT order. When Kumanytjayi became an "assessable person" on 9 August 2014 and was taken to ASAAS she was subject to a health screen. This meant that the PCIS system was accessed and should have revealed Kumanytjayi's medical history; including her seizures and chronic pyelonephritis. Both conditions were potentially life threatening and yet there was no reference to the history of chronic pyelonephritis and no investigation as to whether it still existed. Further there was no investigation as to what was the underlying cause of her seizures beyond the investigations that had been carried out over 2 years prior in 2012.

107. I also note that the care treatment plan eventually developed for Kumanytjayi also made absolutely no reference whatsoever to her history of chronic pyelonephritis. Given that one of the clearly stated objects of the

AMT Act is to improve the health of misusers of alcohol, it appears appropriate that more should have been done to investigate and address this issue. If not, it is arguable that Kumanytjayi was simply being kept in a holding pattern away from alcohol for a three month period. The stated "objects" of the Act however make it clear that far more is required, and/or intended by the legislation, than simply "drying" a person out and keeping them off the streets and away from alcohol for 3 months.

108. Dr Derek Chong was Kumanytjayi's treating doctor and stated he was not aware of the history of chronic pyelonephritis and was not providing Kumanytjayi with any treatment for the same. I accept his evidence however that he was prioritising attempts to stabilise Kumanytjayi's seizures and that even if he had been aware of the chronic pyelonephritis he would not have changed the medications he provided to Kumanytjayi.

109. Given however that one of the potential causes leading to Kumanytjayi's cardiac arrest and ultimate death was Acute Suppurative Pyelonephritis, I am concerned by the failure to have carefully investigated her history of this infection, and the resulting failure to have considered treatment of this condition. This is especially so in light of the fact that she had been subject to a MRT order for almost three months by the time of her death and no investigation had been made of this serious infection despite it being part of her recorded medical history.

110. Given the importance of a person's medical history to decisions to be made as to their future treatment, there should be consideration given by the Department of Health as to whether their current protocols for the recording of a person's medical history as part of their assessment under the AMT Act is in fact sufficiently robust. Although Dr Wright did not consider that such a condition was making a "*contribution*" to Kumanytjayi's ill health, he did acknowledge in his evidence that it would have been "*preferable*" that her history of chronic pyelonephritis was recorded in her medical history and eventual after care plan.

111. Dr Chong also gave evidence that he was somewhat hampered in checking Kumanytjayi's history, and therefore conducting his own review, due to an inability to access some records held by the hospital. It is obvious that access by locum doctors to all medical information held by the Department of Health in relation to a patient is essential. I therefore intend to make a recommendation to this effect.

112. I note Dr Chong's reasonable and appropriate concession that he "could have done better". It is important that the Department ensure that if it employs locum doctors to fill these very important positions, that they are provided with all the tools and information they require to ensure they are fully informed and up to date as to a patient's medical history and that there are robust protocols in place for the handover of such information when positions change (as they do) that is conducted in a formal manner and is documented. I also intend to make a recommendation to this effect

113. Again, it is the lack of documentation, or lack of sufficient detail, that impacted significantly upon the evidence given by the professionals involved in Kumanytjayi's care in this matter. It is extremely important that this change.

114. There should also be in place a process whereby if there is a review of a patient that is scheduled to occur, it be recorded in some way so that it automatically arises in a patient's records and requires a formal acknowledgement and record making of the review having occurred or altered so as to ensure that a patient is seen and their care "followed up" as planned. A review of a patient, and follow up of their care, should not be left to "notes in a book" or someone's "smartphone". They should be recorded in a system that enables checks to take place and also ensures that should something change in terms of a patient's care then the next professional that is brought in can quickly assess that patient and ensure that the previous plans and reviews in fact occur. I shall therefore make a recommendation to this effect.

115. I note that during the course of the evidence a question was raised as to whether CAAAPU was the "*appropriate place*" for Kumanytjayi to have stayed given her condition and particularly her repeated seizures. This arose following evidence given by Ms Wedemeyer that she was concerned as to whether CAAAPU could properly monitor such seizures and respond appropriately. Ms Wedemeyer stated she raised this with Dr Chong and he advised her that he considered Kumanytjayi was "*getting better*" and he "*monitored her medication on a regular basis*". As such she relied upon his opinion and did not take the matter any further.

116. I note that Dr Chong stated that he could not recall anyone at CAAAPU raising concern with him as to whether it was the appropriate place for Kumanytjayi given her medical conditions. He recalled however that "*support staff were very concerned when she had her seizures ... (a)nd it was more of a lack of what to do when someone has a seizure and their own expertise*". As to whether CAAAPU was the appropriate place for Kumanytjayi given her seizures, Dr Chong stated (tp.140.6):

> "The staff are very vigilant. The staff recorded every little detail, and that's what I was quite happy about".

117. Whilst I consider improvements can be made, I do not consider there is sufficient evidence to find that CAAAPU was not the appropriate place for Kumanytjayi to be detained during the period of her order.

<u>Further comment</u>

118. As previously indicated, this is a death in care, not a death in custody. I therefore do not have the extended powers available to me under s.26(1) as I do when it is a death in custody to "investigate and report on a matter connected with public health or safety or the administration of justice that is relevant to the death". I may however "comment" on such matters under s.34(2) of the *Coroners Act*. Pursuant to this power I make the following comments on the evaluation of the legislative scheme created by the *Alcohol Mandatory Treatment Act*.

