CITATION: *Inquest into the death of Kumanjayi Fly* [2025] NTLC 20

TITLE OF COURT:	Coroners Court
JURISDICTION:	Alice Springs
FILE NO(s):	A0013/2023
DELIVERED ON:	5 December 2025
DELIVERED AT:	Darwin
HEARING DATE(s):	14 – 18 October 2024
FINDING OF:	Judge Elisabeth Armitage
CATCHWORDS:	**Death of toddler following submersion in domestic septic tank; insecure and degraded access cover; public housing; repairs and maintenance; cyclical/planned maintenance; 'habitability'; Wastewater Code; Wastewater Code compliance certificate; septic tank access point secondary safety shields; Housing, Health and Infrastructure Departments.**

REPRESENTATION:

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Counsel for Department of Housing and Local Government and Community Development and the Department of Health:	Michael McCarthy
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Judgment category classification:	B
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IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. A0013/2023

In the matter of an Inquest into the death of

KUMANJAYI FLY

ON: 3 APRIL 2023

AT: WOMEN'S AND CHILDREN'S HOSPITAL

FINDINGS

Kumanjayi Fly-ku walytja tjuta, anta ngurra Amunturrngunya-ngurrara tjuta, Ara ngaa tjuta ngayulu kulira nintirringu nyurra-ngarrinytjarra. Ara ngaa tjutangku ngayunya tjiluru-tjiluru palyanu. Ngayulu yuntjurringanyi nyurra-ngarrinya tjanytjumilanytjaku (Thank you), nyurra-languru ngayulu puntra nintirringu.[1]

Judge Elisabeth Armitage

Overview

1. This inquest examined the tragic passing of Kumanjayi Fly, a toddler who, on 29 March 2023, fell into a septic tank in the backyard of his family's public housing home in the remote community of Watiyawanu (Mt Liebig). His family did not know that the cover and access point to the septic tank was neither safe nor secure. Kumanjayi Fly was born on 26 March 2021, and he passed away at the Women's and Children's Hospital in Adelaide on 3 April 2023 from the injuries he sustained. He had only just turned two. His family have suffered an unfathomable loss.

[1] To Kumanjayi Fly's family and community, I am sorry for your loss. I have listened to your stories. You have helped me to understand.

2. It was heartening to hear[2] of the prompt and significant response from the relevant Minister and Government to the inquest findings into the passing of little Ebony Thompson. I am sure Ebony's parents were consoled by the opportunity to engage with the relevant Minister and to hear of her intention to "act fast" and for it to be made clear that this Government will not tolerate "breaches of safety and quality" anywhere in the Northern Territory and those responsible for such breaches will "be held accountable." I agree with those sentiments and Minister's Hersey's reported comments that,

> ***"Child safety is no accident. It requires constant vigilance, strong laws and a shared commitment from all of us - government, educators and communities alike."***

3. A similar commitment is required from those responsible for providing and maintaining public housing for young children in our remote communities. I can only imagine that Kumanjayi Fly's parents would be comforted by the opportunity to meet the relevant Minister. No doubt they would be reassured to hear that the Government proposes a similarly robust and swift response to the tragic circumstances of little Kumanjayi Fly's passing.

4. Although this type of accident is not common, the risk is not theoretical it is very real.

   4.1. Over a 14 month period, 3 children in Australia, including Kumanjayi Fly, died after falling into septic tanks.[3]

   4.2. In 1998 at Minyerri a 2 year old child died in the yard of his family home after falling into a septic tank through an access cover that was not secure.[4]

   4.3. In two separate incidents, in December 2021 in the Katherine region and August 2022 in the Barkly region, a child fell into septic tanks through unsecured lids. Each incident was witnessed, and the two children were rescued without injury.[5]

   4.4. In 2023 an adult visitor to Litchfield National Park stepped on an unsecure septic access cover in the dark. Her body weight caused the cover to rotate, and she fell part way through the opening.[6]

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[2] As reported by G. Kasakov, "NT childcare centres warned to 'fix their act fast' under new crackdown in wake of Ebony's death," NT News 1 December 2025.
[3] Victorian Coroner's findings concerning *the death of Nihal Singh Hundal*, 29 May 2024
[4] Vol 5, *5.27 – Inquest into the death of Clinton Kingsley*, 14 September 1999, file 9825209, case 199/1998
[5] Vol 5, *5.6 – NT WorkSafe incident*
[6] Vol 5, *5.37 – statement of Jacqueline Bradshaw*

4.5. In October 2024 NT WorkSafe investigated 3 incidents in which septic tank covers were identified as being non-compliant. The photographs reveal clear safety risks if these covers were accessible to the public.[7]

5. The risk posed by septic systems is also significant because septic tanks are common and widespread in the Northern Territory. Audits undertaken after Kumanjayi's death recorded more than 900 septic tanks at public housing residences alone. In addition, septic tanks are found at commercial locations, private homes, schools, health clinics, police stations, boat ramps, national parks, roadside stops, and many homelands.

6. Concerning the septic system responsible for Kumanjayi's death, there were multiple missed opportunities to improve safety. If proper and sufficient maintenance or replacement of the septic system had been undertaken, this death would likely have been prevented. This cover failed because of corrosion at the access point which meant it did not sit or seat properly. The corrosion occurred over time, and it should have been detected and rectified before the cover catastrophically failed.

7. Kumanjayi's passing was shockingly traumatic for his family and community, some of whom were present and witnessed the tragic event. They will always mourn and grieve for him. They are worried that there might be other hidden dangers in their homes. They are frustrated because when issues of maintenance in public housing are raised, they can be seemingly ignored, or there may be lengthy delays, and/or repairs may be inadequate or temporary and the problem recurs. The impact extends beyond this family. A dysfunctional repairs and maintenance system not only has the potential to breach statutory obligations of habitability, health and safety, it creates real risks to the health and safety of residents that can have fatal consequences.

8. I heard expressions of remorse and regret and acknowledgment of failures. There appeared to be a desire to make real and practical changes to prevent a similar death occurring again and I commend NT government staff for the significant remedial work that has already been undertaken. However, the family submitted that frustrations with repairs and maintenance of remote public housing have been long standing and past promises have not resulted in meaningful progress. The family seeks a major change of approach, to cyclical and planned maintenance instead of responsive repairs.

Recommendations

9. Pursuant to s 35 of the *Coroner's Act*, I make the following recommendations:

To the Department of Housing, Local Government and Community

[7] Vol 5, 5.36I - NT WorkSafe – Information Release

9.1. There must be a prioritised and timely progression to cyclical or planned maintenance for remote public housing septic systems and more generally. A Road Map as to how this is to be achieved should be prepared within the next twelve months with clear steps for implementation. Independent review and public annual reporting of progress is to be established. Funding levels for repairs and maintenance should be reviewed and reconfigured to meet the actual needs of cyclical/planned maintenance.

9.2. If it has not already occurred, the 10 septic systems at Watiyawanu identified in the 2019 plumbing report should be replaced with septic systems that comply with the Wastewater Code of Practice current at the date of installation.

9.3. Evidence was given that an audit is currently being undertaken in relation to septic systems across 11 priority communities. On completion of that audit, where houses received additional bedrooms under the Room to Breathe program and septic systems are as a result non-compliant with the current Wastewater Code, the systems should be upgraded/replaced so as to be compliant.

9.4. Secondary safety shields are to be fitted to all septic tank access points in public housing.

9.5. Contractors engaged to upgrade, repair, add to or replace components of septic systems or install complete septic systems must provide full technical details of the work and a clear statement of compliance with the applicable Wastewater Code.

9.6. An up to date asset management register for public housing across the Northern Territory must be maintained which includes information about designs and maintenance history.

9.7. Whether it is part of the Rolling Housing Asset Condition Program or another program, ongoing and regular audits should be commenced of public housing assets. These audits should consider safety, performance and maintenance needs. Planned and responsive maintenance must be documented and communicated to the tenants.

9.8. A portion of all building, repairs and maintenance works carried out on public housing should be subject to auditing to ensure it is of a high standard and complies with any relevant statutory, regulatory or code requirements.

9.9. A system is to be established so that public housing safety risks identified in, for example, WorkSafe publications, Kidsafe publications and coronial

findings (NT and interstate) are monitored, considered and responses actioned.

To NT Health

9.10. NT Health is to review the current Wastewater Code and related legislation, policy and guidelines and pursue any changes identified as necessary to:

9.10.1. Remove ambiguity and uncertainty as to when and in what circumstances compliance with the current Wastewater Code must be achieved including, for example, at installation, when significant components are replaced and/or when a dwelling is extended;

9.10.2. Incorporate a certificate of compliance for all septic systems and establish a clear regime as to when certificates are required and who can provide such a certificate;

9.10.3. Clearly identify if compliance exemptions are available, and if so, in what circumstances. Clearly establish a process of application and decision making concerning exemptions;

9.10.4. Introduce as mandatory, secondary safety shields for all septic tank access points.

Preliminary issues

10. On 10 October 2024, before the inquest formally commenced, I travelled to Watiyawanu, with the representatives of interested parties. The importance of this trip cannot be understated. More than 36 people from Papunya, Watiyawanu, Warren Creek outstation and Kintore met the coronial entourage at Watiyawanu on 10 October 2024.

11. The visit provided an opportunity for family and community members to better understand the purpose of the inquest and provided an opportunity for them to voice their concerns and hopes. In addition, the site visit and view were crucial to helping me, counsel assisting, and the interested parties, to better understand Watiyawanu and the circumstances of Kumanjayi's death.

12. Following this visit, many family members were empowered to travel to Alice Springs to attend the inquest and many family and community members attended Alice Springs court each day of the inquest, including those who had travelled in from communities. I sincerely thank the housing department and North Australian Aboriginal Justice Agency for their assistance with logistics and funding of this endeavour. Without this support I am sure that far fewer family and community members would have been able to participate in the inquest. I would not have had the

benefit of hearing directly from family as issues arose, and the community would have lost the opportunity to hear directly from the witnesses.

13. I thank the family for their respect they showed to the coronial process and their engagement and contributions. The evidence they gave and the information they provided was of critical importance to understanding what happened to Kumanjayi and why.

14. During the period considered by the inquest, there have been changes to the machinery of government. The two main government departments involved in this inquest have changed name and responsibilities have also shifted between departments. At the time of the inquest further changes were underway. Following this shift, it may be that the bulk of future responsibility falls to the Department of Housing, Local Government and Community Development. However, because of the governing structures at the time of the coronial investigation, the former Department of Infrastructure, Planning and Logistics, took a lead role in responding to issues raised in this inquest and will still likely have a role to play in the future.

15. For simplicity, when referring to general tenancy services and overarching responsibility for remote public housing I have used the generic phrase 'the housing department'. I have used the phrase 'the infrastructure department' to refer to whichever department was or will be responsible for the:

    15.1. repairs and maintenance;

    15.2. renovation; and

    15.3. construction;

    of public housing homes in remote communities.

16. The findings and recommendations will need to be understood applying that terminology.

Safety issues beyond the scope of the inquest

17. While considering repairs and maintenance to the septic system at lot 8, other remote housing safety issues became glaringly apparent, for example, precarious air conditioners, concomitant concerns about heat and habitability, and building site safety. I could not simply ignore the obvious dangers which were revealed by the site visit. While the other dangers observed by me (and all in attendance) arguably fell outside the scope of the inquest, the fact that there were numerous dangerous items and sites gave me insight into the limitations of the building, repair and maintenance systems operating in remote public housing and its effect on housing and community safety. It seemed to me that standards that would not be accepted in urban public housing were passed as acceptable in remote public housing or were overlooked.

18. Specifically, during the visit to Watiyawanu on 10 October 2024, I observed the following risks, particularly to children:

    18.1. air conditioners dangerously balanced on makeshift structures;[8]

    18.2. gates inappropriately left open to a building site when no workers were present;[9]

    18.3. hard rubbish, including a dangerous metal spike, left on the street in front of a building site; and

    18.4. unsafe sheet metal at the community singalong area.

