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NORTHERN TERRITORY OF AUSTRALIA

CORONERS COURT

A 51 of 2019

AN INQUEST INTO THE DEATH

OF KUMANJAYI WALKER

ON 9 NOVEMBER 2019

AT YUENDUMU POLICE STATION

JUDGE ARMITAGE, Coroner

TRANSCRIPT OF PROCEEDINGS

AT ALICE SPRINGS ON 13 OCTOBER 2022

(Continued from 12/10/2022)

Transcribed by:
EPIQ

THE CORONER: Please sit, thank you.

Yes, Mr Coleridge.

MR COLERIDGE: If it please the court, we have two witnesses that will be the first hot tub this morning. They are on the AVL. And they are, Ms Sally Halton and Dr Amy Rosser. Dr Rosser is on the left of the screen. And Ms Halton is on our right.

THE CORONER: And Ms Halton and Ms Rosser are appearing from Yuendumu this morning?

MR COLERIDGE: Yes, your Honour. Just before we commence, I think that my friend has something - - -

MR OFFICER: Just a courtesy, just before 10 o'clock I've got to step out for a Supreme Court Matter in Darwin. And again at 2 o'clock this afternoon.

THE CORONER: Thanks for letting me know, Mr Officer.

Yes.

SALLY HALTON, affirmed:

AMY ROSSER, affirmed:

THE CORONER: Yes, Mr Coleridge.

XN BY MR COLERIDGE:

MR COLERIDGE: Good morning to the both of you. Can I just – it's a bit of a formally, but as each of you to state your full name for the record?

THE WITNESS, ROSSER: I'm Amy Jaye Rosser(?).

THE WITNESS, HALTON: And I'm Sally Jane Halton(?).

MR COLERIDGE: Can I ask you first, Amy – is it okay if I call you both by your first names? I can call you both. What your role is in the Yuendumu Clinic?

THE WITNESS, ROSSER: I'm a – employed as a Senior (inaudible) so I'm the GP. I (inaudible) on chronic disease management, but I also see acute emergency presentations.

MR COLERIDGE: And you're a medical doctor, is that right?

THE WITNESS, ROSSER: Yep.

MR COLERIDGE: And when did you become a doctor?

THE WITNESS, ROSSER: I graduated from medical school in 2007.

MR COLERIDGE: And when did you come to the Territory?

THE WITNESS, ROSSER: In 2015.

MR COLERIDGE: Okay, from where?

THE WITNESS, ROSSER: From Queensland, Sunshine Coast.

MR COLERIDGE: And how long have you been in Yuendumu?

THE WITNESS, ROSSER: Since December 2015.

MR COLERIDGE: And Sally, Ms Halton, what's your current role within – perhaps your managerial role, within the clinic?

THE WITNESS, HALTON: Currently the Yuendumu Clinic Manager, Acting.

MR COLERIDGE: And do you have a clinical role within the clinic as well?

THE WITNESS, HALTON: I'm actually employed as the midwife here, but because there's no manager, I stepped into that role in July. So I can still women, but I – it's very difficult.

MR COLERIDGE: What was your background before you came to Yuendumu?

THE WITNESS, HALTON: I was an enrolled nurse, and then a registered nurse. Then I did my degree in 2010, and – and then in 2000 – I just worked as a midwife, and – in a hospital. And then in 2017, I moved to Alice Springs and worked for Congress as a midwife. And then in 2019, I moved – I commenced working in Tennant Creek as an outreach midwife for the Northern Territory Government. And then moved – moved on 1 March last year as a permanent midwife at Yuendumu.

MR COLERIDGE: So I take it that most of your clinical practice, before you came to the Territory was in Mildura, or thereabouts?

THE WITNESS, HALTON: Yes, correct.

MR COLERIDGE: Can I ask you both, perhaps if we start with you, Dr Rosser? What was your level of – how much engagement, or interaction had you had with Aboriginal people, or Aboriginal patients, before you came to the Territory?

THE WITNESS, ROSSER: So in my personal live, I'm Aboriginal, from Queensland. So I guess my family. In terms of health, the Sunshine Coast, I think

we've been told that it's statistically the whitest area in (inaudible). So I had a few Aboriginal patients, but not many.

MR COLERIDGE: And how about you, Ms Halton?

THE WITNESS, HALTON: Yeah, I grew up in Western New South Wales, on the Darling River. Between Menindee(?) and Wilcannia(?), and did – had – grew up with Aboriginal people. And yeah, so I lived with them all my life and went to school with them.

MR COLERIDGE: I'm just losing words here and there. It's not – it's not you, it's the quality of the link,
I think.

Could we just ask the court clerk, is it possible to move that little box down, you can see on the big screen, we've got her Honour and me too, is it possible to pull that down to the bottom of the screen? No.

Perhaps can I do this? Your head is getting cut off, Ms Halton. Can I ask the two of you, just to shift to – can you shift the camera to your left?

THE CORONER: That's better, thank you.

MR COLERIDGE: Fantastic. You just stay there. Fantastic, all right, great.

Look, appreciating that you both had quite a bit of interaction with Aboriginal people in your personal lives, did you have to kind of make adjustments to your practice, or your style, as a medical professional, when you moved to the Territory and started working with a much larger number of Aboriginal people?

THE WITNESS, ROSSER: Yes. It's – I guess it's quite different medicine and most people in the Northern Territory, Aboriginal people, English is their second language versus the Aboriginal people I've worked with and have known in my own life have had English as their first language.

MR COLERIDGE: And what about kind of regional differences? I take that you've, from time to time, worked in different places in the Territory, have you noticed regional differences between different groups of Aboriginal people; you know, Warlpiri versus Arrernte people versus Yolngu people.

THE WITNESS, ROSSER: Yes, yes, every group is different.

MR COLERIDGE: When you came to Yuendumu, Dr Rosser, in 2015, and
Ms Halton in 2020, what was done, at least formally or informally, to induct you or introduce you to the Aboriginal population you would be serving?

THE WITNESS, ROSSER: So, I met the local workers and Jameson Williams, the ACW. He drove me around community and showed me the different areas and he

told me some of the local stories. And I also had chats with Nola Fisher and Mary Butcher.

MR COLERIDGE: And Ms Halton?

THE WITNESS, HALTON: I had induction training with the Northern Territory Government. But when I actually moved to Yuendumu, it was a time of - like people were leaving. I feel like I didn't actually have that "on the ground" induction.

MR COLERIDGE: And I think you've said – I mean, we had conversation earlier this morning and you said that one of the things that you've put in place since you became the manager was, you know, ensuring that that induction occurred when new staff joined you in Yuendumu?

THE WITNESS, HALTON: I'm finding it really difficult to hear.

MR COLERIDGE: I might get rid of the lectern.

THE WITNESS, HALTON: Sorry.

THE CORONER: And if you need to, you can also sit down.

MR COLERIDGE: I might do that.

THE CORONER: Sure. It's just that you can get a bit closer to the microphone.

MR COLERIDGE: Ms Halton, what do you do as the manager – or do you do anything as the manager to ensure that that induction takes place when new staff join your clinic?

THE WITNESS, HALTON: Yes, I get Jameson to do it, because he comes from here and he knows everything. So, I get Jameson to take the staff around.

MR COLERIDGE: And does he do both induction for male and female staff members?

THE WITNESS, HALTON: He does.

MR COLERIDGE: If you have female staff members, do you ever involve a – or do you ever have the induction done by a female Aboriginal health worker?

THE WITNESS, HALTON: Yes, absolutely. At the moment, both of my Aboriginal strong women are off because it's sorry business, but yeah, definitely because the main programs usually are to do with women. So, yeah, definitely.

MR COLERIDGE: Can you tell us a little bit about what that involved – sorry, what that induction involves?

THE WITNESS, HALTON: Well, just they explain the ways of the community. They show you where you can and can't go. And you know, things to exp.

MR COLERIDGE: And does that induction kind of involve – or does it influence the way that you practise as a health professional in the community?

THE WITNESS, ROSSER: I think it's very helpful in, initially, getting to know the community and what's important. But it's not something I think that can just be taught in one session. It's also an ongoing process and learning from our local staff. And the patient - - -

MR COLERIDGE: Do the Aboriginal staff members kind of provide you with ad hoc suggestions, for example, you might be treating a patient. Do they ever make suggestions about how you should treat in a more culturally-competent way?

THE WITNESS, ROSSER: They're not clinical, so they know they don't give advice on treatment.

MR COLERIDGE: Let's say in the clinical context you were, you know, taking a history from someone, asking someone questions, would an Aboriginal staff member ever provide you with tips on how you might communicate with the person you were treating?

THE WITNESS, ROSSER: Yes, sometimes.

MR COLERIDGE: Can you think of any examples of that? I know I'm testing your memory?

THE WITNESS, HALTON: Well, I do because I had a lady from Yuelamu came over here telehealth and Roxanne, who is our ACW from Yuelamu who brings clients over to Yuendumu for treatment or to see a nurse or a doctor, we did a telehealth with the client's consent. She was an older lady and didn't speak very good English, and we were speaking to doctors in Darwin. So, Roxanne came in and translated for her. And it was much better, because she could understand everything that was going on and was able to give consent for what the doctors were wanting to do and understood more what was going on.

MR COLERIDGE: Do you ever use interpreters in the course of your work as doctors and nurses, midwives?

THE WITNESS, ROSSER: I have, but mostly out here - generally there's a small level of understanding of English, however, also sometimes, we use our local staff.

MR COLERIDGE: Could I ask you now some questions about the kind of health needs of Yuendumu? What do you perceive the greatest health needs of the community to be?

THE WITNESS, ROSSER: So, we've got a lot of chronic disease. We've got

exceptionally high rates of diabetes, kidney disease and heart disease. So, they need a lot of chronic disease management and as a result of that, we have a lot of acute presentations, a lot of sepsis, a lot of very sick people.

MR COLERIDGE: So, conditions that in the urban centres might not be so serious, end up quite acute in the remote setting?

THE WITNESS, ROSSER: Yes. And then we have things that you don't see rarely, if ever, in urban centres, like acute rheumatic fever.

MR COLERIDGE: Now, that's kind of – it sounds like the population at large, but can I just ask you what the kind of major age groups you're dealing with are?

THE WITNESS, HALTON: They're very young. They're very – like middle aged and above.

THE WITNESS, ROSSER: Yeah, the most people who present, we see these young kids and then we see middle age and above people. We have less presentations from the older kids and young adults.

MR COLERIDGE: And when you say, "older kids", what age bracket are you talking about?

THE WITNESS, ROSSER: Five to 15.

MR COLERIDGE: All right. Is that because that age bracket tends to be healthier, or because they're harder to engage, or both?

THE WITNESS, ROSSER: Both.

MR COLERIDGE: Okay. What are some of the health needs; health or mental health needs of that age bracket, so the kind of young adult age bracket?

THE WITNESS, ROSSER: So, they're probably the age that's most at risk for rheumatic heart disease. So, that's a big one. But they at more risk for mental health conditions.

MR COLERIDGE: And sexually transmitted diseases?

THE WITNESS, ROSSER: Yes, the teenagers' sexually transmitted diseases is a big one as well.

MR COLERIDGE: Can I just focus on the mental health needs of that age bracket? What are those needs? Could you provide a bit more detail about that?

THE WITNESS, ROSSER: So, I guess in coming into the young adult and older teenagers, a bit of drug use. And generally, there's a lot (inaudible), so we sometimes see acute mental health presentation. And so, we – it had been, you

know, really good to explore mental health more with the young people, because we often don't see that until they present acute mental health.

MR COLERIDGE: What is an acute mental health presentation?

THE WITNESS, ROSSER: So, a suicide attempt in the case of depression or an acute psychosis.

MR COLERIDGE: So, is it fair to say that you're seeing this kind of really acute tip of the iceberg. You suspect that there is a much more significant rate of untreated mental ill health in that age bracket?

THE WITNESS, ROSSER Yes, that's likely.

MR COLERIDGE: How well serviced do you think the Yuendumu clinic is to assist these kids with these really significant mental health issues?

THE WITNESS, ROSSER: At the moment not well. We've had - we've had some great counsellors in the class. We had Kerri-Anne Chilvers and Karen Mundel(?), who were both excellent but we don't have anyone at the moment.

MR COLERIDGE: So is it fair to say that kind of counselling and counsellors, psychologists, trauma counsellors are a bit of a gap in the service that the clinic is currently providing?

WITENSS ROSSER: Yes, definitely.

MR COLERIDGE: Do you have any suggestions on what might be done to fill that gap?

THE WITNESS, HALTON: We need a permanent social worker and I feel we also need a permanent male and female counsel.

MR COLERIDGE: Why is it so significant to have both genders?

THE WITNESS, HALTON: Because I feel that young women would relate to it another - to a woman better and it's the same for young men, they're more likely to engage with a male counsellor than a female counsellor.

MR COLERIDGE: Ms Halton, can I just remind you, if possible, to sit back in our chair because we just lose your face when we - thanks very much. I think you also say, Ms Halton, in your statutory declaration that one of the recommendations to improve community relations for service delivery would be to engage a health workforce that was targeted at school age children.

THE WITNESS, HALTON: Yes.

MR COLERIDGE: So are we talking about more than counsellors there?

THE WITNESS, HALTON: Yes, I think, you know, sports and recreation, things like - because they're developing and they're - you know, some of the kids have been through trauma and they have good things and they've got some people to understand them. It would go a long way to helping them to get through what they've been through or going through.

MR COLERIDGE: And would that help workforce be linked in with other institutions in Yuendumu like education of the school?

THE WITNESS, HALTON: Yes, correct.

THE WITNESS, ROSSER: A school nurse would be great.

MR COLERIDGE: So a school nurse - so a nurse based in the school itself?

THE WITNESS, ROSSER: Yes, yes.

MR COLERIDGE: Why do you think that would be advantageous?

THE WITNESS, ROSSER: I think that being based in the school would give the nurse - you know, they would get to know the kids and then have - you know, it would be easier to access them, so to get them consent from the parents and then they can - they can see the kids as required and communicate with the clinic as needed.

MR COLERIDGE: Perhaps moving away from school-aged kids and mental health, can you see any other service gaps, you know. If you had a wish list, you know - we might be here for days, but can you give us a sense of what might be on that wish list if you were to completely service the community of Yuendumu?

THE WITNESS, HALTON: Like it is now, a chronic disease nurse and a dentist. (Inaudible).

MR COLERIDGE: And definitely a social worker you said?

THE WITNESS, HALTON: Yes.

MR COLERIDGE: All right. Perhaps I am going to ask you some questions about kids. Have you guy had any involvement with WYDAC?

THE WITNESS, HALTON: Yes.

MR COLERIDGE: I might ask you that question over time. At the moment are you having that much involvement with WYDAC?

THE WITNESS, ROSSER: Not really.

THE WITNESS, HALTON: I only communicate with them when I go to the stakeholder meetings.

MR COLERIDGE: Do you have a sense f whether social work is being provided by WYDAC?

THE WITNESS, HALTON: I'm unsure.

