ATTORNEY-GENERAL

Parliament House
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**REPORT TO THE LEGISLATIVE ASSEMBLY**

Under section 46B of the *Coroners Act 1993*

In the matter of the Coroner's Findings and Recommendations regarding the death of Kumanjayi Johnson

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Pursuant to section 46B of the *Coroners Act 1993* (the Act), I provide this Report on the findings and recommendations of Ms Chrissy McConnel, Deputy Coroner, dated 23 January 2026, in relation to the death of Kumanjayi (Daniel) Johnson (the Deceased) (Attachment A refers).

This Report includes the responses to the recommendations of the Deputy Coroner by Ms Erin McAuley, then Acting Chief Executive Officer (CEO), Attorney-General's Department (AGD), on behalf of the Office of the Public Guardian and Trustee (OPGT), and by Mr Travis Wurst, then Acting Commissioner, Northern Territory Police Force (NTPF).

The Deceased was 45 years old when he was located deceased in a gully on Mount Gillen (Alhekulyele), Alice Springs, on 9 December 2022, after he walked away from his supported accommodation located in Larapinta, Alice Springs, on 3 December 2022. The cause of death was environmental exposure and dehydration. The Deceased was under the care of OPGT at the time of his death.

**Recommendations of the Deputy Coroner**

The Deputy Coroner made the following formal recommendations regarding the death of the Deceased:

> '161. **I recommend that** the Office of the Public Guardian and Trustee implement all seven recommendations specified in the OPGT internal review dated 18 March 2025.
>
> 162. **I recommend that** the Office of the Public Guardian and Trustee review their policy and procedure concerning the regularity of engagement with represented persons.
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> ...

NORTHERN TERRITORY GOVERNMENT

'166. **I recommend** that NT Police review JESCC operations to ensure the integrity of event classification processes.

167. **I recommend** that NT Police review organisations to be directed to provide risk assessments for specific incidents, including directions as to the information required by Police in those risk assessments, to inform call-taking, dispatch and response.'

**Responses to the Deputy Coroner's Recommendations**

**Northern Territory Public Guardian and Trustee**

As OPGT is situated within AGD, the Department has provided the following responses in consideration of all seven recommendations specified in the OPGT internal review dated 18 March 2025 (the OPGT Review):

**Recommendation 161 of the Coronial Findings**

- Recommendation 1 of the OPGT Review

  OPGT accepts this recommendation. Existing training materials address identification of concerns, escalation processes to Team Managers and development of appropriate response plans. Preliminary work has commenced on development of a supporting guideline, and consultation with other jurisdictions will be considered to identify existing guidance, frameworks and best practice approaches to inform future development.

- Recommendation 2 of the OPGT Review

  OPGT accepts this recommendation. Review of the existing Practice Guideline has commenced as part of ongoing quality improvement activities and is a high-priority initiative. Proposed amendments are intended to strengthen existing practice requirements, support consistent implementation across the organisation, and place greater emphasis on family finding, cultural connections, completion of visit reports, and consideration of relevant contextual information in decision-making and practice.

- Recommendation 3 of the OPGT Review

  OPGT accepts this recommendation. While routine review of all visit reports may provide an additional level of quality assurance, implementation of such an approach would require additional workforce capacity and resources. In the absence of additional resources, priority must continue to be given to timely decision-making and escalation of concerns identified during visits. Visit reports will continue to be reviewed in circumstances of heightened risk, through supervision and staff development processes, and as part of existing annual case review mechanisms.

- Recommendation 4 of the OPGT Review

  OPGT accepts this recommendation. Future guidance will focus on supporting Adult Guardianship Officers to identify concerns regarding whether support coordination services are effectively meeting the needs and goals of represented persons, including expectations regarding receipt, review, escalation and recording

of relevant information. Regulation of support coordinators remains the responsibility of the National Disability Insurance Scheme Quality and Safeguards Commission.

- Recommendation 5 of the OPGT Review

  OPGT accepts this recommendation. A Family Finding Policy has been developed and associated staff training delivered by an external subject matter expert was completed in June 2026. Consideration will be given to whether additional training and guidance are required to further strengthen communication obligations and support incorporation into future refresher training programs.

- Recommendation 6 of the OPGT Review

  OPGT accepts this recommendation. Opportunities exist to strengthen consistency of practice in the use of Aboriginal Interpreter Service training, cultural brokers, Aboriginal liaison services and other cultural supports. Consultation is underway regarding additional external training and supporting practice guidance. Existing resources and directories will also be reviewed to improve accessibility to interpreter services and cultural advice.

- Recommendation 7 of the OPGT Review

  OPGT accepts this recommendation. The primary issue identified relates to consistency and accessibility of recorded information rather than absence of information. Consideration is being given to strengthening record keeping requirements and responsibilities, supported by existing work relating to case note practices, business rules and Public Guardian and Trustee Information System guidance.

**Recommendation at paragraph 162**

OPGT accepts this recommendation in principle, subject to resourcing. Existing national standards establish minimum expectations regarding engagement with represented persons. However, additional workforce capacity would be required to consistently meet enhanced expectations across all represented persons.

Further consideration of the issue will occur alongside review of visit requirements and review processes to support a coordinated approach to engagement standards. In the absence of additional resources, priority must continue to be given to timely decision-making, responding to identified risks and meeting the immediate needs of represented persons.

A copy of the Coronial Findings was provided to the Mr Martin Dole APM, Commissioner of Police, on 19 March 2026, in accordance with section 46A(1) of the Act.

A written response to recommendations 166 and 167 was received from the Acting Commissioner of Police on 18 May 2026 as required by section 46B(1) of the Act. The responses include the following:

'The NTPF will review JESCC event categorisation and related procedures to strengthen clarity and consistency in classifying welfare and missing person matters. A clearer default approach will ensure that matters involving unknown whereabouts and wellbeing concerns are prioritised appropriately.

A standard risk assessment framework will be implemented within JESCC to support consistent triage and response decisions. Intake and reporting requirements will also be strengthened to ensure consistent and reliable information is available to inform risk assessment.

Progress will be monitored through established coronial governance and reporting arrangements.'

I am satisfied that the then Acting CEO of AGD and the then Acting Commissioner of Police have considered the recommendations of the Deputy Coroner and have appropriately responded to the recommendations.

DATE: 25 AUG 2026

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MARIE-CLARE BOOTHBY