19. Despite being told that directives have been given to infrastructure and housing department staff not to walk past any safety risks, that is exactly what I observed happening.[10]

20. The unsafe installation of air conditioners in communities is a widespread and longstanding problem. In 2018 Room to Breathe published a photo celebrating a successfully renovated home and in the photo an air conditioner can be seen precariously balancing on a stick.[11] Photos from 2015[12] and from the time of Kumanjayi's death[13] show that unsafe air conditioners have been at lot 8 for many years. The building contractor who undertook the Room to Breathe renovations in Watiyawanu was shown photographs of the air conditioners I saw at lot 8 and he agreed that is not something that would be acceptable in Alice Springs.[14] Are there two different standards for what is accepted in remote communities and what is accepted in our towns?

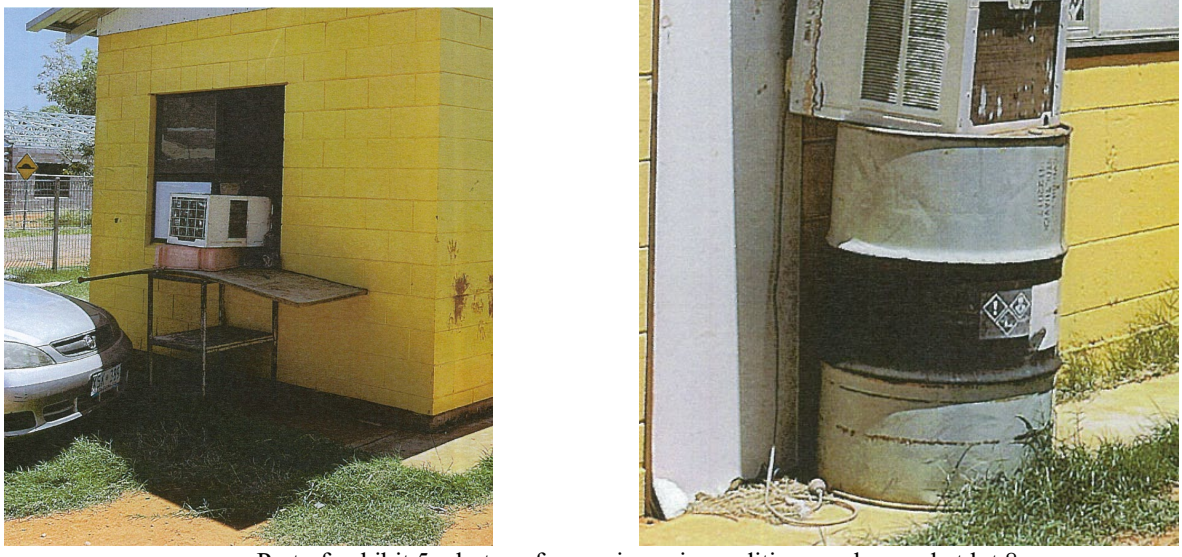
21. Fortunately for Watiyawanu, in response to the inquest visit, the infrastructure department engaged a contractor to inspect all public housing assets and, where unsafe air conditioners were identified, to safely install them with the use of brackets. I was told that there were 25 air conditioners at 16 houses that needed safety brackets.[15]

22. Across the Territory, tenants have installed their own air conditioners in 75% of public houses.[16] This is well known to governments which have required contractors to include removeable windows or metal hatches for this very purpose when

[8] The Room to Breathe building contractor at T 41 agreed that would not be acceptable in Alice Springs.
[9] The Room to Breathe building contractor agreed construction site gates should not be left open, T 43.2.
[10] T 453
[11] Vol 5, 5.16, pp 12-13
[12] Vol 5, 5.14B, p 116
[13] Vol 1, folio 6, p 42.
[14] T 41
[15] Vol 5, 5.13H [20]; T 531.4
[16] Vol 5, *5.30 – Ministerial brief*

constructing new builds in community. In light of what was revealed concerning the safety of self-installed air conditioners in Watiyawanu, in my view there must be a real doubt as to the safety of many air conditioners across many communities. This is an issue about which the infrastructure and housing departments are well aware and should not continue to ignore.

23. Requiring tenants to remove air conditioners[17] would be a cruel response in circumstances where high environmental temperatures impact the health and safety of tenants. More sensibly, I was told that the infrastructure department now expects contractors to carry brackets when working in communities and they are authorised to immediately fix any dangerous air conditioner installations that they see.[18]



Part of exhibit 5, photos of precarious air conditioners observed at lot 8

24. The family submits that the circumstances of this death present an opportunity to make strong recommendations for major and lasting reforms to the management of

[17] Housing department closing submissions at [90]
[18] T 531

maintenance and repairs in remote communities and for there to be a focus on meaningful engagement with residents in remote communities.

25. However, the infrastructure department cautioned me not to go beyond my jurisdiction and reminded me that I do not have the power to conduct an enquiry at large into the legal and regulatory framework governing the provision of housing in remote communities in the NT. The infrastructure department considered that some of the issues raised by the site visit and some of the submissions made on behalf of the family were 'beyond scope'.

26. I accept there are jurisdictional limits as to the scope of my inquiry concerning this death. However, my jurisdictional limits do not apply to the housing or infrastructure departments. Indeed, the housing department helpfully submitted that the current process of institutional/departmental change provided an opportunity for the newly forming housing department to embed all the lessons learned from this death into its policies, procedures and practice. In light of that commitment. I trust that the housing department will engage fully with the breadth of concerns raised in the family's submissions, including any that do not form part of these findings or my ultimate recommendations. It would be a great shame and a disservice to the family, and the safety of other children, if this opportunity was squandered and if the other dangers observed during the site visit, including concerns about heat and habitability, were permitted to continue unaddressed and unrectified.

Structure of these findings

27. The findings are structured as follows:

    27.1. Part 1 considers the circumstances of Kumanjayi Fly's death;

    27.2. Part 2 explores the systemic issues that were identified as relevant to Kumanjayi Fly's death; and

    27.3. Part 3 sets out the conclusion and formal findings.

Part 1 – Family and circumstances

28. Kumanjayi's mother is from Watiyawanu, his father is from Kintore, and Kumanjayi grew up in both communities. Kumanjayi was a happy child. Kumanjayi liked listening to music, especially gospel songs. His favourite song was played at the inquest. He was raised and loved by a large extended family.

29. Watiyawanu is a community of about 150 people just over 300 km west of Alice Springs. I heard from many people that Watiyawanu is a lovely place to live and there is a strong sense of community. Non-Aboriginal people who have lived or worked in Watiyawanu also spoke with affection and warmth about the community and its residents. There are high levels of literacy in Pintupi-Luritja, something not common

to all remote communities, and the principal said the local parents are very engaged with the school. MacDonnell Regional Council also spoke of the high levels of engagement of the local authority members and traditional owners who interact with the council.[19]

30. Watiyawanu is not on mains sewage. Instead, each residential house has its own wastewater management system consisting of a septic tank and leach drains which are dug into the ground in the yard of the house. The septic tanks have access points wide enough for an adult to pass through. Covers on these access points are required to be secure and non-permeable. This is not only to prevent accidental injury or death but is also a matter of functionality, hygiene and public health, ensuring that the sewage is contained, and rain or ground water does not enter the system.

31. On 29 March 2023, Kumanjayi was playing in the back yard of his family home at lot 8, Watiyawanu. His mother and 2 grandmothers, Mrs Wheeler and Mrs Jaycreek, were close by. They were sitting under the big shady tree in the back corner of the yard. This tree is a natural place to sit when it is hot, being the only substantial shade in the yard.[20] They were watching Kumanjayi play.[21] Kumanjayi Fly should have been safe playing in his backyard and his family did not know that the septic tank covers were a safety hazard.

32. Kumanjayi was playing in a small, plastic, 'shell', wading pool set up under a tap next to the house. If you were to walk directly from the tap where Kumanjayi was playing to the big shady tree where his family were sitting, you would pass over or immediately next to one of the septic tank access covers and it was common for family to walk over the top of the septic covers.[22]

[19] Vol 5, *5.35 – MRC* at [27]
[20] T 54
[21] T 19
[22] Mrs Jaycreek gave evidence of family members walking around and on the sewage tanks, T 56.1; Mr Jeffery Wheeler said a lot of people walked on the cover, T 66.3.

Exhibit 7, photo showing the tap (the pole in the foreground) where the 'shell' pool was located, the septic tanks and the shady tree where Kumanjayi's family were seated.

33. The women in the yard did not see or hear Kumanjayi fall into the tank.[23] On realising Kumanjayi was no longer playing at the tap, and not being able to see him, his mother and grandmothers went looking for him in the house and in the yard. Mrs Jaycreek went to the septic tank cover. When she saw that the cover was "a little bit open" she called for help.[24]

34. Roderick Daniels, who was at home fixing his car, heard the wailing, and knew straight away that something was very wrong. He came running.[25] As Kumanjayi was fully submerged, Mr Daniels could not see Kumanjayi in the septic tank. Mr Daniels put his body partly into the septic tank and reached into the sewage but did not immediately find Kumanjayi. Mr Daniels then put his body further inside the septic tank. He was then able to feel Kumanjayi who was upside down in the sewage. Mr Daniels pulled him out of the tank.[26]

35. Mr Daniels did everything he could to save Kumanjayi. Listening to Mr Daniel's evidence he is one of the many people who has been affected by the loss of Kumanjayi, and by the traumatic circumstances.

[23] T 19.10, T 55
[24] T 55-56
[25] T 146
[26] T 151.9, also statement to police, Vol 1, folio 16

36. Kumanjayi received medical treatment from clinic staff, and he was flown to Alice Springs Hospital and then to Adelaide. Despite all efforts, medical staff were unable to save him, and he passed away a few days later as a consequence of having fallen into the septic tank.

1A. When Kumanjayi passed what was the condition of the septic tank access cover?

37. A properly functioning septic tank access cover should be secure and not permit someone to fall through accidentally.

38. The septic tank at Kumanjayi Fly's house had a tapered metal lip, or collar, in which the cover was designed to sit. The metal collar is set in concrete. The concrete block is called a riser, and it sits above the ground level to avoid water pooling on the cover and riser. When properly fitted or 'seated' the cover should sit securely in the collar and flush with the concrete riser.

39. The cover was made from concrete and metal and was very heavy. [27] The cover requires the use of a special tool to move it[28] and even with the right tool significant force or strength is required to remove the cover.[29] These are safety features[30] which are designed to ensure the cover is secure. If the cover had been secure, it would have prevented Kumanjayi from falling into the tank.

40. At the time of Kumanjayi's death the cover was clearly not functioning correctly.[31] The cover did not seat securely in the collar and could be moved by applying force on the outer edges. Mr Lawrence Kenny, who attended the house shortly after the accident, described the cover as "spinning like a coin."[32]

41. Police observed that the cover was not seating properly and there was, "a build-up of rust and dirt".[33] The infrastructure department submit that it was the corrosion of the collar that is likely to have been the critical factor which permitted the cover to rotate[34] and I accept that submission.

42. Although some corrosion is normal and to be expected,[35] substantial corrosion can affect the quality of the seal,[36] and ultimately render the cover unsafe. As well as the safety risk created by an insecure cover to anyone walking on the cover, if the cover

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[27] Police estimated the metal cover to be over 20 kilograms, statement of Tim Van den Berg, brief 1, folio 11 at [16].
[28] Statement of Tim Van den Berg, Vol 1, folio 11, [16]
[29] T 107-108
[30] T 119.9; T 108.2.
[31] See Miller at T 166-7; Kenny at T 188.9; statement of Tim Van den Berg, brief 1, folio 11 at [19]; statement of Scott Anderson, Vol 5, *5.11K*; Vol 5, *5.11B - video*; T 107.9.
[32] T 188.9
[33] Statement of Detective Senior Constable Van den Berg, vol 1, folio 11 [16], [18]
[34] Department of Logistics and Infrastructure closing submissions at [45]
[35] T 107.8
[36] T 106.2. The opposite can also occur where the cover becomes seized to the collar and prevents, or at least makes very difficult, removal of the collar, T 107.3

is not sealing properly this can result in rain or surface water entering the tank or gasses escaping.[37] Water entering the tank through the access point reduces the volume of wastewater the system is able to handle.