THE WITNESS, ROSSER: I think they used to have social workers or at least counsellors but I don't know if they do at the moment.

MR COLERIDGE: In the past you've said that they provided social workers. Is it correct to say that in the past you had more engagement with WYDAC than you do now?

THE WITNESS, ROSSER: Yes.

MR COLERIDGE: But you don't have a sense of why that is?

THE WITNESS, HALTON: Can I just say, when I came as the midwife and COVID was on, a lot of those - those communications we weren't allowed to do because we were minimising contact with other people, but at the be beginning of the year when I was still the midwife I started to resonate with WYDAC, talking about doing some work with young adolescents, but of course I can't do that now.

MR COLERIDGE: Why can't you do that now?

THE WITNESS, HALTON: Because I am a clinic manager and I haven't got enough time.

MR COLERIDGE: Okay. So that's one of the reasons that it's important that someone be employed to service that age bracket?

THE WITNESS, HALTON: Yes. If we had a permanent midwife though and a manager - either - or - when you've got a permanent midwife, it's part of their job to do education for young women.

MR COLERIDGE: Do you have a sense of - I asked you specifically about social work but do you have a sense of what other service WYDAC is currently providing?

THE WITNESS, HALTON: I don't, no.

MR COLERIDGE: I might turn to some questions about staff and staff retention. How well staffed do you feel the clinic is at the moment?

THE WITNESS, HALTON: Not well staffed.

MR COLERIDGE: Do you have a sense of why that is?

THE WITNESS, HALTON: Just - staff come and go. I've just lost four nurses. One moved to another clinic, two were agency - very good agency nurses whose contracts ended and one of our staff had a traumatic medical event and is currently off work, so I've lost four nurses and I've just got three at the moment - two agency and two permanents, like one is an M3 and one's and M4.

MR COLERIDGE: How difficult is it at the moment to attract staff to Yuendumu?

THE WITNESS, HALTON: It's pretty hard - almost impossible.

MR COLERIDGE: Do you have any theories about why that is?

THE WITNESS, HALTON: Because people listen to rumours and think that Yuendumu is not a safe place to be and don't want to come here.

THE WITNESS, ROSSER: Yes, and there's - yeah, there's been some unflattering media attention of staff.

MR COLERIDGE: So this is kind of, you know, media reports in papers like the Australian about Yuendumu being dysfunctional and the like?

THE WITNESS, HALTON: Correct, yes.

THE WITNESS, ROSSER: Correct.

MR COLERIDGE: And do you think that those media reports are fair portrayals of Yuendumu?

THE WITNESS, HALTON: No.

THE WITNESS, ROSSER: I don't think so, no.

THE WITNESS, HALTON: I don't either.

MR COLERIDGE: What do you think can be done to address the - - -

THE CORONER: Before we get to addressing that, what - how do you feel about your safety in Yuendumu at the moment?

THE WITNESS, ROSSER: I've never felt unsafe.

THE WITNESS, HALTON: Neither have I.

THE CORONER: And do you - who do you socialise with and how do you socialise in Yuendumu?

THE WITNESS, ROSSER: I'm outreach no so I'm not here on weekends any more so I don't do much socialisation any more.

THE WITNESS, HALTON: I don't - (inaudible) we're just starting to make some hobby nights on Friday and we - we walk around the airport, that kind of stuff. Some of the nurses are going to the police compound to go to the gym. But as you can see I don't.

THE CORONER: Do you feel safe walking around the community, going to the shop and things like that?

THE WITNESS, ROSSER: Yeah, but I mean I wouldn't do it at 10 o'clock at night but I wouldn't do it anywhere at 10 o'clock at night.

THE CORONER: Sure.

MR COLERIDGE: Why do you go to the airport to walk?

THE WITNESS, HALTON: Because it's six K's and it's a really nice walk and it's sort of out of - like out of the town, it's like around the airport.

THE WITNESS, ROSSER: It's – yeah, it's - it's a nice flat area.

THE WITNESS, HALTON: And it's got a road.

THE WITNESS, ROSSER: You're not walking through the bush, you're just walking on a road.

MR COLERIDGE: And you said that some of the nurses are socialising with the police. Are you socialising with any of the other stakeholder - education, WYDAC?

THE WITNESS, HALTON: Not at the moment.

MR COLERIDGE: Do you have a sense of why that is?

THE WITNESS, HALTON: I think it's just time, too. Like everyone's understaffed. Everyone's gone through some massive changes. There's people coming and going. It's sort of yeah, not – not happened.

MR COLERIDGE: So it sounds like the work force across the board is changing very quickly in Yuendumu?

THE WITNESS, ROSSER: Yes.

MR COLERIDGE: Can you see the benefit in not just building, kind of professional relationships with the other stakeholders, but also building social relationships with those stakeholders?

THE WITNESS, ROSSER: Yes, definitely.

MR COLERIDGE: For example, information sharing, kind of ad hoc information sharing between different stakeholders?

THE WITNESS, ROSSER: No(?).

MR COLERIDGE: And what about emotional support?

THE WITNESS, HALTON: Well we just support each other.

THE WITNESS, ROSSER: But yeah, I think that's important, when you're, you know, everyone in (inaudible) were long way away from the family, so it's good to have a lot of friends, and people who understand.

MR COLERIDGE: Is it also fair to say that, you know, it's intense, and sometimes kind of unrelenting work, working in a community, embedded in the community?

THE WITNESS, HALTON: No, not for me. I like it.

THE WITNESS, ROSSER: What – what do you mean by intense? You mean there's a lot of work? It's very busy?

MR COLERIDGE: Yes, and I get the impression, and you tell me if I'm wrong, that because you're working in the community, sometimes it might feel like, you know, you're not working a 9:00 to 5:00 job?

THE WITNESS, HALTON: Yeah, but that's what remote is. And it's not – it's intense because of the (inaudible) of some of the patients. And – and the amount of patients that we have. Like you don't always finish at 5 o'clock. And someone's always – there's always at least two on-call. And depending on how many staff you've got, how many – how many days they get off. So it's intense, in that there's a lot of work to do, and a lot of work that comes in. (Inaudible) with patients but it's what remote is, so.

MR COLERIDGE: Can I ask you a question about some of the – I'm assuming that some of the work that you do is with young women who've been the victims of domestic and family violence?

THE WITNESS, ROSSER: Yes.

MR COLERIDGE: Does doing that kind of work take an emotional toll on you?

THE WITNESS, ROSSER: It can.

THE WITNESS, HALTON: You know, depends on the event.

MR COLERIDGE: What kind of supports, formal or informal, do you have, when you've had, you know, a really hard consultation in that way?

THE WITNESS, HALTON: We have just our upper management, we will do a debrief session if something tragic's happened. We've also got access to EASA which is the counselling service. But when Karen Mundel was here, she used to - - -

THE WITNESS, ROSSER: She saw staff as well, yeah.

THE WITNESS, HALTON: - - - yeah, (inaudible) after us.

THE CORONER: Can I just go back for a minute to the social opportunities. Is there any sporting teams, and things like that, that people can get involved in?

THE WITNESS, HALTON: Not for us.

THE WITNESS, ROSSER: Well there's – there's – no there's – you can go and watch the football, but that's - you can go and cheer them on.

THE WITNESS, HALTON: There's a pool as well.

THE WITNESS, ROSSER: But – yeah.

THE WITNESS, HALTON: But the pool was closed a lot when our COVID was rampant.

THE CORONER: And are there any places to sort of meet, socially, outside of work, other than homes?

THE WITNESS, HALTON: No.

THE WITNESS, ROSSER: Not really, no.

THE CORONER: So there's no café or barbeque area or anything like that?

THE WITNESS, ROSSER: No.

MR COLERIDGE: Do you think it would make it easier to socialise if there was?

THE WITNESS, HALTON: Yes.

THE WITNESS, ROSSER: Yes.

MR COLERIDGE: I've asked you some questions about, you know, recruiting and retaining staff. Can I ask you now about the Indigenous staff? Who are they currently?

THE WITNESS, HALTON: Currently I have Jameson Williams, who is the ACW, and Dean, who is our Aboriginal Health Practitioner. Roxanne works from Yuelumu, but she's currently away, because her sister's unwell. And MJ(?) and Tilly are currently off on sorry business.

MR COLERIDGE: And what value do the Indigenous staff add to a health clinic in a remote community?

THE WITNESS, HALTON: Huge.

THE WITNESS, ROSSER: They're really important. They make the job slightly easier, help a lot.

THE WITNESS, HALTON: For the patients, if they don't understand what you're talking about, or they need somebody that's the same, yeah, support wise. It's really good for them. And also they know where people are. And they – they often are really good at bringing people in, so that you don't have to leave the clinic.

MR COLERIDGE: What about kind of establishing trust or respect between the clinic and the community? Do you think they have anything to add there?

THE WITNESS, ROSSER: Yes.

THE WITNESS, HALTON: Yes, definitely.

MR COLERIDGE: Do you think you have enough Indigenous staff?

THE WITNESS, HALTON: Well if everyone was here, it would be all right, but no, probably not.

MR COLERIDGE: Can you see any kind of barriers to recruiting, or retaining Indigenous staff?

THE WITNESS, ROSSER: (Inaudible) there's a lot of things you need to do. Driver's licence and Ochre card, all of that needs to be done before (inaudible) a job.

THE WITNESS, HALTON: But I usually refer them to Gwenn(?), in town, she organises the recruitment and – of staff. Like it's – I've had some interest lately from a young woman, and a couple of other people for jobs. So I just discuss with them what's expected, and then I refer them to Gwenn. Who does all that work.

THE CORONER: Does she come out to community?

THE WITNESS, HALTON: Yes she does.

THE CORONER: Okay.

MR COLERIDGE: And she's the one who's kind of helping them, you know, fill out forms, get the Ochre card application off?

THE WITNESS, HALTON: Yes, she does.

MR COLERIDGE: Is it fair to say, that you know, some of that form – filling out forms, that might feel pretty routine to people who've grown up in big cities, can be pretty unfamiliar to some of the Indigenous staff you're trying to recruit?

THE WITNESS, HALTON: I don't know, because you know, (inaudible) they can read and write, so.

THE WITNESS, ROSSER: It – it varies (inaudible).

THE WITNESS, HALTON: It depends how old they are, because the young ones are pretty savvy.

MR COLERIDGE: Are you getting much interest from the community at the moment?

THE WITNESS, HALTON: No.

MR COLERIDGE: In recruitment?

THE WITNESS, HALTON: No, I've got one young man that's willing to do lots of stuff, but I've referred him to Gwenn. And I've spoken to him. So not a lot, but yeah (inaudible).

MR COLERIDGE: As far as you're aware, have there been any recruitment drives, advertisements, attempt to engage, kind of proactively, by the Department or the Clinic?

THE WITNESS, HALTON: Yes. There's posters up all over about what jobs are available. And there's also staff at – I think the Central Desert do a lot of work with getting the – getting people driver's licence, helping with that kind of stuff. And you know, the – upskilling them. Like with things like basic life support, first aid, that kind of stuff.

MR COLERIDGE: Do you think that there might be a role for your current Indigenous staff in recruiting more Indigenous staff?

THE WITNESS, HALTON: (Inaudible) would be good - - -

THE WITNESS, ROSSER: Yeah.

THE WITNESS, HALTON: - - - because he knows everybody, and yeah, he would be really (inaudible).

MR COLERIDGE: Do you think it could help, for example, if the Department supported him, to be a bit of a spokesperson for the clinic?

THE WITNESS, ROSSER: Yes, and I think he's a bit of that anyway.

MR COLERIDGE: Can I ask you now some questions about general engagement with the community. Outside your clinical work, what level of engagement are you having with, for example, Elders, in the community?

THE WITNESS, ROSSER: So I know most of the Elders quite well. So if I was to see them down the street, or at the shop, I will say hello.

THE WITNESS, HALTON: Yeah, I try to identify all the Elders in the community, because we need to start having – I think – they used to have meetings with Health, and that stopped because of COVID. But we want to try and get that going again. So I've tried – I've spoken to one of the Elders about recommencing meetings with the staff – with Health staff and the community Elders.

THE CORONER: Do you know when the last meetings were held, like that?

THE WITNESS, HALTON: Before – before my – before I was here. I think it was – sort of - (inaudible) would have done it. Probably not since COVID. But I had one with one of the - with Therese(?) the other day about starting this again.

MR COLERIDGE: And what might be up for discussion at some of those meetings?

THE WITNESS, ROSSER: Well, I'd want to know if that happened with the service delivery, if anything - they've got suggestions about what could be better, what could be worse on – if they're happy.

MR COLERIDGE: Has there been interest from the community in recommencing those meetings?

THE WITNESS, ROSSER: Yes.

MR COLERIDGE: Can you see any barriers to starting those meetings up again?

THE WITNESS, ROSSER: No, not really.

MR COLERIDGE: What about your engagement with other stakeholders in a more formal way. Are you meeting with them to discuss, you know, health and other needs in the community?

THE WITNESS, ROSSER: Yes, a lot of it has been on the break-ins and the riots that have been happening lately.

MR COLERIDGE: So, that's occupying a lot of your time at those meetings.

THE WITNESS, ROSSER: Yes.

MR COLERIDGE: All right. Can I ask you now some questions about safety. You said, "break-ins and riots". Can I start with kind of property offending? Sally, in your statutory declaration at par 56, you talk a little bit about what things were like in December of 2020. How have things been since then?

THE WITNESS, HALTON: I feel like better. We have securities and police to monitor our houses when we're in the clinic and help to monitor – protect us in the clinic afterhours.

MR COLERIDGE: And that security guard joined you in Yuendumu shortly after Christmas Day in 2020. Is that right?

THE WITNESS, HALTON: Yeah, I think so. I'm not exactly sure, because I didn't start back again until 1 March. So, when I came, security was in place.

THE WITNESS, ROSSER: When I came back from Christmas holidays, yeah, there were security guards.

THE WITNESS, HALTON: Yep.

MR COLERIDGE: And so, there has been a security guard in Yuendumu more or less permanently ever since?

THE WITNESS, ROSSER: We usually have two and they do 12 hour shifts to cover 24 hours.

MR COLERIDGE: How do they do that? Are they patrolling; do they sit at a base somewhere?

THE WITNESS, HALTON: No, they have a car and they drive around. They go into everyone's yard and make sure everything's secure. They also come to the clinic any time we need them, but if they're in afterhours, you have to ring security to let them know that you're there.

MR COLERIDGE: Is it fair to say that there have been fewer break-ins since December 2020?

THE WITNESS, HALTON: I'd say, yes.

THE WITNESS, ROSSER: Yep.

THE WITNESS, HALTON: Yep.

MR COLERIDGE: Have there still been break-ins?

THE WITNESS, HALTON: Yes.

THE WITNESS, ROSSER: Yes.

MR COLERIDGE: Okay. On nurses' quarters?

THE WITNESS, HALTON: Yes.

MR COLERIDGE: Do you know if they were reported to the police?

THE WITNESS, HALTON: Yes.