119. I note the stated "objects" of the AMT Act as earlier referred to in these findings. I also note the attempts by Mr Allnutt to identify possible measures of success, all of which were without any documented evidence to support the same. As I stated during the course of the inquest, a measure of the success of this scheme, and therefore the legislation, is not what is seen in the 3 month period that the person is subject to the order, but it is what is seen when that person goes outside of the program and remains abstinent. It is therefore important that the success of such a regime be able to be evaluated particularly when the legislation itself takes away ordinary human rights such as the liberty of choice, association, and freedom of movement and detains a person against their will. Unfortunately, despite the fact that the AMT Act has been in place for two years, there was no evidence provided of any actual numbers, data or research in this regard.

120. I was therefore pleased to receive the following information from Mr Macdonald on behalf of the Department of Health during the course of the evidence (tp.186.7):

> "MR MACDONALD: … In March this year, the new minister for health approved an evaluation of the scheme, including not just in relation to outcomes but also in relation to processes. Aspects of that evaluation require some approval of the medical ethics committee that's made up, I understand of Department of Health employees and in particular Menzies School of Health personnel and I'm instructed that the process to get the evaluation underway is well underway itself.
>
> Essentially it's been put out to tender because an independent body is going to conduct it. That independent body is going to be guided by a steering committee that's made up of people from service providers, peak organisational bodies and some government staff as well but the conduct of the evaluation will be done by an independent body and it's something that needs to go through the Procurement Act and so forth. They're in the process of doing that at the moment.

And further (tp.242.1):

> "MR MACDONALD: And lastly, your Honour, albeit from the bar table, you've received evidence in relation to the evaluation that's being proposed. There really is now a sufficient cohort to enable that

evaluation, which will be carried out by an independent body and both the outcomes and the processes that are being applied will be the subject of that independent consideration and ultimately report to government.

I confirm in response to my learned friend's wish that stakeholders be sufficiently consulted, that that is certainly the intention.

THE CORONER: Okay. Thank you.

MR MACDONALD: It's too early to know what the outcomes are, your Honour, but the evaluation will be transparent. It will be fulsome and it will clearly state ultimately what the outcomes of the program that's been applied have been since July 2013."

121. Given the clear importance of such an independent evaluation, I encourage the Department of Health to work quickly on ensuring that one takes place in the near future. Should such an independent evaluation not occur promptly there can be no real assessment as to whether this scheme is truly achieving positive results and achieving positive change for persons who are chronically ill in our community and who are extremely vulnerable, just as Kumanytjayi clearly was. A failure to conduct a proper evaluation also only lends support to the growing criticism and sentiment that this legislative regime is simply another way of detaining persons and keeping them off the streets and temporarily away from the community, only to put them back on the street with the very same habits they had before. Given the stated objectives of this legislation, I recommend the Department of Health ensure that this review is undertaken as soon as possible.

Formal Findings

122. On the basis of the tendered material and oral evidence given at this inquest, I am able to make the following formal findings:

i. The identity of the deceased person was Virginia Nabarula Brown who was born on 25 December 1967 in Papunya, in the Northern Territory of Australia.

ii. The time and place of her death was some time prior to 9.00am on 31 October 2014 at the Central Australian Aboriginal Alcohol Programmes Unit, 290 Ragonesi Road, Alice Springs in the Northern Territory of Australia.

iii. The cause of death was Cardiac Arrest of unknown origin.

iv. Particulars required to register the death:

a. The deceased's name was Virginia Nabarula Brown.

b. The deceased was of Australian Aboriginal descent.

c. The death was reported to the Coroner.

d. The cause of death was confirmed by post mortem examination carried out by Dr Terence Sinton on 5 November 2014.

e. The deceased's mother was Anna Pultara (deceased) and Teddy Amananu (deceased).

f. The deceased was unemployed at the time of her death.

Recommendations

To the Minister for Health

123. That authorized treatment providers under the *Alcohol Mandatory Treatment Act* be resourced and funded to provide full time medical trained staff including addiction specialists to assist in rehabilitation.

124. That protocols be established to ensure that all authorized treatment providers under the *Alcohol Mandatory Treatment Act* have as part of their clinical and organizational governance; provision for the formal recording of all versions of care treatment plans prepared in relation to persons subject to an order and any changes to such care treatment plans together with details as to what risk and/or need has been identified to require such amendments.

125. That protocols be established to ensure that all authorized treatment providers under the *Alcohol Mandatory Treatment Act* have as part of their clinical and organizational governance; provision for detailed and documented handovers of a person's care between care providers during periods of extended absence of leave.

126. That systems be established to ensure that locum doctors employed by the Department of Health are granted full access to all medical records held by the Department in relation to any and all designated patients.

127. That protocols be established to ensure that locum doctors employed by the Department of Health undertake detailed and documented handovers of a patient's care and treatment planning with formal acceptance between locum doctors of the same.

128. That systems be established to ensure that scheduled reviews of a patient's care and treatment automatically arise on their computerised file with such scheduled reviews requiring formal acknowledgement of having been undertaken and results recorded or formal alteration of the review date and the reasons why.

129. Finally, I have heard it argued that the compulsory detention of citizens against their will for rehabilitation purposes is a gross infringement of their human rights of freedom, association, movement and ability to make one's own decisions about life style. However, if the detention process results in therapeutic outcomes that save lives and restores the health of citizens, then arguably the abrogation of such rights may be justified. Without data in relation to the results of the detention process (ie. What has happened to the individuals released after three months detention?, have they been truly and successfully rehabilitated?); the community will not know if the process is arguably justified or merely a process to "warehouse" alcoholics so as to remove them from public eyesight.

130. Sadly, I was advised during the Inquest by Counsel for the Department of Health that of the over 400 citizens compulsory detained since the legislation came into effect, only eight are non-aboriginal. In my view, the perception that this legislation unfairly impacts on Aboriginal citizens is manifest.

131. I recommend that the promised independent evaluation mentioned in paragraph 121 hereof take place as soon as possible.

Dated this 14th day of August 2015

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GREG CAVANAGH
TERRITORY CORONER