43. There is a connection between the corrosion and this septic system 'not coping' or 'failing'. Mr Azar, a civil engineer specialising in wastewater engineering, reviewed the information available about the septic system at Kumanjayi's house. Mr Azar gave evidence that "high water levels, and/or overflow from the tank are likely to have contributed to the corrosion of the cover and the frame."[38]

44. Methane and other gases are produced inside a functioning septic tank. Over time these gases contribute to corrosion of both metal and concrete. One of the many plumbers called to give evidence considered that overuse of the system probably hastened the corrosion.[39]

45. It is not possible to determine definitively when the cover became unsafe. Deterioration from corrosion is a process that happens over time. Noting that attending plumbers were tasked to perform works and not to assess or consider corrosion, there was some conflicting evidence as to when the safety risk became critical:

    45.1. A plumber who took photos of the cover in November 2019 thought it was "sound".[40] Another plumber who reviewed those photos considered what they depicted was a concern and "absolutely" increased the possibility of a safety risk.[41]

    45.2. Photos of the access cover from multiple attendances in 2019 and 2020 show the cover sitting higher than it should, it was not flush with the concrete. This may indicate that the cover was not seating properly and possibly because of corrosion.

    45.3. Photos from late 2022 show that the riser that Kumanjayi fell through was covered in dirt or grass and the concrete was no longer visible[42] and may in part explain why a plumber who visited lot 8 on 8 November 2022 said he was not concerned by the corrosion he observed on this visit.[43]

    45.4. In 2019 the infrastructure department engaged a plumber to assess multiple septic systems at Watiyawanu and advise whether they required upgrading.

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[37] T 119.3
[38] Vol 5, *5.11A* at [5] and [22]
[39] T 119.6
[40] T 121.10
[41] T 107.5
[42] Vol 3, *2022.11.07 - eml - soakage drain insufficient*; Vol 3, *2022.11.07 - Work order 1612192*; vol 3, *2022.11.25 – invoices*.
[43] T 106.3, T 158.9

('**the 2019 plumbing report**').[44] As well as identifying other concerns, the 2019 plumbing report recorded the access covers at Kumanjayi Fly's home as being 'incorrect'. The report writer's recollection was that he believed the covers were incorrect, not due to corrosion, dirt or grass, but because they were less than 65 mm thick, which he understood to be the minimum thickness required by the Department of Health Code of Practice for On-Site Wastewater Management – July 2014 (**the 2014 Wastewater Code of Practice**).[45]

46. As to the 'correctness' of the cover, the infrastructure department is now of the view that the 2019 plumbing report misapplied regulation 6.2.9 of the 2014 Wastewater Code of Practice and the minimum thickness requirements did not apply to the steel reinforced concrete tanks at lot 8.[46] I make no finding as to whether or not the cover was non-compliant due to thickness, what is relevant is that:

    46.1. the 2019 plumbing report advised the NT Government that the cover was incorrect and non-compliant with regulatory requirements;

    46.2. no-one at the time of receiving that report questioned the opinion expressed in the report or determined it was wrong;

    46.3. on its face, the report raised safety concerns that either needed to be addressed immediately, or at least needed to be further investigated; and

    46.4. the safety concerns were neither addressed nor properly investigated prior to Kumanjayi's death.

1B. What was the condition of the septic system as a whole?

47. The 2019 plumbing report documented that all the tanks inspected in the community were "generally in poor condition", and concerning lot 8, the tanks were "non-compliant due to the fact that the access covers are incorrect, missing bollards/protection, no distribution pit, joint putty coming adrift from the saddle riser and tank, baffles corroded."[47]

48. As discussed further in Part 2A, the maintenance records for 2018 through to 2022 also demonstrated that the lot 8 septic system was failing. Photos and/or maintenance reports depicted and/or discussed instances of the sewage overflowing, that is rising above the cover[48] and the age of the septic system was raised in 2020 emails between

[44] Vol 3, *2019.11.26 – Inspection report*
[45] T 125.5
[46] T 125.3
[47] Vol 3, *2019.11.26 - Inspection report - JC Services*, see also T 117.
[48] Vol 3, *2019.12.11 – work order*; Vol 3, *2020.03.27 - Work order 1424197*; Vol 3, *2021.08.10 - maintenance order*; Vol 3, *2021.08.24 - maintenance order*; Vol 3, *2022.11.25 - invoices*.

the NT Health and the housing department[49] as a reason why it was no longer functioning effectively.

49. I am satisfied that the septic system at lot 8 was in poor condition and there was compelling evidence that it was not functioning properly when Kumanjayi passed away.

1C. Where was the cover when Kumanjayi fell into the tank?

50. The inquest considered how a child as light as Kumanjayi could have fallen through the cover into the septic tank. There were three possibilities:

    50.1. The cover was completely off, and the access point was fully exposed;

    50.2. The cover was ajar; or

    50.3. The cover was seated in such a way that even a small amount of force (the weight of a small child) was sufficient to cause the cover to rotate.

51. ST provided a statement to police. She said that she was sitting out the front of house 54 and saw Kumanjayi Fly look into and then fall headfirst into the sewerage "hall", presumably hole. This evidence suggested that the cover may have been completely off. Despite concerted efforts to have ST testify, she did not give oral evidence at the inquest.

52. Having considered her statement, I do not find her account persuasive. Firstly, her statement does not directly comment on the location of the access cover. Second, although she said that she was 50 metres away from and across the road from lot 8, the map of Watiyawanu[50] shows lot 54 is not on the same road as lot 8. Third, she said she was seated at the 'front of the house' and if that was the case she would not have had a view of the septic tank at lot 8.[51] Finally, while it is possible there is a direct line of sight from house 54 to the septic tank in lot 8, it would be between and past houses 35 and 36, across the road, and into the back yard of lot 8. Exhibit 6 in the inquest shows a photo in the other direction, from the septic tank access point towards houses 35 and 36. While I acknowledge there are real limitations in using such a photo for definitively determining what ST could or could not see, it certainly adds to my doubts about the proper weight that can be given to her evidence.

53. Mr Miller, a long standing resident, gave evidence at the inquest. He recalled hearing others say, "that the lid was away from the hole." He could not remember who said

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[49] See email from Mr Rogers, Vol 3, *2020.02.10 – eml DIPL*. The builder understood the septic systems to potentially be 40 years old, T 36.7. A septic tank upgrade took place in Watiyawanu and other communities in the late 1990s, if lot 8 was replaced at that time the system would have been about 25 years old, see Vol 3, *2020.02.10 – Stuart to George*.

[50] Vol 3, *2018.09.04 – pre-engagement report*, p 4

[51] The road is on the southern side of house 54 (the front of the house), whereas lot 8 is northeast of house 54.

that. Police also gave some very general second-hand hearsay evidence of speaking to a group of family who had gathered near the church. The police said, "most people seated there stated that the manhole cover was already off when they rushed to the house to help." [52] There was no precise evidence as to when these persons arrived on the scene and the scene must have been chaotic. To my mind, the possibility remains that, following the accident, the cover was moved by one of the many witnesses who attended during Kumanjayi's recovery and witnesses later recalled seeing it in this new position or they assumed the cover must have been off the tank based on the nature of the accident.

54. When Mr Miller personally attended the scene, he said that community members were gathering and were distressed. At lot 8 he found the lid was over the septic tank but slightly ajar. He said he replaced the lid but when he put weight on it "it spun 180 degrees inside the opening" and he partially dropped into the tank.[53]

55. Commonsense dictates that Kumanjayi's mother and grandmothers who were sitting nearby, could not have failed to see or smell an open septic. But that was not their evidence. Furthermore, it would be neglectful to permit a young child to play near an open septic tank, and the mother and grandmothers were the opposite of neglectful, they presented as highly protective. Finally, had there been an open septic it would have been the first place Kumanjayi's mother would have looked but it was not. When Kumanjayi went missing she looked in the house and yard first.

56. In contrast to the witnesses who arrived later, Mrs Wheeler and Mrs Jaycreek were at the location and were the first witnesses to observe the access cover after Kumanjayi had fallen into the septic tank. Mrs Wheeler said the cover was "a little bit open"[54] and Mrs Jaycreek's description was similar.[55] I find their evidence to be credible and persuasive and I accept it.

[52] Vol 1, folio 11 at [23]
[53] Brief 2, Transcript of interview with Mr Miller on 30 March 2023 p2
[54] T 20.4
[55] T 55.9

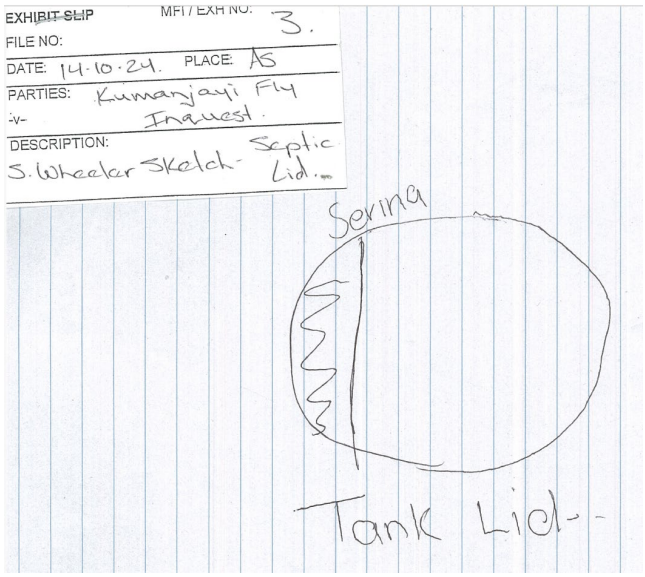

Exhibit 3 diagram of the position of the cover drawn by S. Wheeler

57. Based on my assessment of the evidence, the witnesses and the situation, I am satisfied that the septic tank access cover was not seated properly or optimally when Kumanjayi fell in and was slightly ajar when first seen by Mrs Wheeler and Mrs Jaycreek after he fell in.

58. It still needs to be explained how Kumanjayi fell in when the cover was not seated properly or optimally.

59. Mr Azar, an expert in water supply and wastewater engineering, opined that the poor condition of the cover allowed Kumanjayi Fly to fall in.[56] Mr Kenny, the school principal, saw Mr Miller stomp on the cover to make sure it was safe, and he said it, "flipped like a coin". He said that when the lid tipped it "made it completely open" and he said "you could see that that's how the kid must've fallen in."[57] In contrast to that evidence, the police and the plumbers who tested the cover found that significant force was required before it would tip.

60. Having carefully considered the matter I am satisfied that each of these, on their face conflicting, observations were truthful and that the different observations can be logically explained. The evidence established that both the collar and cover were corroded, such that the cover could not be securely seated and was potentially unstable. When it was optimally seated, as re-positioned by the police, it could still be moved and dislodged but required adult force, as police and plumbers demonstrated in their re-enactments. However, once accidently moved or dislodged, there was the potential for the cover to no longer be optimally seated. In this position the cover was even more unstable, and easily moved with much less force, as described by Mr Kenny and Mr Miller.

[56] T 244.6
[57] Vol 1, folio 17, p 128

61. Given the evidence of adult persons repeatedly walking across the lid at lot 8, it is entirely plausible that the cover had become less than ideally seated and more unstable over time. At the time of this incident, I am satisfied the cover was not optimally seated and, therefore, more unstable. This instability permitted Kumanjayi to fall in, as opined by Mr Azar and as re-enacted by Mr Kenny and Mr Millar.