THE WITNESS, ROSSER: Yes.

MR COLERIDGE: What's the general feeling amongst the clinic staff about their safety?

THE WITNESS, HALTON: I don't think anyone feels unsafe.

THE WITNESS, ROSSER: I don't – yeah, I think everyone feels safe.

MR COLERIDGE: Can I ask you, when we were conferencing earlier this morning, you mentioned something about the nurses wanting to have the health compound. Can you tell us something about that?

THE WITNESS, HALTON: Well, it lessens your – if the houses are dotted throughout the community, it makes you more vulnerable to that kind of thing. Whereas, if they had a compound, it's a lot harder to break-in.

MR COLERIDGE: Is there also a social – a kind of social dimension to wanting a compound.

THE WITNESS, HALTON: Yes.

MR COLERIDGE: Can I just - - -

THE WITNESS, HALTON: We also encourage them to come here. It's a matter of having a safe compound. Like that's part of the reason why people don't want to come here, because they think that they're going to be unsafe.

THE CORONER: Have you spoken to your Aboriginal staff about what they would think or feel about all the other staff living in a compound?

THE WITNESS, HALTON: No.

THE CORONER: Or would you include them in the compound as well.

THE WITNESS, HALTON: Well, they have their own homes.

THE CORONER: So, do you – can you see that there might be some difficulties for the community or the local staff, if all the rest of the staff were behind a big fence?

THE WITNESS, HALTON: No, I don't think so, because I feel like some of the older owners are a bit worried. They don't want nurses and teachers leaving. So, if we put it to them that we were going to do that, I'm sure they would support it, if they felt that it was going to keep good staff here.

MR COLERIDGE: Can I ask you a quick question about the break-ins, once the security guards came, what type of break-ins are we talking of? You know, break-ins into homes or the clinic?

THE WITNESS, HALTON: Homes.

THE WITNESS, ROSSER: Homes.

MR COLERIDGE: Homes. And that's despite the fact that a security guard was patrolling the community?

THE WITNESS, HALTON: Yes.

MR COLERIDGE: Not all of the nurses' quarters are in the same place, are they?

THE WITNESS, HALTON: No.

MR COLERIDGE: And the security guard can't be everywhere at once.

THE WITNESS, HALTON: Correct.

THE WITNESS, ROSSER: No.

MR COLERIDGE: Okay. So, it's reduced the number of break-ins, but they can't eliminate it.

THE WITNESS, HALTON: Correct.

THE WITNESS, ROSSER: Yes.

THE CORONER: If there wasn't a problem with break-ins, would you have any difficulty continuing to remain in houses around the community, as compared to a compound?

THE WITNESS, ROSSER: I have other thoughts about the accommodation than you, I think.

THE WITNESS, HALTON: Why's that?

THE WITNESS, ROSSER: Well, I actually – I don't like the big fences. Before we

had the Colorbond fences, we had little chain-link fences, and that was actually quite social. Like if you're walking back – I know not all the houses are together, but in that cluster of houses, we had milk crates at the corners, and we used to jump over each other's fences and all hang out together.

THE WITNESS, HALTON: Yeah. That's why compound would be good too. It would be social. I don't have an issue living where I live, but Amy's right. It's not social.

THE WITNESS, ROSSER: And that was one – when they put in the Colorbond fences, one of the things it does is it does allow anyone who's breaking in to not be seen from the outside. But it also cuts you off from the community.

MR COLERIDGE: Do you think there's a sense in which, as the fences get higher, you start to feel more and more isolated from the community?

THE WITNESS, HALTON: I don't.

THE WITNESS, ROSSER: I guess to some extent.

MR COLERIDGE: One of the other things you said when I first asked you about safety was that unrest and rioting has been an issue in the community. Can you tell us how things are on that front at the moment?

THE WITNESS, ROSSER: So, there's fighting going on. I think it's important to note that it's targeted at two factions against each other. So, it's not targeted against us or other people who aren't apart of either of the factions.

MR COLERIDGE: So, although there's some fighting between families, as health staff, you haven't felt threatened by the community?

THE WITNESS, HALTON: No.

THE WITNESS, ROSSER: No.

MR COLERIDGE: From time to time, has that fighting spilled over onto the clinic grounds?

THE WITNESS, HALTON: Yes.

MR COLERIDGE: Can you tell us something about that?

THE WITNESS, HALTON: Because it often starts at the shops which backs onto the clinic, and it spills into the ground, people with weapons, serious weapons. So, I have to close the doors and shut the clinic.

MR COLERIDGE: And why do you have to close the doors?

THE WITNESS, HALTON: Just to protect. I don't want them fighting in the clinic, but also, we've already got people in the clinic, clients in the clinic and to check them, and also when they start coming in with their head injuries and their lacerations, we just let them in.

MR COLERIDGE: So, you close the doors and just let injured people into the clinic.

THE WITNESS, HALTON: Yes.

THE WITNESS, ROSSER: Yes.

MR COLERIDGE: What kind of injuries are you seeing as a result of this fighting?

THE WITNESS, HALTON: Broken arms, lacerations.

THE WITNESS, ROSSER: A lot of lacerations.

THE WITNESS, HALTON: Yes. Broken limbs, some serious head wounds from axes and boomerangs. Bruising, stab wounds.

MR COLERIDGE: Are you seeing more injuries of this kind than you have at other times?

THE WITNESS, HALTON: Yeah.

THE WITNESS, ROSSER: Yes.

MR COLERIDGE: Can I ask you, and you know, I acknowledge that you're health experts, but what do you think Yuendumu's needs are more generally? Stepping away from issues related to health, if you had a wish list for the community of Yuendumu, what might it be?

THE WITNESS, ROSSER: I guess more activities for the kids.

THE WITNESS, HALTON: Yes, yeah.

THE WITNESS, ROSSER: More things to do.

THE WITNESS, HALTON: Yes.

MR COLERIDGE: Is it fair to say that you know, supporting and servicing the needs of kids in Yuendumu requires a whole of government approach?

THE WITNESS, ROSSER: I think so.

MR COLERIDGE: So buy in, is needed from the Department of Education?

THE WITNESS, ROSSER: Yes.

MR COLERIDGE: Do you think that housing issues are effecting kids in Yuendumu at the moment?

THE WITNESS, ROSSER: Definitely. There is a lot of over-crowding. You can have houses with 20 people in them. And that's a significant problem. I think that makes it more difficult (inaudible) because there's people coming and going at all hours, and they're not getting as much sleep. So they're more likely to wander around at night, instead of staying home.

MR COLERIDGE: So there's a relationship between poor housing and these break-ins?

THE WITNESS, ROSSER: I think it might be one factor.

MR COLERIDGE: Do you think that, you know, over-crowding, is affecting the mental health of some of these kids?

THE WITNESS, HALTON: Definitely.

THE WITNESS, ROSSER: Yes.

MR COLERIDGE: How so?

THE WITNESS, HALTON: Well, they've got nowhere proper to sleep, and I feel like if there's a lot of people in the house - - -

THE WITNESS, ROSSER: The more people in the house, the more - - -

THE WITNESS, HALTON: - - - less food, less - - -

THE WITNESS, ROSSER: - - - less food, increase the chances of - - -

THE WITNESS, HALTON: Getting abused, yeah.

THE WITNESS, ROSSER: - - - fighting.

THE WITNESS, HALTON: Fighting.

THE WITNESS, ROSSER: A lot of things.

MR COLERIDGE: And you mentioned that you thought that there needed to be more activities for kids. What types of activities are you talking about?

THE WITNESS, HALTON: Sporting camps.

THE WITNESS, ROSSER: Yeah, they used to do a lot of movie nights and things like – things like that, that kept kids occupied. And I don't know – I know they play –

the do – play basketball and things at the moment, but I don't know if there's a lot else happening.

MR COLERIDGE: So in your experience, Dr Rosser, over the six or seven years that you've been in Yuendumu, you've seen a decline in the number of activities offered to kids, is that right?

THE WITNESS, ROSSER: I think so, yes.

MR COLERIDGE: Okay. And over that period of time, that same period of time, you've seen an increase in the number of property offences?

THE WITNESS, ROSSER: Yes.

MR COLERIDGE: So do you think there might be a relationship between fewer activities for kids, and more bored kids breaking into houses?

THE WITNESS, ROSSER: Yes, definitely. I think boredom is a – is a big factor.

MR COLERIDGE: What's a big factor?

THE CORONER: Boredom.

MR COLERIDGE: Okay.

Those are my questions, your Honour.

THE CORONER: Can I just ask about the community, or the meeting between Health and Elders that used to occur, but hasn't occurred since COVID.

Ms Halton, are you aware of a Department of Health policy in relation to establishing local health advisory groups?

THE WITNESS, HALTON: Not the policy, but they – we do have – we do have advisory groups.

THE CORONER: Is that different from the group that you're talking about?

THE WITNESS, HALTON: Don't know, because I haven't been here long enough to know.

THE CORONER: All right. The most recent – or this policy that I'm looking at, was approved on 9 November 2021. Has anyone from Health, that you're aware of, been out to talk to you about how those groups might be established, or re-established, or supported you, or the clinic, to re-engage?

THE WITNESS, HALTON: No. No.

MR COLERIDGE: Your Honour, Ms Heinrich(?) will be able to assist with that.

THE CORONER: Sure.

THE WITNESS, HALTON: Yep.

THE CORONER: All right, are there – there's a number of other lawyers here. They might be easier to see on your screen, I can't – I don't know. But I'm sure there are some additional questions, if you don't mind waiting a little bit longer. I'm sure we're taking time out of your otherwise busy day. I appreciate it.

Mr Mullins.

MR MULLINS: Thank you, your Honour.

XXN BY MR MULLINS:

MR MULLINS: Dr Rosser, and Ms Halton, can you hear me?

THE WITNESS, ROSSER: Yes.

THE WITNESS, HALTON: Yes.

MR MULLINS: My name is Mullins. I appear on behalf of the Brown family, and Walker, Lane and Robertson families. I just have a few questions, and hopefully won't take too much of your time. Firstly, when you were questioned by counsel assisting, he asked you some questions about acute events, or emergency events that you need to deal with.

THE WITNESS, ROSSER: Yes.

MR MULLINS: And I think you both explained that there are a significant number of acute events that arise out of chronic illness. Is that right?

THE WITNESS, HALTON: Yes.

THE WITNESS, ROSSER: Yes.

MR MULLINS: But are there, on an irregular basis, other acute events, such as cardiac arrest, that you might need to deal with?

THE WITNESS, HALTON: Yes.

THE WITNESS, ROSSER: Yes.

MR MULLINS: A stroke, or a - - -

THE WITNESS, HALTON: Yes.

MR MULLINS: - - - another type – cerebral type event?

THE WITNESS, HALTON: Yes.

THE WITNESS, ROSSER: Yes.

MR MULLINS: Can you give me some other examples?

THE WITNESS, ROSSER: Heart attacks, injuries, car accidents - - -

THE WITNESS, HALTON: Axe wounds to the head.

THE WITNESS, ROSSER: Yes. Respiratory presentations, asthma, allergic reactions.

THE WITNESS, HALTON: Children that are sick.

THE WITNESS, ROSSER: Unwell children, yes.

THE WITNESS, HALTON: Yeah, sick little ones.

MR MULLINS: Things like - - -

THE WITNESS, ROSSER: (Inaudible).

MR MULLINS: You mentioned allergic reactions. Things like an anaphylactic reaction, you can deal with pretty quickly, as long as you're there?

THE WITNESS, ROSSER: Yes.

MR MULLINS: Am I correct to say that one of the important things about the Yuendumu Health Clinic, is that you can provide that emergency assistance, if I can call it that, within a relatively short period of time?

THE WITNESS, HALTON: Correct.

THE WITNESS, ROSSER: Yes.

MR MULLINS: And you are called on regularly to do that.

THE WITNESS, HALTON: Yes.

THE WITNESS, ROSSER: Yes.

MR MULLINS: And if it is something that is very serious, that may need, for example, elaborate surgical procedures, that's maybe not a good word, maybe a complex surgical procedure, are the patients air lifted out of Yuendumu?

THE WITNESS, ROSSER: Yes, they are.

THE WITNESS, HALTON: Yes.

MR MULLINS: Now, not just for surgical procedures, but when a patient is taken out of the community, to – air lifted to – is it Alice Springs?

THE WITNESS, ROSSER: Yes.

MR MULLINS: How often does that happen?

THE WITNESS, ROSSER: Very often.

THE WITNESS, HALTON: Yeah, a lot.

THE WITNESS, ROSSER: Yeah, we – I think we'd have an evac most days.

THE WITNESS, HALTON: Yeah.

MR MULLINS: So are you saying most days, you have somebody air lifted, out of Yuendumu, into Alice Springs?

THE WITNESS, HALTON: Yes.

THE WITNESS, ROSSER: Yes.

MR MULLINS: Now would be a combination of treatment, as I understand it – I withdraw that. Are there some dialysis patients who actually get their treatment in Alice Springs, because they are so seriously ill?

THE WITNESS, ROSSER: There's dialysis patients who receive dialysis in Alice Springs because there's not enough dialysis seats in Yuendumu, for everyone.

MR MULLINS: All right, so - - -

THE WITNESS, ROSSER: But they can't – but – because the dialysis unit is run by nurses, they also can only take well dialysis unit – patients.

MR MULLINS: In terms of those emergency responses that you are dealing with, is it the case that you are dealing with an emergency response almost every week, at least one?

THE WITNESS, ROSSER: Yes.

MR MULLINS: And, if there was a suggestion, for example, that the Yuendumu Clinic was – we – I'm not saying this is a suggestion, but I'm just giving you an example. The Yuendumu Clinic was relocated to Yuelumu, so that it might take you

an hour or so to provide that emergency response, do you think that would be satisfactory?

THE WITNESS, ROSSER: No.

THE WITNESS, HALTON: No.

MR MULLINS: Well, in most of the emergency responses that you're providing, the assistance needs to be provided in 15 to 20 minutes, doesn't it?

THE WITNESS, ROSSER: Yes.

MR MULLINS: So the patient can be stabilised?

THE WITNESS, ROSSER: Yes.

THE WITNESS, HALTON: Correct.

MR MULLINS: So for example, the treatment of an asthma attack, a serious asthma attack, the patient needs to be stabilised in 15 to 20 minutes, if possible?

THE WITNESS, ROSSER: Ideally, yes.

THE WITNESS, HALTON: Correct, yes.

MR MULLINS: The treatment of a stroke, the patient needs to be stabilised within 15 to 20 minutes?

THE WITNESS, HALTON: Correct.

THE WITNESS, ROSSER: Yes.

MR MULLINS: The application of a defibrillator to a person whose having a cardiac arrest. That needs to be in the shortest time as possible?

THE WITNESS, HALTON: Correct.

THE WITNESS, ROSSER: Yes. Minutes.

MR MULLINS: So in terms of those – going back to the air lifting out of the community into Alice Springs. What proportion of those, are people with chronic illnesses and are being dealt with, and what proportion are emergency events? Roughly.

THE WITNESS, ROSSER: So by chronic illnesses what - you mean less acute?

MR MULLINS: Yes, less acute.

THE WITNESS, ROSSER: So I think the time critical evacs are a lot less often. Maybe - maybe 20 percent of the time you might have someone who is very (inaudible) to a bit unwell.

MR MULLINS: Yes, so fair to say then across 14 days if you have 10 out of 14 days there are evacuations, two to three of those will be emergencies and the other six to seven might be acute illnesses that are being - sorry - chronic illnesses that are being dealt with? Is that a fair - - -

THE WITNESS, ROSSER: They're still acute illnesses, just less - less unwell. Any chronic outpatients none appointments would go on the bus.

MR MULLINS: Thank you, your Honour, nothing further.

THE CORONER: Yes? Mr Espie?

XXN BY MR ESPIE

MR ESPIE: Ms Halton and Dr Rosser, my name is Espie, I am appearing on behalf of NAAJA. I have just a few questions for you. Dr Rosser, you've - I'm not sure what your answer was for this but you've been in - working in Yuendumu for a number of years now, could I just clarify that?

THE WITNESS, ROSSER: Yes, it will be seven years in December.

MR ESPIE: So you were there obviously before the period that we are discussing, that incident in 2019 and then since?

THE WITNESS, ROSSER: Yes.

MR ESPIE: What is your view or your assessment of some of the challenges you've had rebuilding trust or a relationship with the community following the shooting incident?

THE WITNESS, ROSSER: Yes, so immediately afterwards when we came back and we went to the community meeting there were a lot of people who were upset and angry and feeling betrayed and we (inaudible) Liam and I were asked to speak at that meeting and I think - there was a bit of strife afterwards but there was not too much. I think slowly we've regained a lot of trust.

MR ESPIE: And you think that's been restored now? Is there still some lingering concerns or comments that you get from people?

THE WITNESS, ROSSER: No, I haven't had any recent comments.

MR ESPIE: Are you - I suppose this is a question for both of you. Are you aware now of what the policies or protocols are in relation to situations where you may have to consider withdrawing services or closing the clinic?

THE WITNESS, ROSSER: Yes.

THE WITNESS, HALTON: Yes.

MR ESPIE: Is that something since the shooting incident that has been made, you know, fully aware to you both?

THE WITNESS, ROSSER: Since then, yeah.

MR ESPIE: Dr Rosser, you've been in the community quite a long time. It's fair to say you've seen a lot of staff - nurses and other staff come and go in that time?

THE WITNESS, ROSSER: Yes, I have.

MR ESPIE: Retention of staff is challenging, that the non-Indigenous staff that come out and live in the community"

THE WITNESS, ROSSER: Yes.

MR ESPIE: The local Aboriginal staff, their retention has been quite consistent, is that fair to say?

THE WITNESS, ROSSER: Yes, yes, it's been reasonably consistent. We've had a couple who've worked with for a short time but on the whole they stay.

MR ESPIE: Just some questions, you both have given slightly different answers to our view on what might help with staff socialising or perhaps another word is "integrating" in the community. Ms Halton, do you feel that having a safe and secure compound where you can mix between staff houses would be something again, as my friend suggested, a wish list, that's something that you think would improve and keep staff out in the community longer?

THE WITNESS, HALTON: Yes, correct.

MR ESPIE: Was there anything done for you - or for either of you when you come out to the community to help you feel integrated and beyond a normal induction, like ways of interacting with other stakeholders and other community members in fact?

THE WITNESS, HALTON: No.

THE WITNESS, ROSSER: For community members I think it took some time. They've seen a lot of doctors come and go so people were happier with me the longer I stayed and now I think there's a lot of trust.

MR ESPIE: And people are - ultimately being there for quite a long period of time, people - has allowed people to get to know you and take the time because they realise that you're someone that's going to stay?

THE WITNESS, ROSSER: Yes.

MR ESPIE: Do you think there's things that could be done from either of your perspective to improve that for new staff coming in, ways of being able to mix and socialise and form meaningful relationships with people in the community?

THE WITNESS, ROSSER: Yes, I think having staff - there's a lot of things that can be done and lifestyle visits especially. If you get good stuff and younger then people are less fatigued. If you're exhausted and on-call every second night then you're not going to stay as long because you'll get burned out so I think ensuring adequate staffing numbers is one of the most important things to ongoing retention of staff but also allowing enough staff that people can have weekends off and go into Alice Springs and have some time out.

MR ESPIE: All right. And I guess just going back to the suggestion of having a bigger compound, certainly from a security point of view, Ms Halton, can you suggest that's something important. Do you see that it could also create a situation where you become segregated from the rest of the community?

THE WITNESS, HALTON: Yes, yes.

MR ESPIE: And that it might make it hard to form relationships with people outside of your own colleagues?

THE WITNESS, HALTON: Well no not really, you can still socialise with people.

MR ESPIE: But Dr Rosser you've I think mentioned you notice a difference between the chain mesh fences and the Colorbond fences, it really did shut people out?

THE WITNESS, ROSSER: Yes.

THE WITNESS, HALTON: Are you talking about people outside (inaudible).

THE WITNESS, ROSSER: Yes.

THE CORONER: I think Dr Rosser was just clarifying that there was better socialisation among the nursing and clinic staff when there were chain fences, not that it permitted greater integration into the broader community.

Do you think if there was greater integration into the broader community that would also assist with retention?

THE WITNESS, ROSSER: Yes, I think so. If people feel a part of community they will be happy to stay longer.

MR ESPIE: And you both talk about the value of your Aboriginal staff and obviously their retention has been quite consistent. Looking towards the future, I mean what is

- is that the solution, having more Aboriginal nurses and Aboriginal doctors in the community?

THE WITNESS, ROSSER: Yes, that would be excellent.

MR ESPIE: Ms Halton, you mentioned in your statement that there is - there are beyond just employment in health - that there are employment opportunities but that people in the community perhaps either see disengaged or not a lot of interest or opportunities for people that undertake employment?

THE WITNESS, HALTON: I didn't hear the end of that, sorry.

MR ESPIE: I'm just referring to some of your suggestions in your affidavit that, whilst there might be some employment opportunities, there's not a lot of interest, or perhaps education is a barrier to that.

THE WITNESS, HALTON: Yes, I think so.

MR ESPIE: And I think you both – or one of you mentioned somebody named Gwen. Is she the Aboriginal employment and career development officer?

THE WITNESS, HALTON: Yeah, correct.

MR ESPIE: All right. So, is she able to proactively seek out or headhunt Aboriginal staff that might be suitable for - - -

THE WITNESS, HALTON: She does.

MR ESPIE: All right.

THE WITNESS, HALTON: Yeah, she does.

MR ESPIE: Do you know if there's training opportunities for local Aboriginal staff to travel into town and undertake courses or - - -

THE WITNESS, HALTON: Yes.

MR ESPIE: - - - or university or - - -

THE WITNESS, HALTON: Yes. Yes, there is.

THE WITNESS, ROSSER: Yes, and there's the Batchelor Institute.

THE WITNESS, HALTON: Yes.

THE WITNESS, ROSSER: And they train up Aboriginal health care and nurses and we've had AH school students - - -

THE WITNESS, HALTON: Yep.

THE WITNESS, ROSSER: - - - working with us on the past.

MR ESPIE: Right. Do you think there's more that can be done to create more flexible pathways to that sort of training for local people?

THE WITNESS, ROSSER: I'm not sure what the current pathways are, so I wouldn't feel confident saying either way. I don't know enough about that process.

MR ESPIE: Are either of you familiar with Aboriginal-controlled health organisations that operate in some communities and perhaps the differences in - - -

THE WITNESS, HALTON: Yep.

MR ESPIE: - - - in their model, as opposed to NT Health?

THE WITNESS, HALTON: Yeah, I am.

THE WITNESS, ROSSER: To some extent. I have – I've never worked for one, but I'm aware a little bit about them.

THE WITNESS, HALTON: I do. I worked for Congress for two years(?).

MR ESPIE: Right. And Ms Halton, what's your understanding of the differences – or perhaps I'll just mention some of them. Are you aware that they do seem to have a higher percentage of Aboriginal staff, for example?

THE WITNESS, HALTON: Correct.

MR ESPIE: Would you be aware that, not only the retention of Aboriginal staff, but they have better health outcomes, more effective health outcomes in their remote communities' clinics.

THE WITNESS, HALTON: I don't know about their remote clinics, but I know I worked in Alice Springs and – as a midwife, and while I was there, we were told that the outcomes for pregnant women and their babies had increased to the same as – their better outcomes were the same as the rest of the population, but it didn't include - that data did not include communities, so I don't know about communities, only in Alice Springs.

MR ESPIE: And that data was specific to Congress - - -

THE WITNESS, HALTON: Yes, in Alice Springs.

MR ESPIE: Sorry, was that in relation to - - -

THE CORONER: Alice Springs.

MR ESPIE: - - - what area of health, sorry?

THE WITNESS, HALTON: Midwives; I was a midwife, yeah, so midwifery. And it was about the better outcomes for pregnant women and their babies.

MR ESPIE: Right. And were you aware that the opportunities for the Aboriginal staff to have a lot more input in the ways of Aboriginal staff advisory groups and that sort of thing?

THE WITNESS, HALTON: No.

MR ESPIE: No. Were you – did you participate in their cultural induction or cultural protocol training and that sort of thing?

THE WITNESS, HALTON: Yes, I did.

MR ESPIE: Did you participate in anything similar in your current role or with NT Health?

THE WITNESS, HALTON: Yes, I did. The only thing I didn't have was the on the ground – like when I've moved (inaudible) in Yuendumu, I didn't get like the tour with Jameson.

MR ESPIE: Right. Are you able to compare the difference or did you think the Congress training was more or less comprehensive and useful?

THE WITNESS, HALTON: To be quite honest, the Congress one was longer. It was two full days. But yeah, I wasn't totally – it wasn't totally foreign to me.

MR ESPIE: All right.

THE WITNESS, HALTON: Because as I said, I grew up in the outback with Aboriginal people, and when I was in Mildura where I worked, there is a very high Aboriginal population. But as was said earlier that Aboriginal that are living in more urbanised centres are completely different to up here.

MR ESPIE: All right. And to some extent, you're probably aware of Congress being part of a broader Aboriginal health network Ampersand in the Northern Territory and NACCHO more nationally, do you think having the ability for Aboriginal staff to access those sort of networks and relationships and capacity-building opportunities? Do you think that would assist in attracting Aboriginal staff, perhaps from the Yuendumu clinic, if they could be linked into those sorts of opportunities.

THE WITNESS, HALTON: Yeah, yes. You have to – I think two communities are different and depending on the community, you know, some communities have wonderful Aboriginal staff who have been permanent for years, but Yuendumu doesn't.

THE CORONER: Did you see any difference between the engagement and inclusion of Aboriginal staff in a Congress setting, as compared to your NT Health setting?

THE WITNESS, HALTON: Well, it was different, because Congress staff are executive Aboriginal people, most of them are. So, it's more the other way around. And you know, there was a percentage of non-Indigenous staff, obviously, but all their staff – most of their staff are Indigenous, except for, you know, maybe the doctors and the nurses. It would be more varied.

THE CORONER: And did you feel included and integrated into that health system?

THE WITNESS, HALTON: Do you mean personally or like - - -

THE CORONER: Yes.

THE WITNESS, HALTON: Well, yes. I had friends in Congress, but I still communicate with our Aboriginal staff there.

MR ESPIE: Is that, perhaps, different to the situation you're in now, that you're not able to – or there's not as many opportunities. You have less Aboriginal staff to interact with.

THE WITNESS, HALTON: No, because I interact with the Aboriginal staff we have here.

MR ESPIE: All right. You've described your Aboriginal staff there at Yuendumu Clinic as being the backbone to the clinic. Amongst other things, they assist in communication and they're Warlpiri speakers. They assist in interpreting. Do you think that – are you aware whether they get any accreditation, such as the NAATI accreditation for – in actually forming the function of an interpreter. Is that something that you're aware is or isn't part of their training?

THE WITNESS, HALTON: I don't think so. No, they're not accredited interpreters.

MR ESPIE: Do you, on other occasions – or there are occasions where, rather than using staff, you utilise or have access to utilising interpreters through the Aboriginal Interpreter Service?

THE WITNESS, HALTON: Yes.

THE WITNESS, ROSSER: Yes, we always have access to that.

MR ESPIE: And are there challenges in accessing interpreters other than your staff?

THE WITNESS, HALTON: No.

MR ESPIE: Thank you both. Those are my questions.

THE CORONER: Mr McMahon.

XXN BY MR MCMAHON:

MR MCMAHON AC SC: Nurse and doctor, I only have one idea I wish to discuss with you. My name is McMahon and I act for the Parumpurru Committee, which is a committee – justice committee from Yuendumu created for the purpose of this inquest. And one of the recommendations that we'll be making to her Honour at the end of all of this is about reconstituting a properly funded and organised local council And that's the idea I just want to briefly discuss with you. It's emerged in other material in this hearing and also with both of you today, firstly that there has in the past been a health advisory group and her Honour mentioned it to you and there's - our understanding in this room has been that although it has occurred in the past, since COVID it basically hasn't really been able to operate or perhaps only in an emergency situation or something like that. So the idea I want to test with you is if there was a locally constituted group of leaders in the community, not just Elders but leaders in the community, like a local council, can you see the benefit in such a group for the purposes of your work if they were auspicing, for instance, a health advisory group. Can you see the benefits for your work of having such a body to enable you to have one clear defined group of people to go to to organise meetings of a health advisory group to transfer ideas to lean what the community wants from you and for you to be able to communicate back to the community? Can you see the advantage of that?

THE WITNESS, HALTON: Yes.

THE WITNESS, ROSSER: Yes.

MR ESPIE: Is there anything you would like to add to that? I mean, it's a kind of obvious question from my point of view but perhaps a fresh idea for you. If there was such a local council that was properly organised and funded and elected representatives can you see that helping the way that your clinic operates within the community of Yuendumu?

THE WITNESS, ROSSER: Yes.

THE WITNESS, HALTON: Yes.

MR ESPIE: Simple as that?

THE WITNESS, ROSSER: Yes.

THE WITNESS, HALTON: Yes.

MR ESPIE: Is there anything you would like to add, nurse? I don't want to put you on the spot but - - -

THE CORONER: I am just trying to understand what you see as the benefit and where that arises from. Does it arise from the fact that whether you call it a council or how it is formed, is it arising from the fact that there is one identified body within the community that you can access to talk about issues or to - or that can convene meetings so that specific issues can be discussed. Is that what the benefit is or is it - does it come from somewhere else?

MR ESPIE: Is that to me, your Honour?

THE WITNESS, ROSSER: No, that's - - -

THE CORONER: I think it's to them, I'm just trying to understand.

THE WITNESS, ROSSER: Yes, that's a good point. And having a formal point of contact with the Elders I think would be very beneficial.