62. I accept the evidence of Mr Azar, Mr Kenny and Mr Miller and am satisfied that the lid was not securely seated likely because of corrosion and tipped allowing Kumanjayi to fall in. While I consider it more likely that it spun or tipped under Kumanjayi's weight allowing him to fall in, I cannot exclude the possibility that it was slightly ajar and tipped from that position or he fell through the gap.

63. Finally, if I am wrong and the access cover was off to the side (consistent with the hearsay evidence), I would still be satisfied that the poor condition of the access cover and the collar contributed to Kumanjayi's death because:

    63.1. the cover and collar were corroded;

    63.2. as a result of the corrosion the cover could not be properly seated in the collar and was not secure;

    63.3. the corrosion meant the cover could be moved (accidently or deliberately) by applying body weight; and

    63.4. the corrosion made it possible for the cover to be moved without a special tool.

1D. What were the safety responses following Kumanjayi Fly's passing?

64. Following this tragedy, the infrastructure and housing departments took significant steps to identify and rectify current safety risks in respect of septic tank access covers at public housing and NTG owned assets:[58]

    64.1. contractors were promptly engaged to make safe the septic tank at lot 8;

    64.2. further contractors were engaged to audit septic tank access covers at all public housing in Watiyawanu and to rectify any immediate safety risks. Some fixes were temporary, and workers returned when material was available to complete more permanent remedial work. This work was completed by mid-June 2023;

    64.3. an additional external audit was commenced for assets at the school and clinics with no safety issues being identified; and

    64.4. a Territory wide audit was commissioned to inspect access covers at septic tanks installed not just in public houses but also government employee

[58] See Vol 5, *5.13G – DIPL – Lilliebridge*, [9] onwards, re Territory wide audits undertaken in 2023 and 2024.

housing, schools, police stations, health clinics, roadside stops, boat ramps and aerodromes across the Territory in urban, regional and remote areas. This audit is being undertaken in stages and is clearly a substantial piece of work. As set out in the infrastructure department's submissions, "where safety issues were observed, immediate risk mitigation measures were taken."[59] Following that audit two actions will be undertaken:[60]

64.4.1. where houses received additional bedrooms under the Room to Breathe program and septic systems are as a result inadequate, they will be replaced; or

64.4.2. where the system meets minimum standards and is functioning properly a secondary barrier for septic tanks (safety net) will be installed.[61]

64.5. a plumbing company has been engaged to replace all 'septic tank systems' identified in the 2019 plumbing report; work was to commence in January 2025.[62]

65. The infrastructure department has agreed to keep tenants informed of the outcome of the audits and timeframes for completion of the work, and it is essential that this occurs.

66. Given the breadth of risk identified to date and the age of many septic systems, I urge that audits and responses are delivered in all remote communities.

67. On 10 October 2024 the Chief Executive Officer of the infrastructure department issued a public apology.[63]

Part 2 - Systemic issues

68. There were warning signs that the septic system at lot 8 was not functioning properly. Multiple system failures resulted in those warnings being missed or ignored.

2A. Repairs and maintenance

A systemic failure to identify and properly rectify repeat problems

69. Plumbing is a frequent and ongoing issue in Watiyawanu. The perception of Mr Miller, who had lived in Watiyawanu for 10 years, was that "plumbing's probably one of the main biggest issues in community housing."[64] One plumber said that they

[59] Department of Logistics and Infrastructure closing submissions at [23], [25] and [26].
[60] Submissions indicate the work will be undertaken by the Housing Department.
[61] T 507.4
[62] Vol 5 - 5.13H at [10]; the 2019 plumbing report covered 11 houses, 1 has already had the system replaced. See also T 507.1.
[63] Vol 5, *5.26 – Media Statement*
[64] T 168.8, see also Kenny at T 190-192.

were still doing a lot of septic work in the 6 months prior to the inquest.[65] The problem concerning the maintenance of septic systems was systemic and not limited to lot 8.

70. Maintenance records revealed that the septic system at lot 8 was failing. Even though repeat plumbing work was undertaken significant problems recurred. For example, from 2018 to 2022 the septic tanks or leach drains were pumped out 13 times.

71. Mr Peter Rogers, a retired Environmental Health Officer with over 40 years' experience, most gained in the NT overseeing the wastewater management policy for NT Health, assisted the inquest by providing an expert report and evidence.[66] Mr Gideon Azar is a civil engineer specialising in water supply and wastewater engineering with over 30 years' experience in water cycle management and he also assisted the inquest by providing an expert report and evidence.[67]

72. Mr Rogers said that pumping out absorption trenches is not typically required,[68] and the frequency of pump outs at lot 8 was "an extraordinary number. And I've never heard of any system being pumped out so many times."[69]. Both Mr Rogers[70] and Mr Azar[71] said that the frequency of the work was a 'red flag' indicating the system was not performing. I was satisfied that the expensive exercises of pumping out the tanks and the drains was only ever a temporary fix, and the problems inevitably returned because the underlying cause was not addressed.[72]

73. Maintenance records and photos revealed that the septic tanks had previously overflowed. Mr Rogers opined, "if drainage was overflowing and backflowing into the system, that is a catastrophic failure of the effluent disposal area."[73]

74. In addition to the frequent pump outs, the leach drains were extended or replaced in 2016, 2018, 2021 and 2022. Under the Australian National Standards properly installed and maintained septic systems should have a serviceable life of at least 15 years. Accordingly, if the system was functioning properly the drains should not have needed replacing in 2018, 2021 and 2022. This expensive work was another red flag warranting further investigation and proper rectification.

75. At inquest, the infrastructure department recognised that there were failures in its maintenance of lot 8 and expressed deep regret to the family[74] and released a public apology.[75] In its submissions, the housing department acknowledged "that there were

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[65] T 159.5; and the 2019 plumbing report found 100% of houses looked at had septic systems in poor condition and non-compliant with the wastewater code of practice.
[66] Affidavit of Peter Rogers dated 23 September 2024, Vol 5.12A
[67] Independent Expert Report prepared by Gideon Azar dated 20 September 2023
[68] Rogers at T 225.8; Azar, Vol 5, *5.11A* [44]
[69] T 225.5
[70] T 222.6
[71] T 246.2
[72] T 104.4
[73] T 225.8
[74] Department of Logistics and Infrastructure closing submissions at [8]
[75] Vol 5, *5.26 – Media Statement*

periods in which the septic system was clearly not functioning appropriately, and given the frequency of the issues, there was a failure to further investigate the underlying problem and implement a long-term solution."[76]

76. I am satisfied that there was a systemic failure to recognise the serious nature of the septic system problems at lot 8. Even without the addition of 2 new bedrooms to the lot 8 residence in 2020, the problems with the septic system needed to be fixed.[77]

77. The infrastructure department's institutional witness, Executive Director Peter Lilliebridge, identified factors which contributed to the department's failure to recognise and appropriately address the ongoing maintenance issues with the septic system. Although I am told that some improvements have been made, challenges of resourcing and high turnover of staff which may have contributed to these failings continue.[78] In those circumstances, better systems which obviate reliance on the astuteness of individuals are all the more important.

78. I was told that the infrastructure department is updating the asset management system so that when multiple work orders are raised for similar work at the same house, this will trigger a flag in the Asset Information System. The flag will alert staff that they are required to investigate further.

79. While an automatic flag requiring an investigation provides an opportunity for redress, it is not a complete answer. Specific to lot 8, there was corporate knowledge that the frequency of work being undertaken was not usual for a functioning septic system but no (or insufficient) action was taken.[79] Knowledge of a problem is not enough. An investigation must be undertaken by someone with the requisite experience/expertise and/or the capacity to access appropriate experts to ensure the nature and extent of the problem and what is required to rectify the issue is identified. Having identified what rectification is required, there needs to be a process to ensure the that the tenant is both consulted and informed, and that the rectification is completed within an appropriate time frame.

80. It was apparent to me that an acceptance of lower standards for housing in communities has seemingly developed because of the breadth of problems, the challenges associated with improving conditions, and a readiness to attribute maintenance issues to tenant behaviours. For any 'process change' such as flags to be

[76] Closing submissions on behalf of the former Department of Territory Families, Housing and Communities, 11 March 2025 at [109]; Affidavit of Brendan Boyce dated 27 September 2024 at [133]-[141]
[77] Rogers at T 221.2
[78] Vol 5, *5.13F* [44]
[79] For example, Vol 3, *2022.06.21 – eml DIPL*, p 2, noted that the leach field had only recently been extended "but if you see any underlying issues that need addressing please advise Housing"; Vol 3, *2022.11.01 – maintenance order*, p 4, request to "Investigate cause of continuous blockages. Report findings to Housing." The evidence at the inquest showed frequent work orders for septic systems not just at lot 8 but in multiple houses in the community.

effective, there needs to be a culture within the responsible department that encourages staff to identify and fix sub-standard housing issues. That type of responsive culture will be encouraged if staff are confident that when rectifications are identified as being necessary, they will be actioned and not relegated to the 'too hard' or 'too expensive' basket. This means there must be sufficient funding to carry out maintenance and repairs within acceptable time frames.

Community members seek improvements to communication, community consultation and education about maintenance and repairs

81. Communication and engagement with residents are key to achieving housing improvements in communities. The return of repairs and maintenance to the housing department and the implementation of new policies and procedures is an opportunity to prioritise and embed communication strategies with residents.

82. When the plumber who wrote the 2019 plumbing report attended the community to assess the septic systems, the extent of his conversation with residents would have likely been no more than to inform them that he was there to look at their septic systems.[80] The failure to ask the residents about their experience of the septic systems was a missed opportunity to understand the full picture of functionality.

83. A lack of transparency concerning repairs, delays in repairs, and keeping residents appraised about timelines, was identified as a significant issue by residents in Watiyawanu.[81] For example, following the 2019 plumbing report, tenants were not informed of any potential safety risk, nor were they told that the government was looking into replacing the septic systems and, despite the report covering 11 houses in Watiyawanu, the Housing Reference Group, the identified communication and engagement channel for government, was not advised.

84. The infrastructure department has committed to ensuring the septic tank audit assessments incorporate the experience and voices of residents and following completion of the assessments, residents will be told of the outcome and plans for work to be undertaken. Families will be kept informed through officers, "that are regularly in the communities."[82]

85. Evidence was given that tenants could report maintenance issues by phone, or to a tenancy officer, or they could approach contractors or housing department staff when they visit the community directly. While at face value these avenues appear adequate, I was told that at times tenants in remote communities do not report repairs and maintenance issues due to language and cultural traits or fatigue with a system that

[80] T 129
[81] Daniels at T 149.1; Kenny in relation to another tenant, T 191.4; Mrs Jaycreek at T 57.5.
[82] T 515-6

has previously failed to act on maintenance requests.[83] As Dr Quilty noted, "when people don't even bother to put in a maintenance request because they don't believe anyone will ever turn up to fix something, [this] is a culture that's taken decades to develop and it will take a long and committed, strategic effort to overcome that."[84] That some maintenance reports are progressed via external advocacy organisations provides some further evidence that direct approaches by tenants are not working in those instances.[85]

86. Concerning lot 8 specifically, the housing department identified that repairs and maintenance issues were reported 322 times, an average of three reports per year.[86] While I accept that this is evidence of a willingness to report by these tenants, given the number of reports and the recurrency of issues, it is also likely evidence of the risk of frustration and fatigue on the part of the tenants.

87. Acknowledging that there are a variety of avenues currently available to report maintenance issues,[87] I consider that evidence from community members and advocacy organisations about their perception of barriers to reporting issues (and of a failure to receive information) should not be simply dismissed. A genuine effort should be maintained by the housing department to understand these concerns and to work collaboratively with residents to improve existing communication channels and to identify and implement new, culturally appropriate, pathways for effective communication.