MR ESPIE: Part of our answer to that, your Honour, it might help the medical staff if they heard what I said, just in one sentence. It's part of the broader picture which we are hoping to make submissions about, about the importance of more local authority and leadership coming back into Yuendumu, which exists outside and beyond some of the current settings which, for instance, Superintendent Nobbs identified which are committees essentially either constituted or controlled by police or in many ways outside agencies and part of it we will be saying at the end of all this is the importance of recognising the need for greater local authority, greater local decision-making and that's why we keep coming back to this point and I stood up today to ask these questions of these witnesses because they live - they work in the community, they need to be able to communicate in a very important way with the community and we felt that introducing this idea to them might be useful for your Honour.

THE CORONER: Sure. I am absolutely happy to have you introduce that idea. I would be very keen to understand it more deeply about what is being considered and proposed and the sooner that we can understand that and grapple with it, the more helpful it will be, Mr McMahon, so I am not sure if we've received anything by the way of evidence or proposals or anything like that and if you are in a position to provide something for people to consider, we would appreciate it.

MR MCMAHON: We will, your Honour.

THE CORONER: I think it would be helpful to have that earlier, rather than later.

MR ESPIE: I have no further questions.

MR MCMAHON: Yes, your Honour.

MR ESPIE: I have no other questions, apart from this.

THE CORONER: Because we have also had some communication with the Aboriginal Justice Agency who are also, I think, proposing sort of leadership type law and justice groups within community, so understanding the different perspectives and where that might - how they might work either together or whether they overlap, I just don't understand that at the moment.

MR MCMAHON: Well, it's not a secret, your Honour, that some of this is evolving because of what we are doing here as well.

THE CORONER: Sure.

MR MCMAHON: And certainly there were some recent frameworks put into place in the Northern Territory which we want to work entirely with rather than.

THE CORONER: That's what I am trying to understand.

MR MCMAHON: Yes, and we've had some discussions out of court with different parties about some of that and it's - it's a question of piecing it together to make the most practical and useful recommendations that we can for the court.

THE CORONER: Thank you.

MR OFFICER: Just a couple of brief topics, your Honour.

THE CORONER: Sure, Mr Officer.

XXN BY MR OFFICER:

MR OFFICER: Dr Rosser and Ms Halton, my name is Luke Officer. I appear for Constable Rolfe and I just wanted to touch on two aspects of your evidence that interested me and it fell from you, Ms Halton but Dr Rosser, I appreciate your input. You're noticing members carrying serious weapons and our evidence, Ms Halton, was that they come in with head injuries and lacerations - a lot of lacerations, serious head wounds from axes, boomerangs, stab wounds. What is the frequency of stab wounds that you have seen? And Dr Rosser, I think you said you've been in the Yuendumu for seven years, you can recount that?

THE WITNESS, ROSSER: Stab wounds happen but they're rare.

MR OFFICER: They're rare.

THE WITNESS, HALTON: There was screwdriving.

THE WITNESS, ROSSER: No.

MR OFFICER: And that was my next question, Ms Halton, what sort of implements are you seeing?

THE WITNESS, HALTON: Yes, screwdrivers, tomahawks, some of the broken arms and like hand (inaudible) boomerangs and other (inaudible) - - -

MR OFFICER: Sorry. What about scissors?

THE WITNESS, ROSSER: Yes, and I understand we had an incident recently where someone was leaving the clinic and had stolen scissors from the clinic.

MR OFFICER: From your clinic?

THE WITNESS, HALTON: Yes.

MR OFFICER: And Dr Rosser, probably more aimed at you given your involvement in Yuendumu for the last seven years if I've got that correct, you - we were talking a moment ago about the fighting between members and would you agree that it's unusual that fighting or - I withdraw that - or weapons being deployed against other people such as police or nursing, is that extremely unusual?

THE WITNESS, ROSSER: Yes, that's - that's very unusual.

MR OFFICER: And Ms Halton, at par 77 of your affidavit you say that break-ins have been occurring in Yuendumu for many years now and affect community houses too. It is usually carried out by young people and expressly against the instruction or wishes of their Elders and traditional owners. This court received some evidence that often Elders and members of the community are powerless to stop this sort of offending. Would you agree with that?

THE WITNESS, HALTON: Yes.

MR OFFICER: Dr Rosser, has that been your experience in the last seven years?

THE WITNESS, ROSSER: Yes, a lot of Elders and other community members have expressed that they're very frustrated as well.

MR OFFICER: Thank you. No further questions, your Honour.

THE CORONER: Any other questions?

MR COLERIDGE: Just quickly.

THE CORONER: Mr Coleridge do you have a couple of matters to - - -

<u>REXN BY MR COLERIDGE:</u>

MR COLERIDGE: On the subject of Elders saying that they feel powerless to intervene - - -

THE CORONER: Maybe sit down, you're a bit soft.

MR COLERIDGE: Just on the subject of Elders saying that they feel powerless to stop kids breaking into houses, are Elders ever saying to you, "Look, here's what we think we need to feel more empowered"?

THE WITNESS, ROSSER: No, no-one has ever said they need anything specific, no.

MR COLERIDGE: Do you have any ideas of your own?

THE WITNESS, HALTON: I attended a meeting just prior to going on leave and it seemed that some Elders were really concerned and were saying that this is not their way and it's not their tribe - it's not tribal, that they were being - Yuendumu was being held to ransom by (inaudible) and they didn't - like they were really frustrated and clearly upset. They were at a loss.

MR COLERIDGE: Do you have any theories of your own about what is needed to empower Elders to intervene?

THE WITNESS, HALTON: No. I don't know. I don't' think anyone has an answer at the moment.

THE WITNESS, ROSSER: I think it's a multi-factorial problem which leads to no simple answers.

MR COLERIDGE: Those are my questions, your Honour.

THE CORONER: Something for us all to grapple with then.

THE WITNESS, ROSSER: Yes.

THE CORONER: But we very much appreciate both of you making yourselves available. From the little bit we know, we do - well, we're starting to develop an understanding about the important service that the clinic provides and just how busy that environment is and how very important the services that both of you provide are to individuals but also the community and the wellbeing of the community as a whole, and we do appreciate you giving up your important time this morning to assist us by answering these questions. Thank you very much.

THE WITNESS, HALTON: Thanks.

WITNESSES WITHDREW

THE CORONER: So we ill take the morning adjournment and can we return with our next witness?

MR COLERIDGE: Yes.

THE CORONER: Excellent.

ADJOURNED

RESUMED

THE CORONER: Yes, Mr Hutton.

MR HUTTON: Your Honour, Naomi Heinrich.

NAOMI HEINRICH, affirmed:

XN BY MR HUTTON:

MR HUTTON: Can you please confirm your full name?---Naomi Lorna Heinrich(?).

And what is your current business address?---I am located at Eurilpa House, Level 1, 25 The Todd Mall, Alice Springs.

Thank you. Ms Heinrich, have you prepared an affidavit for the purposes of this inquest?---Yes I have.

And that's dated 22 August 2022?---That's correct.

Are the contents of that affidavit true and correct?---Yes they are.

Your affidavit was prepared in response to a request from the Solicitor Assisting, that a senior employee from NT Health provide a response to 13 particular questions. Is that correct?---That's correct.

Did you also author a letter to the Solicitor Assisting, in response to further questions regarding the provision of counselling in Yuendumu?---Yes I did.

And that's a letter dated 31 August 2022?---That's correct.

Ms Heinrich, what is your current role at NT Health?---I'm the Regional Executive Director for NT Health, Central Australia Region.

And how long have you been in that role?---Since 1 July 2021, when NT Health became one entity under the *NT Health Services Act*. Prior to that, I held a similar role as the Chief Operating Officer for Central Australia Health Services, from December 2020.

Thank you. As Regional Executive Director of the Central Australia Region, you're accountable for the management and delivery of health services in the region, and that includes primary care?---That's correct.

And it also includes acute care services, and mental health services. Is that correct?---That's correct.

And they are in effect, three separate branches of health care, that sit underneath the Regional Executive Director role?---That's correct.

Your professional background, Ms Heinrich, is primarily in acute care?---Yes it is.

From April 2014 until December 2020, you were the General Manager of Acute Care Services at the Central Australia Health Service?---That's correct.

What did that role involve?---That role involved the oversight and management of both the Alice Springs Hospital, and subsequently the Tennant Creek Hospital, amongst other services under the acute care umbrella, such as renal services. It involved ensuring compliance against a number of standards, clinic practise indicators. Key performance indicators, as outlined under the Service Delivery Plan, set out by the System Manager, or the Chief Executive of NT Health.

All right. And relevantly, for the purposes of this inquest, you were General Manager at Acute Care Services on 9 November 2019, is that correct?---Yes that's correct.

You played no role in the decision to temporarily withdraw the Health service staff from Yuendumu on 9 November 2019?---That's correct, I didn't.

And I understand, that on behalf of NT Health, you may – you wish to make an expression of condolences?---Yes I do. I wish to extend my deepest sympathies to the family and friends of Kumanjayi Walker. And I offer my sincere condolences to them on this sad loss.

Thank you. And you're clinically trained, Ms Heinrich?---I am clinically trained. I am a registered nurse. I was registered in 1992. I practiced clinically for the period of 1992 to 2001, following which I moved into management roles, broadly, since that period of time.

Where did you practise as a registered nurse?---At the Royal Adelaide Hospital, in Radiation Oncology and Palliative Care.

Before I move to the subject of your affidavit, and the questions that you've responded to for the Solicitor Assisting. I'd like to ask you about the Root Cause Analysis that NT Health has completed in relation to Kumanjayi's death?---Mm mm.

You're familiar with that document?---Yes I am.

And you approved it, in your capacity as Regional Executive Director, is that right?---Yes, that's correct.

Could you tell her Honour, please, what the purpose of completing a Root Cause Analysis is?---The purpose is an opportunity to have a range of stakeholders with expertise, subject matter expertise, to investigate a critical incident, to look at where there could be a recommendation around system improvement. It is very much focussed on system improvement, and development.

All right, it's an effort to lead systems reform, or systems improvement, within NT Health, is that right?---Yes, that's correct.

And it's an internal facing document?---Yes it is.

Now you did not play any – any role in the drafting of the RCA report, is that correct?---No, that's correct.

That's done by a panel – the RCA panel as it were?---Yes, that's right. There's a terms of reference that are set out for – for the Root Cause Analysis investigation. Subject matter, expertise, identified. And it is their role to undertake that investigation.

Are you aware that the panel in this instance, experienced certain challenges in the completion of the RCA report?---Yes I am.

And what are they? Or what were they?---Yeah, certainly. There was some delay in the completion of the report, as you refer to. That was impacted certainly by COVID. So the impact of COVID, both on staff availability, as well as opportunity to meet collectively during that very intense period for Health staff, during that period. In addition, we were conscious in terms of the criminal case for Rolfe. And as such, we did not want to prejudice that by engaging witnesses that were also providing evidence to that case.

Am I correct to say, Ms Heinrich, is it your understanding that in fact, NT Health was unable to access the records with interviews for example, that were completed, with the staff that – some of which are now before the Coroner, for the purposes of the RCA?---Yes, that's correct.

The end result, Ms Heinrich, was that by the time the RCA was completed, a number of changes had already occurred that were relevant to the circumstances in Yuendumu in November 2019, including significantly, the NTG Remote Worker Safety Policy had been developed by the Department of Chief Minister?---Yes, that's correct.

Can you tell her Honour about that policy please?---Yes. It was a policy that was released in January 2021. It serves to provide a cross-government agency policy to better support response, again, across those agencies, in relation to any incident, or potential risk of incident in community. It very much focusses on that collaborative approach. Open and clear communication across – across government agencies. Supporting local decision making as well, within the regions. And again, engaging resources across government agency, to better support outcomes, where risk might be identified. So a very collaborative approach.

Was that developed as a consequence of the events in Yuendumu in November 2019?---Yes, that's my belief.

The evidence before her Honour, has been that there was very limited coordination with other services, prior to the withdrawal of the Health services from Yuendumu. Do you accept that?---Yes I do.

And indeed, no consultation with other stakeholders in the decision making process itself?---Yes, that's correct.

Do you accept that wherever possible, consultation with stakeholders should occur, prior to the decision to withdraw Health services being there?---Yes.

And is it your understanding, or am I correct to say, that the NTG wide policy now facilitates consultation and collaboration?---Yes, that's absolutely correct.

And decision making is required to occur now through a Regional Coordination Committee?---Yes, where the policy's enacted, as such, where there is an at-risk or a risk issue identified in a community, a sub-committee of the Regional Coordination Committee is established, with the relevant agency stakeholders, to work through that particular risk that is identified. Work through solution and communicative calls across agency and within the community.

Thank you. Her Honour has also heard evidence - - -

THE CORONER: Can I just ask, has that been put into practise yet?---Yes it has, your Honour. The sub-committee was established during the criminal trial, to ensure that if there were any issues being raised, both in Yuendumu, and in Alice Springs, as a result of that trial, there was good communication across those agencies. So yes, that group was established, stood up, and communicated regularly during that process.

MR HUTTON: Her Honour has also heard evidence this week, Ms Heinrich, from staff who expressed the desire to contribute their views on lessons learned, coming out of Yuendumu. Are you aware of that evidence?---Yes, I have heard that evidence.

Will you ensure that NT Health seeks input from front-line staff who – who do wish to contribute to the lessons learned?---Yes, I agree, it's very important.

Including, and perhaps particularly from NT Health's Aboriginal staff in Yuendumu?---Yes.

Whose input was not sought during the decision making process?---Yes.

It should have been shouldn't it?---Absolutely.

And yesterday, Dr Reeves evidence was that those staff may have had relevant information in relation to what was happening in community. And why the property crime had intensified, or escalated. Do you accept that?---Yes, I do.

And finally, in relation to the RCA. It did not grapple with Dr Reeves direction to staff, to withdraw to Yuelumu, instead of to Alice Springs. As you will be aware from the evidence, that direction was not properly communicated, or was not followed. And clearly there was a break-down in communication here. Do you accept that?---Yes I do, yes.

Do you consider that that is – that to be a result of a systems issue?---On reflection of that evidence, I do. My understanding from Dr Reeve's evidence, and – and my own investigation into the matters, does reflect that there are some complex management communications, or there were during that period of time, within the primary health care management team. I think they are systemic. And I think there is opportunity to review those and improve those, with clearer lines of communication, clearer lines of decision making.

Thank you. If the circumstances that presented on 9 November 2019 were to present today, would it be handled very differently by NT Health do you think?---Yes I do. We have had the opportunity during the COVID pandemic to respond to emergency. What we have identified through that process, is the need for very strong communication and coordination, not unlike the regional approach, but an internal to NT Health. I would anticipate that the leadership team would support that decision making more broadly, through good communication, some collective decision making, improved documentation around that decision making, including risk, direction and outcomes. And of course, improve coordination and collaboration with all relevant stakeholders. We have seen a change in how we use technology to engage people across our remote community areas. So the use of course of TEAMS and the like, is much more readily accessible to staff. And I think that those opportunities allow us to use technology to support that engagement, and again, support that decision making, and documentation of those outcomes.