88. Consultation must be genuine and effective. Sometimes the skills and resources of housing staff will be the best fit, but the housing department should also consider when collaboration with local agencies and groups could lead to improvements. A standing invitation has been extended to the housing department to attend the local authority meetings conducted by Ngurratjuta/Pmara Ntjarra Aboriginal Corporation which has signed a Local Decision Making Agreement. There may also be opportunities to train local community members to assist tenants to provide information or feedback.[88]

89. Since Kumanjayi's passing, the housing department has produced a safety factsheet for tenants on septic tanks.

[83] T 186, T 373.9.
[84] T 373
[85] T 449.5
[86] Housing Department submissions at [119] - [123]
[87] Housing Department submissions at [114] - [118]
[88] Quilty at 373.1

Part of Exhibit 10, Septic Tank Safety poster displayed in community

90. While this was no doubt a well-intentioned effort to educate and communicate, it was also an example of a missed opportunity to genuinely engage with the community. If the department had engaged with interpreter services, housing reference groups, and/or local knowledge through the school or council, more culturally relevant and effective forms of communication could have been achieved incorporating, for example, Aboriginal languages and/or culturally relevant (and locally produced) pictorial material. I can imagine housing officers working with the local principal and school kids to develop a poster around the dangers of septic tanks; and how much more meaningful and educative that might be for this community which suffered this tragedy.

91. The housing department funds the Living Strong Program, an education program that covers the basic rights and obligations of tenancy and provides advice on maintaining a clean and healthy household. Ideally the program is delivered face to face in communities by Aboriginal led organisations, but where that is not possible housing officers deliver the program and have done so in Watiyawanu.[89] Recognising that, "injuries are the leading cause of death in Australian children aged one to fourteen, accounting for nearly half of all deaths in this age group,"[90] safety in the home should be an ongoing component of community education, whether through this program or separately.

[89] T 282
[90] Vol 5, *5.15 - Kidsafe*

What is being done to identify maintenance issues and mitigate risks? One reason to move to cyclical (or regular or planned) maintenance

92. Except for the 2019 plumbing report, discussed in greater detail in part 2D, none of the procedures in place prior to 2023 identified that the septic tank access cover at lot 8 was close to failing or a safety risk. That the residents at lot 8 were not told about the 2019 plumbing report is not acceptable.

93. Tenancy inspections are one opportunity to identify safety issues. Septic systems were not previously included on the condition report, but this has now been updated so that housing staff are directed to inspect and note the condition of all septic tank access covers. In May 2023 the housing department introduced a mobile inspection tool to be used during inspections. I was told that the tool is designed to promote staff and tenant engagement, assists with prioritising safety, reduces the risk of human error and automatically progresses repairs and maintenance issues that are identified.[91]

94. The inquest received evidence about the difference between cyclical (also referred to as regular or planned) maintenance compared to reactive maintenance. Reactive maintenance takes place in response to breakages and requests for repair. Cyclical maintenance involves regular assessments of assets that consider functionality and safety concerns, identify immediate repair needs and plans for longer term maintenance and replacement. The goal is to maintain properties to minimise asset failure and the need for reactive repairs.

95. I heard evidence and was provided with written materials about cyclical maintenance programs in the APY lands and undertaken by the McDonnell Regional Council across their assets. These examples suggest that cyclical (proactive, regular and planned) maintenance is possible in remote communities and that it brings significant benefits.[92]

96. Accepting there are challenges to moving to cyclical rather than reactive maintenance,[93] failing to act is not a cheaper alternative. Responsive (and ultimately ineffective) maintenance of the lot 8 septic system from 2016 to 2022 cost the NT Government $75,000 for pumping out and a further $75,000 to replace the drains.

97. There is widespread and longstanding recognition of the desirability and imperative to move to cyclical maintenance:

    97.1. In response to a death from electrocution in public housing in March 2005, the housing department conducted a review which recommended that the

[91] T 210, 212.8
[92] Miller T 169.1; Vol 5, *5.35 – MRC* at [10], [15].
[93] T 449-450 and T 475.2 gave evidence about the differences in the context between the Northern Territory and the APY lands, the poor condition of assets presently and budgetary constraints.

housing department shift emphasis from reactive to planned maintenance, noting that this, "had been part of the strategic priorities of Territory Housing since 2005."[94]

97.2. The National Indigenous Housing Guide, which came out of a national reform agenda agreed to by the Commonwealth, State and Territory governments in 2006, identifies that a cyclical maintenance program is "essential."

97.3. The Commonwealth considers cyclical maintenance is a "key focus" of the current National Partnership Agreement.[95]

97.4. An extensive report from the Australian Housing and Urban Research Institute published in 2021 sets out the clear need for and many benefits of regular, planned maintenance.[96]

97.5. The Healthy Homes program in 2020 "promote[d] preventative repairs and maintenance models."[97]

97.6. The housing department commissioned Menzies to evaluate the Healthy Homes program. The 2023 Menzies report noted that the program was "not currently meeting its goal to generalise a preventive maintenance approach across remote communities" as the planned regular assessments that underpinned the approach took place in less than a quarter of houses involved in the project. The Menzies report urged the department to increase preventive maintenance inspections.[98]

98. A regular cyclical maintenance assessment carried out by a properly skilled or qualified person of the septic tank access cover (and of the septic system as a whole) at lot 8 would have provided an opportunity for the cover's deterioration to have been identified.[99] This type of assessment is different to that which might be carried out by 1) tenancy staff conducting a tenancy condition assessment discussed earlier, or 2) a plumber attending to complete a maintenance task; because this type of assessment would be done by a qualified assessor focused on the safety and functionality of the septic system. Whether such an assessment would have prevented Kumanjayi's death is dependent on the timing of the cover becoming unsafe, the timing of the assessment and the quality of the assessment, but it would almost certainly increase safety.

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[94] *Inquest into the death of Monica Presley* [2007] NTMC 037 at [75].
[95] T 339
[96] Vol 5, *5.38 – AHURI Report*
[97] 4.7 – Health Homes Program Guidelines, effective September 2020, p 2.
[98] See 5.9 and 5.10
[99] Azar at T 247.2; Clarke at T 158.3 and T 162.3. An inspection would also prevent covers from seizing and should include checks for signs of concrete cancer, see Clarke at T 162.8.

99. While noting logistical difficulties associated in providing cyclical maintenance, the housing department acknowledges the benefits of such an approach.[100] The infrastructure department has committed to commencing a Rolling Housing Asset Condition Program, starting with 9 identified communities including Watiyawanu. I was told the asset assessments for Watiyawanu, Papunya and Kintore should take place in the second half of 2025. This program will produce condition reports for each house. Urgent safety work will be undertaken, and longer term needs will become part of a planned maintenance schedule. The longer term needs are to be logged and remain recorded against each house. The data will provide an evidentiary basis for identifying budgetary requirements for maintenance.[101] The housing department has now taken responsibility for this program.

100. While that is positive, a one-off condition report is only the starting point for a cyclical maintenance program. Whether it is part of the Rolling Housing Asset Condition Program or another program, regular audits should be commenced of septic tanks (and housing assets more generally) which routinely look for safety, functionality and maintenance issues. Decisions will have to be made as to:

    100.1. The frequency at which the audit is to be conducted. I note that the MacDonnell Regional Council program involves annual audits and Litchfield National Park has 3 monthly maintenance checks of septic tank covers.

    100.2. The minimum qualifications and or experience of the person(s) conducting the audit. Selected auditors/tradespeople must be trained to ensure they can identify safety risks, noting that: despite multiple plumbers attending lot 8, the safety of the access cover was not reported as a concern; and, despite 3 monthly maintenance checks at Litchfield National Park, in mid to late 2023 a visitor to the park fell part way into a septic tank when she stepped on the access cover and it spun in the collar.[102]

    100.3. How the results of the audit and any plans for maintenance are to be communicated to tenants. Communication should be done in a way that improves working relationships with tenants and promotes the transparency and accountability of the housing provider.

WorkSafe incident information release similarly urges routine (regular) inspections of septic tank covers

101. On 10 August 2022 NT WorkSafe issued an 'incident information release' containing the following information:

[100] Housing department submissions at [127];
[101] T 515
[102] Vol 5, *5.37 - Bradshaw*; See also T 510

101.1. two children, one in the Katherine Region and one in the Barkley region, had fallen into septic tanks in the Northern Territory in the previous 8 months, both as a result of unsecured covers;

101.2. unsecure or fragile septic tank covers are a major hazard, with fatalities being a risk;

101.3. there are reports of children in Australia and around the word dying after falling into a septic tank; and

101.4. it included this image taken by a parent after the Barkley incident.[103]

102. The image above is disturbingly portentous given my findings concerning the location of the cover at lot 8 as seen immediately after Kumanjayi fell in.

103. The information release urged all workplaces with septic tanks to inspect and remedy any safety issues. It specifically referred to checking covers for deterioration and security and establishing a routine (regular) inspection schedule. In other words, WorkSafe was also advocating for proactive, cyclical inspections and routine maintenance of septic tank covers. None of the actions recommended by WorkSafe were undertaken by the housing department or the infrastructure department in relation to lot 8.

104. Since February 2020 WorkSafe has provided a free subscription service and will email information releases to anyone who subscribes.[104] The infrastructure department is a subscriber, but by August 2022 the generic subscription email was no longer being monitored.[105] I am advised that an arrangement has now been established between the infrastructure department and NT WorkSafe to ensure

[103] Vol 5, *5.6 – NT WorkSafe incident information release*
[104] Vol 5, *5.36B – Direction 1*
[105] T 524.10

relevant notices are emailed to an email account monitored by the WHS Coordinator, People, Safety and Culture branch, of the infrastructure department.[106]

105. To be clear, it is the responsibility of the department responsible for public housing to ensure they are properly informed of and act on potential safety risks, whether that information comes from WorkSafe releases, KidSafe releases, interstate coronial findings etc. The housing department does not disagree and is considering how this can best be affected.[107]

106. I note that NT WorkSafe has a single Communications Manager and one supporting communications officer. I am informed that with greater resourcing NT WorkSafe would be able to do more to ensure important safety messaging and information is disseminated effectively.[108]

A chronic history of inadequate funding for maintenance and repairs

107. The failings identified concerning the management of repairs and maintenance are in part explicable because even though the budget allocated for remote housing in the current National Partnership Agreement has substantially increased over previous years, this increase must be understood in the context of a history of chronic underfunding and in circumstances where the housing stock was in poor condition when it was handed over to the NT Government.[109] The Menzies review described the situation as an endemic housing crisis.[110]

108. Quality maintenance and improvements can result in across government savings. For example, Dr Quilty pointed to:

    108.1. The high costs to the NT Government for electricity, which is "the most expensive electricity in Australia" and very substantially subsidised by the government.[111] Retro fitting solar panels could offer return on investment in a fairly short timeframe.[112]

    108.2. Tenants retrofitting their own air conditioners, using clothes and blankets stuffed around air conditioners to reduce cold air loss, results in very poor thermal efficiency,[113] and increases the cost.

    108.3. Residents unable to afford air conditioning in each room, crowd into one room increasing the risk of spread of streptococcus, the bacteria that causes

[106] T 526; Department of Logistics and Infrastructure submissions at [185]
[107] Housing department submissions at [175]- [176]
[108] NT WorkSafe submissions dated 13 February 2025 at p 4
[109] T 447.3. The Commonwealth found a greater number of houses were beyond economic repair than expected Persson at T 334.
[110] Vol 5, *5.10 – Menzies*, p 10
[111] T 370.2
[112] T 370.4
[113] Quilty at T 362.2

rheumatic heart disease. Rheumatic heart disease, which is mostly eradicated in Australia (and so is preventable), continues at high rates and at great human and health cost in remote Aboriginal communities.

109. The need remains high for new builds and renovations as well as repairs and maintenance.

    109.1. Evidence indicates that a sustainable building rate is 270 houses/year. If that is achieved over the next 10 years that would result in 2,700 houses being built but it is estimated that there is a need for 4,500 homes in that same time period.[114]

    109.2. In the last few years, the repairs and maintenance spending has regularly exceeded budget by 30% to 40%.[115] Maintenance is underfunded and "under constant pressure."[116]

    109.3. Brendan Boyce, the Acting Deputy Chief Executive Officer of the Department of Housing, Local Government and Community Development and the housing department's institutional witness, is of the view that the component going to cyclical maintenance, in particular, is underfunded.[117]

110. Despite the continual recognition of the benefits of cyclical maintenance, the majority of the budget continues to be spent on reactive maintenance. The housing department agreed that there was a need for further funding to be allocated to cyclical and planned maintenance.[118]

Records of repairs and maintenance are poorly maintained, and they are not being analysed to identify safety or other issues of concern

111. The issue of poor records dates back to when responsibility for houses was handed over to the Northern Territory Government without adequate information. However, more recent work has also suffered from insufficient retention of records.

112. The infrastructure department acknowledged that:

    112.1. there was no database that recorded the location or condition of septic tanks across the Northern Territory; [119]

    112.2. the age of the septic system at lot 8 was unknown;[120]

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[114] T 447.6-10
[115] T 438.5, T 447.3
[116] T 438.2
[117] T 577.4
[118] Housing department closing submissions at [204]
[119] Department of Logistics and Infrastructure closing submissions at [18].
[120] Some of the information gap comes from the handover of assets from the Commonwealth to the Territory. However, that took place many years ago and no steps have been taken in the intervening

112.3. plans for the septic tank upgrades that took place in 1997 could not be located;[121]

112.4. insufficient information was recorded about the specifications for the leach drains that were installed at lot 8; and

112.5. there were information barriers which meant departmental staff did not have access to relevant information held by other departments or programs.

113. The relevant department must ensure an asset management register is kept up to date for public housing across the Northern Territory, including information about design and maintenance history. The Territory wide audits that were planned in the aftermath of Kumanjayi Fly's death are a significant improvement in relation to septic tanks[122] and the proposed Rolling Housing Asset Condition Program will likely be key first steps in understanding housing stock conditions and updating records.

2B – *Residential Tenancies Act*

114. There are legal formalities as to which entity is the landlord under the *Residential Tenancies Act* but given the nature of these proceedings, they are not required to be set out here. It is the housing and infrastructure departments who have managed lot 8, in terms of renovations as well as repairs and maintenance work, and witnesses for both departments gave evidence that their respective departments each had responsibilities for ensuring obligations under the *Residential Tenancies Act* were met.

115. Landlords have the following obligations under the *Residential Tenancies Act*:

115.1. Section 47, A landlord must not enter into, or offer to enter into, a tenancy agreement unless the premises …:

(a) are habitable; and
(b) meet all health and safety requirements specified under an Act that apply to residential premises or ancillary property.

116. The *Residential Tenancies Act* obligation of 'habitability' is a distinct obligation. The infrastructure department submitted that legal precedent established that the concept of habitability in relation to tenancies:

116.1. "is not concerned with ensuring that a rental property is maximally comfortable but rather that it is reasonably fit for human occupation";

time to estimate age of septic systems and incorporate what was known into an asset management system.

[121] Vol 3, *2020.02.17 – info on existing septic designs*

[122] Audit of septic tanks, T 473.10

116.2. "is about fundamental liveability, not the provision of modern conveniences or the elimination of all discomforts"; and

116.3. "trivial inconveniences do not meet the legal threshold for fitness for habitation."[123]

117. As submitted by the infrastructure department, meeting a standard of 'habitability' is not merely determined by compliance with building codes, regulations and government policy, it is a factual question that goes to the "fundamental liveability" of the property.[124]

118. Under the Room to Breathe program the dwelling at lot 8 was extended by the addition of two additional bedrooms and the enclosure of a veranda. The addition of two bedrooms resulted in questions being raised as to the lots 'habitability' by reference to the capacity and historical failings of the septic system and by reference to heat issues.

119. The following potential heat issues were raised about the north facing bedroom built at lot 8:

119.1. The room is constructed from material that absorbs heat through the day then releases it back into the house through the evening;

119.2. it is north facing;

119.3. the western wall has no additional shading through wider eaves or other structures;

119.4. there are two small windows, and they do not appear to be designed to maximise ventilation;[125]

119.5. no air conditioner was installed.[126]

120. Dr Quilty gave evidence that thermal performance is a key concern for housing in Watiyawanu and the thermal design for the Room to Breathe bedrooms at lot 8 was "grossly inadequate."[127] In his opinion, given the high temperatures experienced in the desert, "the rooms would be uninhabitable day and night" without an air conditioner.[128] Mr Lilliebridge sensibly agreed that a bedroom that is too hot to sleep in is not habitable on an ordinary understanding of that word.[129] However, the deputy

[123] Department of Logistics and Infrastructure closing submissions at [197] – [201]
[124] Department of Logistics and Infrastructure closing submissions at [197].
[125] Room to Breathe Guidelines, Vol 4, *4.6 – OCOFOH*, recommend windows on opposite walls to maximise cross ventilation, these guidelines came into effect in August 2019, after the design for lot 8, but the principle would be known to architects. The windows would not capture prevailing winds if the usual wind direction is similar in Watiyawanu and Alice Springs.
[126] Vol 5, *2020.05.28 - Building Permit and Documents*, p 10
[127] Vol 5, 5.16, particularly [1.3], [1.6] and [1.7]
[128] Vol 5, 5.16 at [1.7]
[129] T 533.5

Chief Executive (remote housing) seemed unable to contemplate the potential for the question of habitability to even arise under the *Residential Tenancies Act,* if the property had been signed off as meeting building codes.[130]

121. Although heat issues will no doubt be important for the housing department and/or the CEOH to consider,[131] whether a bedroom that is too hot to sleep in is a "trivial inconvenience" or goes to the question of "fundamental liveability" is not an issue for me to resolve in this inquest. In setting out the evidence relating to habitability, I am not making a specific finding about lot 8 and any heat issues.

122. While a singular or infrequent issue with a septic system would only give rise to an obligation to conduct repairs, rather than rendering a house uninhabitable, the ongoing nature of the issues at lot 8 presented quite a different scenario. *If* a septic system was continually failing, causing regular periods of time when residents had no access to sanitation as well as health risks from sewage overflowing the tanks, at some point a situation may be reached where the premises is not habitable.

123. The evidence did not canvass the historical impact on the residents of lot 8 from the recurring issues with the septic system. I do not know how they managed when toilets became blocked, how long they had to wait for repairs, or how they managed when sewage overflowed. I do not know whether they had to vacate the premises. In those circumstances I am unable to make a finding as to whether the impact of the recurring failures of the septic system is to be considered a "trivial inconvenience" or whether "fundamental liveability" was involved.

124. Kumanjayi passed away due to an unsafe septic tank access cover. In looking at why the safety risk posed by the unsafe access cover was not identified or fixed, understanding the general approach of government departments to meeting their obligations under the *Residential Tenancies Act* is relevant to understanding the circumstances of Kumanjayi Fly's death. This broader background is relevant in that it assists and informs what if any recommendations should be made pursuant to s 35(2) of the *Coroner's Act*.

2C – Plumbing codes

125. Under regulation 73 of the *Public and Environmental Health Regulations* a licenced plumber must not install a wastewater management system that is not in accordance with the prescribed code.

[130] T 486.9
[131] Housing department closing submissions at [83]; also Submissions recognising heat issues and steps being taken to address those issues at [85] – [89]

126. Under regulation 74 of the *Public and Environmental Health Regulations* an owner or occupier must, "operate, maintain and service" a septic system in compliance with the prescribed code.

127. For lot 8 the prescribed code was initially the 2014 Wastewater Code of Conduct, this was then replaced with an updated version approved on 4 November 2020: the Code of Practice for Wastewater Management (**2020 Wastewater Code of Practice**).[132]

128. Prior to Kumanjayi's passing, the most recent work on the septic system at lot 8 was the installation of new leach drains in 2022. The quote was for 40 metres of Atlantis Soakage drains, but there is no reference to a distribution box.[133] Usually a trench bed should be no longer than 20 metres, and where more is required multiple trenches would be installed with a distribution box.[134] No additional details were provided after the work was completed to confirm what was actually installed or the layout. There are photos but no plan, the photos show a single line of drains.

129. The lack of comprehensive records means it is not possible to know with certainty what was installed or whether what was installed complied with the applicable Wastewater Code. Of significance for this inquest, there is nothing in the records to suggest that the infrastructure department took any steps to satisfy itself as to compliance. There was no evidence that the work was inspected (on paper or on site) to confirm compliance.

130. Both Mr Azar and the building certifier for the Room to Breathe project gave evidence about the importance of record keeping and failures to do so in relation to lot 8.[135] The information that should have been obtained (and retained) from a contractor should include technical details and a clear statement and/or certificate as to compliance with the applicable Wastewater Code. These are matters that should form part of any contract.

131. Ultimately, the two experts who gave evidence, Mr Rogers and Mr Azar, reviewed what material was available and considered that the area of the drains was insufficient and did not comply with the requirements under either the 2014 or 2020 Wastewater Codes.[136] In addition, Mr Azar opined that evidence of the trench area being saturated

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[132] Vol 4, *4.12 – Septics*
[133] Vol 3, *2022.12.02 - eml DIPL* for the quote and *2022.12.01 - Work order*, for photos.
[134] Vol 4, *4.12 – Septics – 2020 Code of Practice*, p 71 and 72
[135] Azar at T 253, building certifier at T 76
[136] Section 34(3) of the *Coroner's Act* prohibits inclusion of, "a statement that a person is or may be guilty of an offence". This however does not prevent a Coroner from commenting on evidence or findings that could in theory underpin an offence. "The mere recital of relevant facts cannot truly be said, of itself, to hint at criminal or civil liability. …criminal or civil liability can only be determined through the application of the relevant law to the facts, and it is only the legal conclusions as to liability flowing from this process which are prohibited by s 26(3)." *Perre v Chivell* (2007) 77 SASR 282 [57]; see also *Keown v Kahn* [1999] 1 VR 69

and tanks overflowing indicates an overloaded septic system due to insufficient absorption trench length.[137]

132. At inquest the infrastructure department accepted that the septic system was not compliant with either code.[138]

Oversight of contracted work

133. It is not necessary to make a finding about what size leach drains were installed in 2022 and whether they were compliant with the applicable code to recognise that the matters raised by the 2019 plumbing report (discussed further later in these findings), the evidence of Mr Rogers and Mr Azar, the ongoing failures of the system, and the extensive repeat works in 2018, 2021 and 2022 all point to the need for proper oversight and/or auditing of works and repairs to ensure that they are carried out to the appropriate standard and in compliance with statutory or code requirements.

134. The housing department submitted that they inspect all minor new works and vacate works, and they are "supportive of expanding this program to include a review of a portion of contractors' work."[139] I do not comment as to whether this is sufficient. Ultimately, the housing department must ensure its housing stock complies with legislative and code requirements as well as with government guidelines, objectives and policies.

Which Wastewater Code applied to lot 8?

135. Both NT Health and the infrastructure department submitted that when the new leach drains were installed, as occurred in 2016, 2018, 2021 and 2022, there was no requirement that the new drains or the septic system (as a whole) comply with the most current Wastewater Code. They submitted that standards under the *Public and Environmental Health Regulations* were only triggered when an entire wastewater management system was installed (r 73) and the installation of only a part of a wastewater management system did not fall within the phrase "operate, maintain and service" a wastewater management system (r 74).

136. A second uncertainty was whether, when the Room to Breathe renovations were undertaken adding the 2 additional bedrooms, the septic system was required to meet the specifications for a 5 bedroom house instead of the original 3 bedroom house. Did it need to be replaced or upgraded when 2 new rooms were added?