Thank you. Can I move then to your affidavit. And have a copy of it - - -

THE CORONER: Just before we do. Jut in relation to the Root Cause Analysis, clearly there's been some additional communication failures identified through the evidence of these proceedings, and you've told us a little bit about that. I was just looking at page 16 of 33. It says here, "Options to keep Health workers in Yuendumu were considered, but not pursued." We haven't heard any options that were being considered to keep workers in Yuendumu. And I'm just wondering what that referred to.

MR HUTTON: I think that might be a question for Ms Gill tomorrow, your Honour.

THE CORONER: All right.

MR HUTTON: I'm not sure that this witness would be able to assist in any event.

THE CORONER: All right. And I'll just – the other thing I would raise is, there was – there was a decision that the panel considered, that the decision to withdraw Health workers from Yuendumu for safety reasons was appropriate. And I'm

wondering whether or not at that time, the panel also considered the additional evidence in relation to the increased police response which was planned.

MR HUTTON: That might be a question for the panel.

THE CORONER: Anyway, I just raise those two issues.

MR HUTTON: Thank you, your Honour.

Ms Heinrich, if I can move to your affidavit, at par 46, you refer to NT Health's Aboriginal Cultural Awareness Program, or ACAP. And that is a program that NT Health engaged Flinders University to deliver?---Yes, that's right.

When did that occur?---Some years ago. We've had an ongoing arrangement with Flinders University for some years. It has been subject to, of course, assessment and evaluation in terms of the effectiveness of that program as perceived by the participants of the program. The development of that program was in collaboration with our senior NT Health Aboriginal staff to inform that program. And that program is ongoing to this date.

Do you know who – which senior Aboriginal staff at NT Health were engaged in relation to the ACAP?---I can specifically refer to Maxine Austin, who is the senior workforce manager for NT Health Services. And I understand that various members of, particularly, the primary health recruitment and workforce teams had been engaged as well.

And NT Health is about to go to tender, as I understand, to engage an external service provider to review the contact of the ACAP. Is that right?---Yes, that's right. NT Health has recently appointed, for the first time an executive lead, the Aboriginal Health and Cultural advisor. She is taking a lead across NT Health to support these types of activities. One of the activities that's referred to is to engage an external stakeholder to review the content of the ACAP program across NT Health. As a result of that, I would expect that there will be some recommendations, possibly relating to principles around content.

Would you be prepared to make available to the parties at this inquest the ACAP material, so that they might have an opportunity to provide their comments or input on its content?---Yes, of course, we'd welcome that.

Can you tell her Honour about the Aboriginal Health Workforce Leadership, Recruitment and Professional Support Team, please?---Yes, we like long names in health. That team is specific to our primary health care branch or division and includes a number of senior leaders, such as our Director of Aboriginal Health Practitioners. In recognition of the need to ensure that there is some cultural training, or cultural training within each of the remote communities. In addition to the ACAP training, this team has an Aboriginal recruitment officer identified for each of the district areas to provide that cultural training and again, support the recruitment and development of Aboriginal work staff, again by district, but coordinated locally

here in Alice Springs through a leadership team.

And how many districts are there, Ms Heinrich?---There are four districts.

At par 88 and 89 of your affidavit, you refer to the established staff cohort at Yuendumu and then the cohort at the time of preparing your affidavit, the Yuendumu Health Centre is not fully staffed at the moment?---No, it's not.

And do you know why that is?---We have very significant challenges around recruitment in Central Australia, both within primary health care, as well as our other branches of mental health and acute care. Recruitment is a very significant challenge for us at the moment across disciplines and as a result, we're having challenges to fill those vacancies.

I'll come back to recruitment challenges in a moment. Just as a general proposition though, you would accept, wouldn't you, that having a full cohort of permanent staff based in community is the best way for us to – or for NT Health, rather, to deliver health services effectively in a remote community?---Yes, absolutely.

Why is that so important, in your view?---I think it's essential in terms of establishing relationships within that community. It is about ensuring that there are trust relationships established. Of course, an understanding from our workforce of the cultural needs of that particular community, the clinical or the health profile of that community, so that we can best meet the needs of that community and again, those – developing those trust relationships is very important, hence we have maintained the establishment in those communities, despite the fact that we're not able to recruit to them, that is our ongoing goal, to recruit into those vacancies.

In the absence of having a fully established staff, is NT Health trialling or considering other methods of delivering services in a way that encouraging delivering or developing relationships like you've just described?---Yes, we are. It's a very multi-faceted strategy and I think it's about being as created as we possibly can at the moment to achieve that continuity of practice within the community. And example is the establishment of Nurse 2 level, remote area nurses are Nurse 4 levels. And new Nurse 2 level that works with a remote medical practitioner to routinely visit communities, working with that remote medical practitioner, but again with an establishment of communities, so that there is that early development of relationships and trusts built within the community, and a better understanding of that community. That model is two-fold, but it does mean that there is routine and regular contact with that nurse into that community. Equally, it introduces that nurse at the more junior level of the N2 level, to ideally engage in remote area practice and eventually make that decision to transition into remote area nursing. Similarly, for many of our models of care delivery and service delivery into remote communities, again utilising remote medical practitioners into specific communities. So, remote medical practitioners will go to communities, much like we heard from Dr Rosser this morning, that we do work very carefully to stabilise staff within communities to again create relationships. There are a number of strategies that we're looking at again to support staff into communities, both giving them an opportunity to learn about what

life is like working in a remote community, but at the same time, ensuring that that relationship is built up.

Thank you. You've outlined in your affidavit a number of challenges NT Health faces in relation to recruitment. Could you tell the court, please, what you consider key challenges or key difficulties in recruitments, as currently?---Yes, certainly, we have been impacted like the rest of Australia and indeed, internationally, as a result of COVID. We have seen the reduction of available staff, particularly nursing staff, into Central Australia. That has had a very significant impact on our staffing availability and certainly, those issues around available staff have had an impact in terms of our recruitment.

And are there any Central Australia specific issues in relation to recruitment?---Yes, I think from our perspective, we are identifying challenges again across a number of our work areas. So, to give you an idea of our current vacancy rates, within Central Australia itself, we have a nursing vacancy rate of 23 percent. In primary health care, we have a vacancy rate of 27 percent. In mental health, unfortunately, a vacancy rate of 42 percent and in acute care services, 20 percent. So, I think there's a combination of things that lead to these outcomes and they look quite different within those – in those areas. We, as in NT Health, are advocating for remuneration that is equivalent to other jurisdictions, and that is an ongoing challenge for us. So, there are certainly those issues that we're addressing amongst another – a number of issues in terms of both attracting and retaining staff.

At par 100 of your affidavit, you've outlined some challenges specific to recruitment in remote areas. What are you views, or can you explain to the court your views on those?---Yes. And I think we've heard from some of our witnesses who had previously been employed with NT Health or perhaps employed with NT Health as agency staff. There has been, I think, a change in the way that staff prefer to work. There is opportunity for nursing staff that never existed previously, perhaps in my time, of that flexibility to work across areas. Nurses now are seeking flexibility to move across areas, rather than have long periods of time, in particular, communities, or even in particular hospitals. The challenges of working in a remote community in Central Australia are significant. It is hot, dry, there are limited services available for people in those communities. It is challenging for people to relocate with their families to those communities in terms of service availability. So there are particular concerns of that relocation and we've seen, certainly, those impacts of people choosing not to work in long-term roles in remote communities because of some of those factors.

All right. And we've heard this morning – and you've referred to in your affidavit as well – there may be a problem associated with negative media reporting in Central Australia?---Yes, yes, I think that's – that's certainly a real issue for us, yes.

And how have you come to be aware of that?---I would say that we've had feedback certainly in terms of some of our marketing campaigns. There is anecdotal feedback around – around those challenges that these are not comfortable communities, necessarily, to work within, and we've worked very carefully to ensure a good

representation of what life is like working in those communities, to try and attract people. But there is media. There is national media around occurrences in community, safety issues in community, and they are things that we need to work through carefully.

Your affidavit sets out a number of things that NT Health is doing currently to try and address recruitment in the Central Australia region. Could you explain how that is operating, please?---Yes, I can. Following – following COVID and the return to what we're calling a business as usual model, we re-evaluated risk across the service, and identified that nursing vacancy in particular was one of our most significant risk, and I'm using nursing, but certainly this is broader than nursing across Central Australia. As such, in May of this year, I established a recruitment task force, indeed, to address that most significant risk that we are facing, and I've talked through those percentage numbers which are quite challenging to hear and work with. That recruitment task force is – has been tasked to look creatively at recruitment. How can we do this differently. How can we do this better. We need to be innovative. I think there's an opportunity to strengthen our consumer focus in recruitment, engage staff as consumers as they enter into the workforce here in Central Australia. We will be establishing a recruitment hub in Alice Springs with that concept of a wraparound service for new staff entering into Central Australia, so that work is being established to prepare that hub, looking very much at that onboarding experience. The first experience you have on arrival is a very important experience. So we need to ensure that as we onboard staff, both here in Central Australia and in Alice Springs, and out in remote communities, is the best experience we can provide for a particular individual.

Thank you. What can you tell her Honour about what NT Health is doing to increase its employment of Aboriginal staff?---Yes. We have a number of strategies around recruitment of Aboriginal staff. We have a number of staff who are dedicated into those roles to support and coordinate recruitment. We have a senior Aboriginal Leadership Employment Opportunities Committee, again, encompassing senior leaders across Central Australia to oversight that work. Recently, as an example, we had an Aboriginal staff forum to consider recruitment and retention specifically to Central Australia, and we anticipate those outcomes will be tabled shortly with executive to address. Beyond that, there are a number of strategies, including, for example, right throughout the spectrum of learning and development. We undertake school work experience visits, so industry visits or industry tours into our services to ensure that, in this case, school children have an understanding of the scope of positions or roles that we – that we have in health services, and ensuring that those – all of those roles are open to people. We offer school apprenticeships for school students studying a Certificate II or a Certificate III, again across a number of specialty areas through that school apprenticeship program. We offer cadetship programs for people undertaking bachelor programs such as nursing or perhaps social work. And we, in addition, have particular targets towards Aboriginal specific positions such as Aboriginal health workers at the Certificate II level, Aboriginal health practitioners at the Certificate IV level. We're currently looking at the establishment of a new role, a health coaching role, that is likely to be pitched at the Certificate III level. We're working with leads across NT Health and in association

with the Commonwealth around establishing that particular function. A lot of the work that we're doing is looking at that succession planning, so that opportunity for our Aboriginal employees to enter the workforce. But, equally, to gain further skills and to succeed within the workforce, so again, those opportunities for career development is – are very important to us, and to developing staff within our service.

And you've told me recently about some successes that you observed in that process?---Yes, yeah, we have a – a fabulous story of somebody who is working direct to me. She is the Director of Safety and Quality in her role as – across Central Australia. She entered into work – the workforce through the cadetship program. She became a bachelor – she studied a Bachelor of Nursing to become a registered nurse. She progressed through that program to a graduate nurse program. She became the clinical nurse manager of the surgical ward at Alice Springs Hospital, has had a great career in infection control, safety and quality, and as I say, is now the lead across Central Australia in safety and quality. So a really significant achievement.

And can you explain what the role of a health coach would be, or is?---It's in its infancies. And certainly what we're looking at is, again, that engagement, so really ensuring that people in communities – so the health coach would be likely specific to remote communities. It is about working with consumers or clients in that community to work with them. It has very much a strong focus on the chronic disease portfolio of community members, and again, working side by side with community members in terms of health improvements, health prevention, health promotion, within that chronic disease portfolio.

Thank you. In addition to efforts to recruit staff, NT Health is also implementing measures to retain staff. Can you tell her Honour about what is being done under that heading?---Yes. Perhaps on a lighter side, but no less important, we established a wellness program at the end of the COVID pandemic. These were some of the strategies that indeed were implemented nationally to recognise the work of all of our staff throughout that period of time, and recognise the likely fatigue of staff during that very intensive period. So our wellness program was conducted over a period of around three months with a number of activities to engage staff. Of course, our challenge is that staff are living across very broad regions, so we needed to ensure that that program would meet the needs of both a range of staff and a range of staff across geographical areas. The types of activities that we undertook during that program were cinema nights, quiz nights, karaoke nights, yoga, wellness discussions with – with qualified staff and in remote areas, things like dinner party packs. In addition, we ran a photographic competition whereby remote staff were able to engage, so again, ensuring that we had that opportunity for remote staff. While that may seem a softer aspect to recognition, I think the feedback that we received out of that program was very supportive, and people certainly recognised the efforts that NT Health made to recognise staff, and staff appreciated that engagement. We have subsequently followed up, particularly with remote staff, to understand how we can best recognise their efforts, given that it's less – less easy for them to attend functions in town, and we're responding through to those, including – they each received a cinema ticket recently, those programs are

continuing. We've agreed that those programs will continue on – into the future, and we recently had an event in – in late August as part of that program. Perhaps on a more significant note, we are looking at allowances, so considering the allowances of staff, particularly in those remote areas. We have been working with NT Health team and specifically the Chief Nurse Midwifery Office, to consider what we are now referring to as a Professional Isolation Allowance. Again, recognising, much like the Medical Enterprise Bargaining Agreement recognises the – the Remote Living Allowance to the Professional Isolation Allowance. As I understand, that will be considered as part of the Nursing Industrial Negotiations. There are a couple of other allowances that we're looking at, or – or negotiations, including flexible working arrangements. So considering how we might better support staff to spend periods of time in remote, and then periods of time on paid leave. So as an example of that, an eight week's on in community, and a four week's off at – at that person's choice of residence, of course. So looking at how we can use those models differently to better support our staff. In addition, and we talked to this earlier, around how do we attract new nurses into remote area nursing, noting that that is a particular speciality and a skill. We're also looking at an allowance that may attract a nurse from an acute care, or an urban setting, into a remote area as well. So looking at those singular payments to again attract people into those remote areas. And give them the opportunity to develop their - their experience and exposure into those areas.

Are those flexible working arrangements being trialled at this stage?---They haven't been trialled. We are looking to develop those. So we have been in collaboration with the Office of the Public Employment Commission. And we're working through those arrangements at the moment. But – but by all means, we have identified that Yuendumu would be the preferred community to trial, because of the volume of staff in that area. So that would give us the best opportunity to trial. So Yuendumu being the larger of the services for us is a great place to trial some of these opportunities. So that work is in progress as we speak.

Returning then to Yuendumu, and you may have heard the evidence earlier this week, regarding a Social, Emotional Wellbeing Program?---Mm mm.