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[137] Vol 5, *5.11A* at [4]
[138] Department of Logistics and Infrastructure submissions at [116].
[139] Housing department closing submissions at [91]; The housing department's institutional witness agreed contactors work should be audited, T 310. A similar suggestion was made on behalf of Territory Housing, and recommended by the coroner, in the *Inquest into the death of Ms Presley* in 2007. The departmental review said the department should formalise an agreement to "procur[e] qualified electrical safety operators to conduct random audits of the work done by contractors."

137. Mr Rogers, who was described as the lead author and key contributor to the 2020 Wastewater Code of Practice, understood the Wastewater Codes applied to both the installation of entire systems and to the installation of components. He was unequivocally of the view that when new leach drains were installed, they would have to meet the requirements of the Wastewater Code current at the time of installation.[140] Consistent with this evidence, at least two of the invoices for the installation of leach drains referred to compliance with the Wastewater Code. As a matter of logic, it would be extraordinary if the Wastewater Code required tanks and drains to be of a particular size when installed together, but if one fails and is being replaced there are no longer any requirements at all.

138. Concerning the addition of bedrooms, Mr Rogers' opinion was also clear: builders were required by the Wastewater Code to upgrade the septic system when the new bedrooms were added and this was the advice he gave the housing department in 2020.[141] The plumber, certifier and builders undertaking the Room to Breathe renovations also believed there was a requirement to upgrade the system in order to comply with the Wastewater Code, and that was the advice they gave the housing department in 2019 and 2020.[142] Again, as a matter of logic, it seems very odd if a septic system could be installed that was suitable for a one bedroom house and it did not have to be upgraded when additional bedrooms were added. If that were the case endless bedrooms could be added to a house with the Wastewater Code providing no or limited protection against an inadequate septic system remaining at the residence.

139. Considering this evidence and applying a commonsense approach, I am not persuaded that the NT Health and infrastructure departments submissions are necessarily correct.

140. Given the systemic nature of the failings concerning lot 8, the widespread issues of concern identified by audits of septic systems, and the current ambiguity and uncertainty as to when compliance with the Wastewater Codes is required, at a minimum there is a need for clear guidance from NT Health as to the circumstances when changes to a dwelling or septic system trigger the need to comply with the current Wastewater Code, and, if exemptions are permitted, in what circumstances an exemption can be sought, and how and who can approve an exemption.

Should there be a certificate of compliance for septic systems?

141. In the coronial case of *Nihal Hundal*[143] a Victorian coroner considered the death of another child who drowned after falling into a septic tank through an insecure access

[140] Tracey Ward, acting Executive Director in Department of Health, was unsure if this was accurate T 301; and the government submissions are that this is not the case.
[141] See T 226.10 – T 227 and T 228
[142] T 116.5, T 37.4
[143] Vol 5, *5.5 – Finding into a death of Nihal Hundal without Inquest* COR 2023 001485

cover. As a means of preventing future deaths, the Victorian coroner recommended that a system be introduced requiring certificates of compliance for septic systems. Kidsafe has similarly advocated for certificates of compliance which confirm the proper working order of septic tanks whenever a house is sold or rented.

142. The introduction of a certificate of compliance for septic systems may be warranted. If this approach were to be adopted, it would need to be determined when a certificate will be required. Appropriate times *may* include: the sale or lease of the property, installation of all or part of a septic system, and/or when a dwelling is altered to add bedrooms. Accepting that NT Health does not have the internal resourcing or expertise to provide a certification service to confirm whether a septic system is compliant with the wastewater code of conduct,[144] privatised certification processes (similar to building certifiers approving residential dwellings) or alternatively a government managed process (similar to pool fencing) could be implemented.

Should safety nets/shields (secondary safety barriers) be mandated?

143. In *Nihal Hundal* the Victorian coroner also recommended that the relevant building authority consider mandating the installation of child resistant shields or nets on access points to septic tanks.[145]

144. The housing department supported a recommendation that would progress the introduction of secondary safety barriers to reduce the risk of septic tanks, and the infrastructure department has already commenced investigating suitable products for this purpose. A product recommended by Mr Rogers is currently being investigated and, if it is found suitable, the housing and infrastructure departments have undertaken to install it in all septic tanks at public housing assets.[146]

145. It is appropriate that such action is taken promptly but the breadth of septic tanks installed across the Territory means that more than this one initiative will be required.

2D – The 2019 plumbing report and a failure of management

146. The infrastructure and housing departments were aware that decisions had to be made as to whether the septic system at lot 8 needed to be upgraded or replaced, and that this was not an isolated issue. Neither lot 8 nor Watiyawanu were outliers in terms of septic concerns which were being identified across multiple homes in multiple communities. For example, on 3 December 2019 the Room to Breathe program received a report relating to septic systems in Tara. That report also identified issues

[144] Former housing department closing submissions at [25].
[145] Vol 5, *5.5 – Finding into a death of Nihal Hundal without Inquest* COR 2023 001485
[146] Vol 5, *5.13H* at [24]-[27]

of non-compliance, the need to replace tanks and/or soakage areas and upsize soakages where additional rooms were being built.[147]

147. The broader issue was first brought to the Minister's attention in a March 2019 briefing note which advised that:

> - When modifications to a house are undertaken as part of the Room to Breathe Program, where additional showers or toilets are installed, the construction contractor has an obligation to ensure that the plumbing works, including septic systems, meet the requirements under the Code of Practice. Plumbing contractors who undertake these works are generally self-certifying and provide the applicable certification for the works they undertake.

148. Mistakenly at that time it was thought that the septic system compliance issues arose when Room to Breathe renovations added showers and toilets, when in fact the issue arose when new bedrooms were added. The briefing note went on to advise that where a plumber identified that a larger septic system was required, the work would be undertaken under a contract variation.[148] The briefing identified implications for 14 communities with tanks and drains installed in each lot[149] and a further 11 communities where a tank only was installed in each lot.

149. In 2019 a contract was awarded under the Room to Breathe program for building work on 13 houses in Watiyawanu.[150] At the start-up meeting the building contractor questioned whether, for houses receiving additional bedrooms and bathrooms, the existing septic systems would comply with the Wastewater Code.[151] In response, the infrastructure department's Contracts Manager for the Room to Breathe project reviewed the plans and identified the houses that he believed would likely require a septic upgrade. He identified 8 of the 13 houses as likely requiring upgrades, including lot 8, "given the size, age and capacity of the existing septic system."[152]

150. The infrastructure department arranged for a plumber to assess 11 houses, including lot 8, to determine the condition of the septic systems and to advice whether upgrades would be required. The result of that assessment was the 2019 plumbing report.

151. The 2019 plumbing report raised concerns about the safety[153] and adequacy of the septic systems. It was reported that all 11 houses had septic systems that were in poor condition and were non-compliant with the applicable Wastewater Code. In addition

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[147] Vol 3, *2019.12.03 – Septic Report*
[148] Vol 3, *2019.03.12 - Dot Point Briefing*
[149] The communities as identified in a Ministers Dot Point Briefing dated 12 March 2019 at Vol 3: Ampilatwatji, Atitjere, Canteen Creek , Imangara, Kaltukatjara, Laramba, Mt Liebig, Nturiya, Tara, Tjikala, Wilora, Willowra, Wutunugurra and Weemol.
[150] Vol 3, *2019.05.09 - Request for tender*
[151] Vol 5, *5.13B* at [18]
[152] Vol 5, *5.13B* at [22]
[153] The deputy Chief Executive (remote housing) agreed the report raised a safety risk that needed to be addressed, T 487.

to raising concerns about the sufficiency of the leach drains, [154] concerning lot 8 the report stated:[155]

> *"Tanks are non-compliant due to the fact that the access covers are incorrect, missing bollards/protection, no distribution pit, joint putty coming adrift from the saddle riser and tank, baffles corroded.*
> *With the upgrade, and to meet health requirements, the new tank sizes will have to be 5000L (Sewage) & 6000L (Sullage) as a minimum."*

152. Early advice from the building certifier was that upgrades would be required, and exemptions were not available.[156] The building contractor put in a quote for the work and confirmed that building certification of lot 8 could not be achieved without the septic system being replaced.

153. In evidence, the deputy Chief Executive Officer of Remote Housing said, "I've told my teams numerous times that if it's health and safety, deal with it, I'll deal with the budget issues."[157] But despite those directions the health and safety issues were not dealt with and no one was able to satisfactorily explain why the 2019 plumbing report was not properly actioned.[158]

154. Instead, in order to ensure construction works continued it was resolved as follows:[159]

> It is intended to discuss the Room to Breathe occupancy scenario with the Department of Health and seek a dispensation to the septic tank system specifications for these houses. If a dispensation is provided contractors and plumbers may not be required to replace the septic tank systems to achieve certification.
>
> In the interim construction works should continue. To avoid works stopping it is proposed to issue a 'letter of comfort' to contractors instructing them to continue work while the Department resolve the septic issue. A letter has been drafted for your consideration (Attachment B).

155. The Contractor at lot 8 certified his work having received such a letter of comfort:[160]

> I have received advice to continue progressing the Room to Breathe works at Mount Liebig noting that should it be determined that replacement/upgrade of the septic system be necessary, the Department will make arrangements to have this done at a later time.
>
> Please ensure that any work completed has the necessary building certification. It will be acceptable to hand over a house that has been completed but has the septic system issue outstanding. The certifier should note this issue on their certificates provided all other works are to the necessary standard.

156. By letter dated 23 April 2020 the infrastructure department's Contract Superintendent:

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[154] 9 m is grossly inadequate against the specifications set out in both the 2014 and 2020 wastewater codes of practice.
[155] Vol 3, *2019.11.26 – JC Services*
[156] *2019.12.12 – eml Gilby*
[157] T 455.7
[158] T 454.10; T 426.5; Infrastructure department's closing submissions at [125].
[159] Vol 3, 2020.3.12 – Memo to DCEO through Executive Director, Senior Director, and Program Director
[160] Vol 3, *2020.03.12 – email to builders*

156.1. informed the building contractor that they could "provide an occupancy certificate only for the works you have completed noting the non-compliance issue with the septic system being outstanding";

156.2. advised that the housing department was working with the Department of Health to determine what was required for septic systems;

156.3. directed that the construction works were to continue; and

156.4. provided an assurance that the Northern Territory Government accepted responsibility for completing upgrades if it was determined they were required.[161]

157. On 29 June 2020 the Minister was briefed that discussions had commenced with NT Health to seek an exemption from compliance with the Wastewater Code but if this was not forthcoming, "the septic systems will have to be upgraded" in 5 communities. [162]

The issue was 'swept under the carpet'

158. The approach to this significant health, safety and compliance issue adopted by the infrastructure and housing departments was flawed. There was an inadequate investigation as to the nature and extent of the problem. In consequence, the departments relied on arguably fallacious and/or unjustified grounds in support of their application for an exemption. Ultimately, the departments failed to adequately brief NT Health and did not actively pursue or receive an exemption. Instead, the departments permitted the status quo to continue. Whether it be because of budget or some other reason, the health, safety and compliance concerns were, for all intents and purposes, 'swept under the carpet' and ignored.

<u>An inadequate investigation</u>

159. When it sought an exemption from the Wastewater Code, the infrastructure department had not properly investigated the circumstances of the septic system at lot 8 (or at any other lot).

160. A proper investigation would include:

160.1. speaking to the residents about how the system was functioning;

160.2. a review of the maintenance records;

160.3. a determination of the age of the septic system and information about the usual lifespan;

[161] Vol 3, *2020.04.23 – Email*
[162] Vol 3, *2020.06.29 – Ministerial Briefing*

160.4. clarification of the size of the septic tanks and drains; and

160.5. acceptance of advice from plumbers or other experts about what was legally required (except, for example, where it was without basis or there was conflicting advice).

161. These investigative steps were not taken and the advice of the plumbers and contractors (which all supported the need for replacement/upgrade) was ignored without a proper basis for doing so. [163]

Arguably spurious reasons advanced in support of an exemption

162. The arguments advanced as to why there should be an exemption from the Wastewater Code for lot 8 specifically, but also for other houses extended under the Room to Breathe program, were flimsy at best.[164]

163. The departments argued that:

163.1. Post renovation there would be no change to number of residents and so no change in the load on the septic system; and

163.2. The septic system was functioning under the current load.

164. I could not identify a sound evidentiary basis for the first proposition.

164.1. The housing department had already received advice from NT Health "the load to this system may be increased by the dwelling extensions."[165]

164.2. Arguing that the septic system did not need to be upgraded because of the number of people living in the house at a particular moment in time was a misapplication of Wastewater Code which is designed to accommodate changes in occupation over time.[166] If, 12 months after the renovations, 3 additional people had moved permanently into one of the additional bedrooms at lot 8, there was no process which would have ensured the septic system was re-assessed and upgraded at that time to meet the new occupancy levels.

164.3. It was possibly mistakenly assumed that the requirements for greater capacity of septic systems in remote communities (as compared to urban systems) were to address overcrowding. However, the 2014 Wastewater Code assumed the same number of residents per bedroom (2 people) for both remote and

[163] Mr Rogers told housing staff that the system's performance was likely affected by age, Bullant Building and other contractors gave advice about the need to upgrade.
[164] Formally no decision was made not to upgrade the septic systems, however deferring the decision for years without any ongoing investigation or attempt to progress a decision is in effective a decision not to upgrade.
[165] Vol 3, *2020.02.04 - Stuart to George*
[166] Rogers at T 227.6; Ward at T 304.5

urban houses. Accordingly, the difference in capacity was potentially designed to address other issues associated with community living, such as a higher daily flow per person in recognition of the frequency of visitors, issues with maintenance, and/or higher volumes of water entering the system through leaks or taps not being turned off. It was not 'excess capacity' that could be converted to accommodate additional residents.

164.4. There was no basis for arguing that once overcrowding was addressed the urban rather than the remote requirements under the Wastewater Code should be applied.[167] Even if there was, there is no evidence that the existing septic system would meet the urban standards. Under the 2020 Wastewater Code it was assumed that a 5 bedroom house in an urban area would have 7 occupants. The housing department expected the number of permanent occupants at lot 8 to be 8 people. Accordingly, on its own calculations the expected residents at lot 8 exceeded the standard allowances for a 5 bedroom house in an urban area.[168]

164.5. It was disingenuous to argue that the addition of two bedrooms would not result in an increase in residents given the common knowledge that:

164.5.1. Aboriginal people in remote communities are highly mobile with significant variation in occupancy of houses over time. This was expressly recognised in the Room to Breathe Program Design Guidelines.[169] Mrs Jaycreek and Mrs Wheeler gave evidence about frequency of family visiting Watiyawanu generally[170] and Mrs Jaycreek gave evidence that "there were lots of crowd" in lot 8 specifically and referred to family staying who were not recorded by the housing department as living at lot 8.[171]

164.5.2. The Room to Breathe program knew housing records were not always correct.[172]

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[167] Vol 3, *2020.03.12 – Email from George* p 3
[168] Vol 4, *4.12 – Septics – 2202 Code*, p 43. The 2020 guidelines came into effect in November 2020, after the work at lot 8 had started, but in November 2020 the housing department was still supposed to be investigating whether or not upgrades were required. There is no evidence of the housing department undertaking calculations as to whether or not the flow capacity of the existing septic system met the requirements for an urban residence.
[169] "fluidity of occupation due to seasonal, cultural or other drivers", "the 'elastic' nature of housing occupation from seasonal and cultural", "Visitation may be complex and difficult to easily quantify, and can range from long term visitation to daytime visitors." Vol 4, *4.6 – OCOFOH - Room to Breathe Program Guidelines*, p 10.
[170] Jaycreek at T 58-9; Serena Wheeler T 16 - 17
[171] Jaycreek at T 57.2, housing records see Vol 3, *2019.02.12 - scope of work*
[172] T 402.9

164.5.3. Specifically in relation to lot 8, the Room to Breathe program knew that there were often visitors staying for sorry business or cultural reasons.[173]

164.5.4. The Room to Breathe proposal for lot 8 was to enclose a secure outdoor area for visitors to sleep in.[174] As this was not classified as a bedroom it was not incorporated into the calculations for the septic system, but these people would obviously place a load on the wastewater system.

164.5.5. Any improvement to housing, but particularly increasing the number of bedrooms, creates a risk that additional people would choose to stay at that particular house on a permanent or temporary basis. This risk was flagged for Room to Breathe staff when they were told by some residents that they did not want additional bedrooms because of the likelihood of this occurring.[175]

164.5.6. At Watiyawanu modelling indicated 54 bedrooms would be required to resolve overcrowding in the community. In February 2019 the proposal of work was to construct an additional 24 bedrooms. [176] Given the ongoing overcrowding issues in other houses, it was naïve to think lot 8 would not be used to accommodate additional visitors or residents.[177]

165. There was no evidentiary basis for the second proposition, that the septic system was functioning under the current load. All the evidence in fact pointed to it failing to function as it should. [178]

A failure to adequately brief NT Health or pursue the exemption

166. By letter dated 24 June 2020[179] to NT Health, the infrastructure department applied for a dispensation/exemption from compliance with the Wastewater Code for houses extended under the Room to Breathe program. The 2019 plumbing report was not included with that application. The infrastructure department accepted that it should have been provided, and further, that if it had been provided it was likely NT Health would have rejected the application and required septic system upgrades/replacements.[180]

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[173] Vol 4, *2019.02.12 – Scope of works*, p 2
[174] Vol 3, *2019.02.12 – Scope of works*, p 2
[175] T 433.2
[176] Vol 3, *2019.02.18 – approval of concept design*
[177] T 431.5 acknowledged experience that Aboriginal people move between residences.
[178] Vol 5, *5.12A* – Rogers' statement, p 261, email from Munnich to Rogers, 6 February 2020; Vol 2, *2020.06.25 – eml and ltr Housing to DoH*
[179] Vol 3, *2020.06.25 – eml and ltr Housing to DoH*, p 2-3.
[180] Department of Logistics and Infrastructure closing submissions at [141]

167. Further, as discussed above, the arguments advanced in support of the exemption were unconvincing. Specifically, concerning the letter of 24 June 2020:[181]

    167.1. The statement that the septic systems were operating effectively was incorrect and without evidential basis.

    167.2. The statement that household occupation levels would not change was an assertion without proper foundation.

168. In June 2020, NT Health sought further information concerning the application.

169. In August 2020 staff at the housing department collated material to provide to the NT Health, however, the material was never sent.

170. Between August 2020 when documents were collated and April 2023, when Kumanjayi Fly passed away, the housing department took no steps to follow up with the NT Health to either:

    170.1. provide the requested information; or

    170.2. find out whether the dispensation/exemption had been granted.[182]

171. The updated 2020 Wastewater Code of Practice was approved in November 2020, and this did not prompt the housing department to act.

172. At the inquest the deputy CEO for the remote housing program gave evidence that, as at 2024, the infrastructure department had still not determined whether or not NT Health required the septic systems be upgraded.[183] Even following Kumanjayi Fly's death, the deputy CEO was unsure whether there was any flexibility in the Wastewater Code because that question "has not been progressed."[184] This failure is even more disturbing considering the issues were not confined to one house in one community but extended across housing in numerous communities.

173. One infrastructure department employee, who was aware of the 2019 plumbing report, expressed his views in writing within the Room to Breathe program and the repairs and maintenance group that the septic system needed to be upgraded/replaced, and that NT Health could not provide an exemption. He also articulated his concern about a lack of action in an email on 16 March 2020:

    "I am concerned this matter will be sweep (sic) under the carpet".[185]

174. In 2020, if houses already under contract required septic system upgrades the financial risk was estimated at $5 million, the risk rose to $10 million if all houses

[181] Vol 3, *2020.05.25 – eml and ltr Housing to DoH*
[182] T 494.9
[183] T 494.7
[184] T 491.4
[185] Vol 5, *5.13B*, p 69

identified for work under the Room to Breathe program were considered.[186] This was clearly a significant matter of concern. The emails and memoranda obtained in the coronial investigation indicate knowledge of this issue was widespread including to the executive of the infrastructure department and with briefings to the Minister.[187]

175. While the infrastructure department has acknowledged that the system at lot 8 should have been upgraded and expressed deep regret, I do not accept the submission that there had been a "decision to defer the upgrade."[188] Instead there had been a systemic failure by the executive in the infrastructure and housing departments to grapple with a significant health and safety issue which extended across many houses in numerous communities, lot 8 being just one such house. I do not accept that the failure to deal with this issue was a mere oversight or an active 'decision'. The departments sat on their respective hands and failed to address the issue, and an unacceptable status quo was permitted to continue for years.

176. There were undeniably budgetary pressures. Evidence was given that the budget issues could have been dealt with by reducing the number of houses that were upgraded,[189] but under the funding agreement with the Commonwealth, the National Partnership for Remote Housing NT, the NT Government was required to deliver 1,950 additional bedrooms by December 2023.[190]

177. Alleviating overcrowding through additional rooms is clearly an important priority, but if achieving that comes at the cost of:

    177.1. well-designed builds;

    177.2. proper repairs and maintenance; and

    177.3. safety issues;

    the goals of the program are not being achieved.

Part 3 – Conclusion and formal findings

178. The relevant Government departments knew[191] that the septic system at lot 8 was failing and had been failing for many years and numerous experts had recommended that it be upgraded or replaced. Similar concerns have been raised about other homes across numerous communities. It was a big and potentially very expensive problem to upgrade or replace failing or inadequate septic systems.

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[186] Vol 3, *2020.03.12 – Memo to DCEO*, estimates were lower in the 29 June 2020 briefing to the Minister
[187] Vol 3, *2019.03.12 – Dot Point briefing;* Vol 3, *2020.06.29 - Ministerial briefing* ; Vol 3, *2020.03.12 – Memo to DCEO*; Vol 5, 5.13B, annexure GG-15 and GG-16.
[188] Department of Logistics and Infrastructure closing submissions at [8] with reference to written evidence of institutional witness.
[189] T 497
[190] Vol 5, *5.24A - NIAA statement* at [13]
[191] Individual and corporate knowledge

179. Instead of addressing this widespread safety issue, the relevant Government departments sat on their hands and did, effectively, nothing. The Government departments did not prioritise safety and Kumanjayi tragically passed away in traumatic circumstances. Had action been taken when it should have been taken, the septic system at lot 8 should have been upgraded and/or replaced and this tragedy would likely have been avoided.

180. Every child in public housing across our remote communities should be able to play safely in their own backyard without the risk of falling through a degraded access cover into a septic tank. The risks are not theoretical, they are real and widespread. Urgent action is required to make public housing septic systems safe for now, and for robust cyclical maintenance systems to be introduced to ensure safety is maintained into the future.

181. In respect of the mandatory matters in s 34(1)(a)(ii) to (iv) of the *Coroners Act* I make the following findings:

    181.1. Kumanjayi Fly was born on 26 March 2021, at Alice Springs Hospital, he was just over 2 years old when he passed away.

    181.2. Kumanjayi Fly died at the Women's and Children's Hospital in Adelaide on 3 April 2023.

    181.3. The cause of death was hypoxic-ischaemic encephalopathy due to out of hospital cardiac arrest following immersion in water.[192]

    181.4. Kumanjayi Fly met the criteria under the *Death (Definition) Act 1983* (SA) for brain death on 2 April 2023 at 12:35 pm. The death was reported to the South Australian Coroner as having occurred at this time.[193]

    181.5. On 3 April 2023 life support was turned off and death was pronounced at 10:07 am. [194]

[192] Post Mortem Report, Vol 1, folio 5.
[193] Dr Gautam, Vol 2, folio 23
[194] Dr Gautam, Vol 2, folio 23