Which was, we were told, has been operating for some time in Wadeye. Are you able to tell the court about the Social and Emotional Wellbeing Program in Yuendumu?---Yes I am. The Social, Emotional Wellbeing Program, is an adjunct to existing services around mental health and drug and alcohol services. It's a Commonwealth program. And in the Territory it is a program that is managed by the Northern Territory Primary Health Network. The Northern Territory Primary Health Network or the NTPHN allocate funds through the NT Health. So NTPHN allocate funds to Central Australia. I believe they have done so since around 2016. There are a number of aspects of that program. There is a therapeutic steam. That supports the employment of a psychologist. And more of a social stream that supports the employment of perhaps Aboriginal health workers, or similar in a community, depending on the needs of that particular community. Specifically to Yuendumu, there has been funding for one FTE of a psychologist in Yuendumu. That position most recently has also covered a number of other communities, including, for example, I think it's Nyirripi, Ti-Tree and Willowra. Unfortunately, that

position is currently vacant. Despite recruitment efforts, we have not been able to recruit into that position. There is some thought that we may be able to recruit into that position early – in the early new year. There is some discussion with potential candidates around that. But beyond – but prior to that period, I believe that we've had that position recruited into, and until December 2021. So there have been a number of people who have held that position and worked within community. I think the witnesses this morning made reference to – to those people in that position.

And that was Kerri-Anne?---Kerri-Anne and Karen.

And you are supportive of the delivery of a Social, Emotional Wellbeing Program in Yuendumu?---Absolutely. I think these programs are essential. And they certainly, as I have mentioned, provide an adjunct to other services within Yuendumu. In addition to the SEWP program, we also have a remote AOD Program, equally that is Commonwealth funded. And through that program we provide a visiting drug and alcohol social work support into – into Yuendumu. Again, we are currently are challenged with some recruitment challenges in that position. But that position is Commonwealth funded, and supported in an – in an after-care social work counselling role.

What is the extent of the counselling services currently provided in Yuendumu?---There's a range of counselling services. And all registered nurses are required to provide some level of counselling. So remote area nurses specifically undertake a training program to transition to a remote area nurse. They undertake a number of domain, or training around domains. One of those domains is indeed around counselling and mental health services. So while it is not at a specialised level, it does provide some basic understanding of counselling and mental health services. So those staff who are stationed in Yuendumu, in those established roles, would provide some level of counselling. Equally, there are a number of visiting – visiting services into Yuendumu. Either again by those visiting nurses, or other visiting specialist teams. Specifically, from a mental health perspective, we provide visiting specialists into Yuendumu, and have done so for a number of – a number of years. That of course is at the very specialised mental health aspect of counselling. So counselling can kind of range through a number of aspects, depending on the acuity of the person. From a mental health perspective, we have – in fact a Clinical Director of Mental Health for Psychiatry - - -

Perhaps if I can just interrupt you there?---Yeah, sure.

I'll come to the subject of mental health services - - - ?---Mm mm.

- - - in particular- - -?---Mm mm.

- - - but just to remain with counselling for now?---Mm mm.

Her Honour has heard from a number of witnesses how useful they think trauma counselling in particular, in Yuendumu, would be?---Mm mm.

Do – do you have a view on that?---Yes absolutely. And certainly the principles of the Social, Emotional Wellbeing Program do encompass a trauma framework.

Why do you think that would be beneficial?---I think it recognises the needs of that community. Recognises the trauma that the people in that community have experienced. And it's an approach that – that works on an understanding of the trauma that people may have experienced.

And what are the difficulties then with putting trauma counselling in place in Yuendumu?---Recruitment. It's – sorry, it's very repetitive. So recruitment is a real issue for us. As I say we have – we have an FTE that is funded. We can't recruit into that position at the moment. Equally in the AOD space. Who would also – the social worker there would also likely use a trauma informed approach to service delivery. Again, there's recruitment challenges. So certainly, recruitment into those positions is a significant challenge.

Your letter to the Solicitor Assisting stated that the federal government provided in the order of $300,000 in funding to WYDAC - - - ?---Mm mm.

- - - to provide Social, Emotional Wellbeing services, in response to the events of November 2019, is that correct?---That's correct.

And WYDAC sub-contracted Gan'na at hearing to deliver those services, is that right?---Yes, that's my understanding.

And that's an organisation based in Northern New South Wales?---I believe so, yes.

It is an organisation that NT Health is also engaged?---Yes, we have utilised Gan'na through, again, the Social, Emotional Wellbeing program. So our team have engaged that organisation to support our work as well.

And are you aware of an equivalent service based in Central Australia?---I'm not, I'm sorry, no.

And let's return to the subject of mental health services then. The services – the services delivered in Yuendumu, that's done by Outreach - - - ?---Yes it is. In addition to the – the team, or the established team that we have in Yuendumu, we provide a very significant number of Outreach services into – into Yuendumu. So a fly in, fly out approach of specialist services. One of those services, amongst many, of course, is psychiatry services. So our Director of – or Clinical Director of Mental Health, Dr Marcus Tabart has been travelling to Yuendumu for the last 24 years. He – he started his career as a remote psychiatrist in Central Australia, and has continued that commitment to visit Yuendumu. He, along with a training registrar, so a trainee psychiatrist, and an Aboriginal health worker, visit Yuendumu on a period of six to eight weeks. Of course, there has been some interruption with COVID over the past couple of years. But the schedule of visiting is six to eight weeks.

Do you consider there's a need for greater mental health services in

Yuendumu?---There is always a requirement for more and certainly, it is about assessing what services we provide. So, we need to consider, what is it that we provide, what are the demands from that community and what are the referral requirements from that community. Certainly, that is something that we do across all services, not just mental health services. We very much utilise the expertise of the staff in a community such as Yuendumu to provide that referral, and that gives us an understanding of what services would be required in that community. So, again, that should be evolutionary in terms of what services are going into communities.

All right. At par 164 of your affidavit, you've noted that there is a longstanding local health advisory group in Yuendumu?---Yes.

And are you aware that that group has not convened for some time?---Yes, I am.

Many months, as I understand?---Yes. During the COVID period, the health leads met with community staff with a very different type of, I guess a focused discussion. Since COVID, since again, our return to business as usual, I understand there have been challenges to re-establish that advisory group.

What are those challenges?---I think it's a challenge around coordination. My understanding is that there have been a number of attempts, perhaps up to six attempts to coordinate a meeting. We, as NT Health, now utilise the Chief Minister in cabinet position that is posted at Yuendumu to facilitate some of that coordination of meetings along with our own Aboriginal recruitment officer for the district that we referred to earlier to facilitate the scheduling of those meetings. But for a number of reasons, those meetings have not gone ahead.

On one recent occasion, I understand from your affidavit that that's been a consequence of unrest?---Yes, that's correct.

Am I right to say that Dr Reeve has travelled out to Yuendumu on a number of occasions in order to try and meet with the local advisory group. He's a participant?---Yes, he is.

But he's been unable – but the group has not convened?---That's correct.

And noting that this inquest is being livestreamed and as we understand, being watched by people in Yuendumu as well as those here, can you explain why it is that that group is so important to NT Health?---Yes, absolutely. The engagement of community staff – sorry, community with our staff in that community is essential to ensure that we are hearing the needs of the community, responding to the needs of the community, that the community have an opportunity to participate in the health service delivery and equally, the strategic development and directions of the health service. So, it is about community and participation to ensure that we are indeed meeting the needs of that community and strengthening their engagement in health.

Are you aware that there has been unrest recently in the Yuendumu Community that has also resulted in the health centre needing to lock its doors at times?---Yes.

And that's – did you hear that evidence this morning?---Yes, I did.

And patients have had to be treated on an emergency basis only?---Yes.

Unrest in community does and is having an impact on the services that NT Health is able to deliver. Is that correct?---Yes, that's correct.

We heard yesterday that a method that NT Health has employed to increase staff safety in remote communities since December 2020 is the use of security guards?---Yes, that's correct.

Are you aware of which communities currently are being serviced by security guards?---Yes, today, we have security guards in Yuendumu and Papunya. In recent times, we have also had security guards in Mount Leibig and Hermannsburg.

Thank you. And finally, at par 170 of your affidavit, you refer to the regional coordination group. Can you tell the court about that group?---I can. The regional coordination group is local to the Central Australian region. There are regional groups across NT. This is the Central Australia regional coordination group. It is chaired by the senior executive of the Chief Minister in cabinet department here in Central Australia and Alice Springs.

Who's that?---That is Brendan Blandford. And it engages the leads of agencies, government agencies, in that coordination group. The group meets on a fortnightly basis. The group considers issues relevant to the region and as we spoke to you earlier, is equally the group that oversights the establishment of a remote safety subgroup, where that is required.

Which agencies are members of this group?---It would include, for example, police, education, Territory Families and Housing, we also have some of the local council groups represented, correctional services, health.

And what are its aims, would you say?---I think broadly, again, it's about that coordination – again, cross-agency government, and in circumstances again, non-government coordination of services. It is about identifying opportunities for improvement across agencies. It's that coordination. It's the collaboration. It's information-sharing. It's pooling our resources where we possibly can to achieve better outcomes for community, be it urban or remote, in Central Australia.

Can you tell the court about some of its recent achievements or outcomes it has put in place?---Yes, absolutely. Interestingly, the group is in Yuendumu today, so Dr Reeve is attending on my behalf in Yuendumu today. The group has recently commenced regular visits to remote communities, again, to ensure the respect is demonstrated that it is the senior leadership team working with the communities again to look at opportunities for improvement and development. And most recently, I attended a visit to Harts Range where those executive leads spent the day with members of the community to visit the various services within Harts Range, hear

from the community essentially around what is working and what is not working as a result of that collaboration and interaction. The Regional Coordination Group develops an action list that is endorsed by those community present at that day and it is then the accountability of the Regional Coordination Group to oversight implementation and outcome against those actions. We had previously undertaken a visit to Papunya and there, of course, are further visits scheduled, as I mentioned today, there's a group in Yuendumu. I think there's great opportunity again for collaboration. We're working – or are about to commence a piece of work looking at early childhood, where health will work more closely with education against some specific targets as well. So, really, that coordination approach.

And you mentioned "pooling the resources", can you give us an example of that?---Yes. As an example, certainly, it is again looking at where we reduce duplication within a region. So, how can we share resources more significantly. As a small example, certainly the Department of Education through again this coordination and collaboration have, at times, shared the security resources in Yuendumu where that has been a shared funded opportunity and again, looking at some of the programs that we deliver to ensure that there's not duplication. A very recent example is some of the recruitment materials the NT Health have developed, noting the very specific needs in Central Australia, and obviously that's very targeted around the Central Australia experience. We have provided those to the Department of Education here in Central Australia to ensure that they can utilise those materials as well. So, again, opportunity for real collaboration, decision-making and again, communication across those agencies.

Your Honour, those are my questions.

THE CORONER: Thank you. I note the time. We might take the lunch break and we will see you again at 1:30?---Thank you, your Honour.

WITNESS WITHDREW

ADJOURNED

RESUMED

NAOMI LORNA HEINRICH:

THE CORONER: Mr Mullins.

MR MULLINS: Thank you, your Honour.

XXN BY MR MULLINS:

MR MULLINS: Ms Heinrich, my name is Mullins. I'm appearing on behalf of the Brown, Walker, Lane and Robertson families. Now the withdrawal of staff – or the temporary withdrawal of staff had a protocol, as you know. And that required there be a documented risk assessment. That's correct?---That's correct.

And of course, there wasn't a documented risk assessment of this situation was there?---No.

And do you accept the proposition that having a documented risk assessment is not just about having a historical record, but it's also about discipline to process, and ensuring that a process is followed, and shared, as part of the risk assessment process?---Yes.

Now the base model of the risk assessment – were you here yesterday?---No I wasn't.

All right, so - - -

DR DWYER: I'm so sorry to interrupt, the live streams not working, if you could -

I apologise to your Honour, and simply just pause.

MR MULLINS: I do this every time to the live stream.

THE CORONER: You get your practice run, Mr Mullins.

MR MULLINS: We're going on a bear hunt. We're going to catch a big one.

THE CORONER: So we can just start again.

MR MULLINS: I apologise.

THE CORONER: That's all right, no we apologise, but we don't often see what happens.

MR MULLINS: Now, Ms Heinrich, my name is Mullins. I appear on behalf of the Brown, Walker, Lane and Robertson families. Now the withdrawal – or the

temporary withdrawal of staff from a community, as occurred here, requires compliance with a protocol. That's correct?---That's correct.

And it's a written protocol?---That's correct.

And that written protocol required a documented risk assessment, that's right?---That's correct.

And there wasn't a documented risk assessment in this case?---No there wasn't.

And you accept that the documentation of a risk assessment is not only for the purposes of having a historical record, but it's also for the purpose of ensuring compliance and the discipline of a process being followed?---Yes.

Now you're obviously very familiar, because of your vast experience in this field, with risk assessments?---Yes.

And the base level risk assessment, that we're all familiar with, is – has five components. The first step is, identify the hazard. That's correct?---Yes.

The second step is to assess the level of risk of that hazard, in the matrix of likelihood and consequence?---Correct.

The third step is the control measures that might be taken, and if you're dealing with sort of a risk assessment in respect of sharks, in a hospital, you'd run through the hierarchy of elimination, substitution, re-design, isolation, administration – or administrative measures, then PPE as being the last, and most in effect alternative, that's correct?---Yes.

Generally speaking?---Generally speaking.

Then fourth step is you record your finding?---Correct.

And then the fifth step is then you monitor and review the controls you put in place to identify that – or to manage that risk?---That's correct.

Now, there's a more elaborate model that we've been provided with. Although I think we're all still struggling to work out whether this was in place before, or after, 9 November 2019. And I'm holding up a picture of exhibit document 9-18. You're familiar with this document?---I believe so, from what I can see.

And do you know whether that was in place before 9 November 2019?---I can't confirm it. There would have been a risk matrix of sorts. Whether it was that one exactly, I can't confirm.

All right. In any case, we are balancing, in this situation – or there were two hazards that were being balanced. The first hazard, and these are identified in the Root Cause Analysis. The first hazard was the safety of Health workers?---Correct.

And the – the consideration was removing staff from a situation involving risk to their health and safety?---That's correct.

But there was a second hazard, which was the safety of the community?---That's correct.

And the ability of the community to access immediate health care?---Correct.

That's right? Now that – and the process really required a risk assessment of both?---That's correct.

Because there were two hazards. And then there needed to be combined assessment of those two hazards to determine what the appropriate course would be, moving forward?---Yes.

Now in terms of the second hazard, which was the ability of the community to access immediate health care. Were you in court this morning?---No I wasn't.

So one of the aspects of accessing immediate health care, and one of the things that the Yuendumu Clinic provides, as you no doubt are aware, is emergency response?---That's correct.

And they are effectively the first responders?---Yes, that's correct.

So if we draw their equivalent in an urban setting, for example, Alice Springs, they would be the equivalent of the ambulance, more or less, in arriving at a scene and stabilising the patient?---There may be some comparisons.

Well not exactly the same - - - ?---No.

- - - but to some extent they perform that role - - - ?---Mm mm.

- - - of being the first responders in the community setting, is that right?---Yes.

And in fact that's what Ms Walcott did. She travelled over from Yuelumu in the clinic ambulance, to provide services in this instance. That's right?---That's correct.

Now, just so when you nod, because we're being transcribed, you need to say yes or no (inaudible)?---Sure.

So, when we're talking about removing the capacity for somebody to respond to an emergency, that is a very significant impact upon - - -?---Yes, it is.

- - - that community's health service, isn't it?---Yes, it is.

And even if it's moving, the capacity to respond from 15 to 20 minutes to an hour or more is a very significant impact?---Yes.

And that's because there are a number of acute emergency situations – sorry, emergency situations involving acute medical issues where a person's life may be at risk?---It may be. Certainly, that's the concept of an emergency response.

If they don't have emergency treatment within 15 or 20 minutes?---Potentially.

Yes. And we're talking about cardiac arrest?---Yes.

Anaphylactic reaction?---Possibly, yes.

Possibly a stroke?---Possibly, unlikely.

A severe asthma attack?---Possibly.

And a range of different sort of emergency conditions?---Possibly.

And this morning, the evidence was from Dr Rosser and Ms Halton. I stand to be corrected on this, I don't know if the transcript is up yet, but that they have at the Yuendumu Clinic currently planes or flights going in and out almost every day with either acute events connected with a chronic illness or an emergency event?---So, the data that I have available to me, and again, without it being in front of me, I'm hoping I get the numbers exact. Certainly, in terms of the retrieval service, or as we refer to the Medical Retrieval and Consultancy Centre. We, of course, record the number of retrievals that we retrieve from any of the communities. For Yuendumu, I've recently looked at that data and over the last four financial years, plus into this financial year as at the end of September, what we know is that there is an average of 10 retrievals per month from Yuendumu. A retrieval is classified or coded under an Australian triage category, it's called the ATS, the Australian Triage Score and that score can range from, or does range from, one through to five; one being life and limb and five being non-urgent.

THE CORONER: Sorry, five being?---Non-urgent.

MR MULLINS: And are you able to give across that – I'll come back to the 10 a month in a moment, but are you able to give across that 10 a month what the break up is between one and five?---I can. I can from – again, from my recollection of that data, it's an average of six at category three per month.

All right. So – and who categorises that triage?---The nursing staff – again, this can be a slightly different situation, depending on where the call is being made from. In most circumstances and perhaps if I use this as an example, because it can vary depending on how the call is being made. For example, the remote area nurse in the clinic may be making that call to the Medical Retrieval and Consultancy Centre. That call may go through to another registered nurse in – we called MRAC, or it may go direct to a retrieval specialist. So, they will make that assessment. They are again against an Australian guideline or standard, that ATS.

The average over the four years of 10 a month, that's likely to be affected to some extent by COVID, isn't it?---No, it's over the four year period.

Yes, but that four year period up to the last financial years, didn't COVID almost run for almost three?---One would assume, and again this is an assumption, that medical emergencies continued during COVID.

Is that irrespective of the circumstances of the shut down to the community?---We still provided an emergency response, yes.

All right. Are you able to give any data before that time?---The data that I'm referring to commences from the financial year beginning 2018. We, in Australia, really saw the outset or the beginning of COVID in January 2020. More significantly, our planning in Central Australia was approximately from January 2020, but I apologise, I don't have the definitive dates.

That's all right. But in any case, your data indicates 10 a month. The evidence this morning suggests that it was significantly more than that, but that was anecdotal evidence, albeit from people on the ground who were involved in the transfer of patients. Having said all that, in terms of the removal of the emergency service, if the emergency – if the capacity to provide emergency services for acute emergency is removed or changed from 20 minutes to more than an hour, that involves a significant risk of serious injury or death to a person who suffers that acute emergency event during the course of that removal. That's right?---It certainly impacts the risk assessment, yes.

Yes. And we can probably do the probability numbers there. I won't bother you with it, but we can probably do that in due course. So, on the one hand, we're balancing the risk of serious injury or death to a person in the community by removing that emergency response, against the serious risk of injury or death to one of the nursing staff?---That's correct.

That's the balance that we're working on?---Absolutely.

All right. Now, can I go to the root cause analysis and that's at police document 9-56? And in your role as regional director, you approved the root cause analysis, and what is actually involved in an approval?---The approval indicates that I accept that the subject matter expert group that came together to conduct the root cause analysis utilising the terms of reference that will have been set out have indeed completed that, have put forward recommendations and that I have no further questions in relation to the process that was undertaken, noting that I'm not part of that process. But rather, that the recommendations appear to be consistent with the report itself and that I endorse that I will undertake to implement those recommendations outlined in the report.

Thank you. Can we turn to page 6 on the document, and can we just go to the first – the third and the fourth paragraph, and the authors of the root cause analysis say that, "After consultation with all staff members by teleconference, the consensus was

that they were not feeling safe to stay within the community and the decision was made to withdraw the health staff from the Yuendumu Community." Do you see that?---Yes, I do.

"As a result of the reduction of the services to Yuendumu Community, it was arranged that all the emergency call-outs were to be triaged and attended by the neighbouring Yuelamu Community Health Centre. A police escort was to be available for these Yuelamu Health Centre staff if attending Yuendumu afterhours." In the next sentence, "The above arrangement was made in consultation with the local police sergeant, community Elders, other Yuendumu stakeholders and on-call PHC management." Now, do I understand from the evidence that you gave this morning, after questions from Mr Hutton, that you accept that there wasn't consultation with local police sergeant, community Elders and what not before the decision was made?---I have understood that there was not clarity of that consultation and that communication. Again, I was not part of the communications, so I'm working on the witness statements that we've heard, yes.

So, to clarify, insofar as read literally, the suggestion in that paragraph, "The above arrangement was made in consultation with the local police sergeant --", that's in fact incorrect on your understanding of the evidence now, isn't it?---I think there may be an understanding of "consultation" versus "information.

Right. I'm not being critical of anybody, I'm just saying that that statement that there was discussions with the local police sergeant, the community Elders, the Yuendumu stakeholders before the decision was made that, apart from the general discussions between the police officers and the nurses at the house, in respect of this decision, there was no discussion with the local police sergeant before the decision was made about the decision?---Again, I'm not in a position to comment what the sentence here refers specifically to, not having been part of the RCA panel itself, nor the decision-making process.

But insofar as you approved it?---Yes.

You've given your imprimatur to it haven't you?---Yes, I've given my endorsement that I accept the recommendations put forward in the RCA.

But I suggest to you that the - that that assumption that is in the report is fundamentally flawed?---It - it may be in terms of the recommendations of - of the report. The recommendations refer to some enhanced communications through development of policy and training and the like and as such may address that - address that communication that we've talked to.

But I'm not talking about recommendations, I'm just talking about that assumption. It's fundamentally flawed isn't it?---Again, I don't have the depth of that sentence. I wasn't part of the RCA Panel. I understand what the sentence states.

And I suggest to you that it infects the entirety of the rest of the report because of that flaw?---I base - my sense is that the recommendations refer again to

strengthening policy, strengthening process, strengthening training and I think that addresses some of those issues that we've talked through about that consultation.

Can you please flick through to - or scroll through to page 15 of the PDF and at the bottom of the page please. We can see on the document in front of us there there's reference to those two competing considerations that we're talking about?---Yes, absolutely.

Which in themselves each requires an independent risk assessment, doesn't it? ---Yes.

Can we go to the next page? At the top of the page, "Community members were verbally notified by local staff prior to the withdrawal of health workers from the community. Options to keep health workers in Yuendumu were considered but not pursued by PHC management because they did not sufficiently mitigate the risk posed by the identified safety concerns." This is the matter your Honour took you to - or I think asked Ms Hutton about and we were told that Helen Gill is the person really to answer that question. Is that right?---Yes.

And then the next paragraph, "There is a well documented discussion between senior police and health management that included an account from the Health Manager of the following" and then reference to various matters and then, "The RCA panel considers that the decision to withdraw health workers from Yuendumu for safety reasons was appropriate. Now, I just want to ask you about the reasoning process that we have here?---Mm mm.

And if we follow it in the order that it is detailed in the root cause analysis, there doesn't appear to be when that decision is made by the panel, any weighing of that second issue that we spoke about, which is risk to the community - at that point in time?---Sorry, I'm not sure, is that a question?

The question is am I correct in saying in the reading of this document - that you've approved - that there is no weighing in the decision as to whether to withdraw staff of the risks that might be to the community or members of the community? ---Throughout the document there is referral to the alternate strategy in terms of service delivery, that the service - the emergency service - noting that the withdrawal of service was occurring over a weekend where emergency services only were available to the clinic or to the community and the decision was made that the staff from Yuelamu could provide that service, so part of the risk assessment was understanding what were the alternate arrangements and it was determined that Yuelamu staff could provide that emergency service.

But when you say "As part of the risk assessment that was done" put that aside for the moment because we don't have a documented risk assessment that shows us any risk assessment of that component, agreed?---No.

I mean, I am talking about here, for the moment, the root cause analysis?---Mm mm.

And at first blush it appears to be that the persons conducting the root cause analysis concluded - looked at the risks of health and safety to the nurses and the nursing staff, weighed that up and then came to the conclusion that it was reasonable to withdraw the staff. Then they moved to the question of, "Well, what can we put at Yuendumu in order to patch the hole that we've created"?---And I'm sorry, I can't make comment on how the RCA panel reviewed information to come to their conclusions.

But you can comment on their process can't you - because that's what you're approving?---I can comment on the documentation that was provided to me and again I endorsed the recommendations that were forwarded to me.

So if we - can we just pull that document back up again please? If we look then at the second half of that page, the passage I was pointing you to was "The RCA panel considers that the decision to withdraw health workers from Yuendumu for safety reasons was appropriate" and then it being scrolled down, we can see that it appears that the RAC panel then contemplate, "Well, were the alternatives that were put in place reasonable in the circumstances" without necessarily weighing the two?---I think it's difficult to ascertain that from the document without discussing that with the panel.

And my question for you is this. What research have you done and what information do you have about the second risk assessment that needed to be taken - that is first of all what do you know was done to identify - what was the risk of an emergency event happening in Yuendumu on that day? Did anybody do that?---Again, I wasn't part of the decision-making. I had a different role at the time so my - my role was as the Alice Springs Hospital General Manager at the time, so I wasn't in part of that decision-making so I can't confirm what circumstances may have been taken into account.

On your review of the material can you tell her Honour whether there was any assessment - this is on your review of the material?---Mm mm.

To your knowledge, whether there was any assessment of what the risk was that there was going to be - of an emergency in Yuendumu on that night - on a statistical basis?---As we've talked through the example that I've given is that we have an average of ten retrievals per month from the Yuendumu clinic. I can say that over that period of 51 months for the data that we have available to me now, is that during that 51-month period there were six category 1 retrievals. As such, the likelihood of retrieval at a category one or an ATS 1 triage score was low.

And so, someone did that on the night?---I couldn't comment on that, I wasn't part of that decision-making on the night?---So on your review of the material have you seen any suggestion that anybody did that on the night?---I have not seen documentation regarding the risk assessment.

So is the answer "No"?---The answer is no, I have not seen documentation.

Have you seen or are you aware of any documentation that attempts to assess that level of risk of the hazard against the likely consequences?---No, I have not seen documentation.

Have you seen any documentation or other information that suggests that there was a consideration of weighing the risk of there being an emergency event for a person in Yuendumu against the consequences?---I have not seen documentation. However, I understand that the seniority - the management involved would have considered the clinical services that are delivered by the health service and indeed in this case in Yuendumu as part of that decision-making, that is the service we provide and hence that would have been at the forefront of very senior staff decision-making.

The withdrawal of an emergency service, as I said at the very commencement, is a very very significant event for a community isn't it?---Yes, it is, yes.

I understand - am I correct to say that the - does your - are you Regional Executive Director of the Alice Springs Region?---It's Central Australia - - -

Yes?---Which incorporates Alice Springs.

And it's the case, isn't it, that emergency responses for ambulances currently is - is it about 50 to 20 minutes in Alice Springs?---I can't - I can't comment for emergency ambulances, they don't come under my jurisdiction.

All right. But if you were to tell the Alice Springs community, "For the weekend we're not going to have any emergency responders, we're just going to - it's going to take an hour or so for the ambulance to come". That would be an explosive thing to do, wouldn't it?---Likely. I think there are various assessments that are made in terms of staff availability, in this circumstance staff safety, so certainly all of those factors are taken into account in terms of - as you have quite rightly put forward, that balance or risk, that's a balance that we undertake every day in the work that we do to provide the best possible clinical service to our community, be it in Yuendumu or in Alice Springs whilst maintaining the safety of our staff. I would believe in this circumstance that would have been taken into account because that is the core business of our staff. It does sit within the realms of the experience of the staff who made that decision, who collaborated to make that decision, and to understand that risk assessment. I agree that it was not documented. But I believe that those circumstances would have been taken into consideration. And yes, we note the seriousness of that decision.

In any case, you would expect to see, if this event ever happened again, that there was – if staff were withdrawn in a similar situation, that there was a risk assessment in respect of the Health nurses, and the staff safety, and that there would be a risk assessment in respect of what happened to the – what might happen to the community?---Yes, absolutely.

And it would be based on sound statistical data?---Statistical data, amongst other, the context of the circumstance equally is important, yes.

And it would be recorded in writing?---That's correct.

Thank you.

Thank you, your Honour.

THE CORONER: Yes, are there any other questions?

Ms Wild.

MS WILD: Yes, your Honour. Thank you.

XXN BY MS WILD:

MS WILD: I'm Beth Wild. I'm a lawyer at NAAJA, which is the Aboriginal Justice Agency in the Northern Territory. Sorry, is it Dr Heinrich?---No, Ms.

Ms Heinrich. The management of the Yuendumu Clinic is transferred from (inaudible) and Congress, in 2010, to the Department of Health, is that right?---Yes, that's my understanding.

Now at par 88 of your affidavit, which is exhibit 90053, you outline the presently funded positions in Yuendumu?---Correct.

And we – and now those aren't all the positions that are filled. You go on to say which one of – which positions are actually filled, in the next paragraph. But those first lot of the positions that have been – that are funded, is correct?---Yes.

And I won't go through all of those here. We can read them out. It doesn't have any GP's as part of that core funded positions. Would you agree with that?---It – no it doesn't. It doesn't outline the visiting services to Yuendumu, such as a GP. We've from Dr Rosser today, who attends the community on a weekly basis. This does not outline those visiting services.

Okay, so in addition – those are the people that are funded to live there full-time?---Correct.

And in addition to that, there are visiting services?---That's correct.

And included in that is one GP?---Correct.

Is that right?---That's correct.

And that position's filled by Dr Rosser?---Yes, it is.

Who we (Inaudible) today. I would like you to go to par 37 of exhibit 9-3A.

If we can perhaps pull that up. Which is the Congress affidavit of John Boffa and Ms Ah Chee.

And it that, but what they did have in 2010 was two visiting general practitioners as part of their service model prior to the Department of Health taking over the provision of services, is that right?---I understand that's their statement, yes.

And can you say why, when the NT Health took over, that the – the two resident general practitioners were no longer included in the core group of funded positions delivered at Yuendumu?---I can't specifically provide that comparison. Obviously that occurred in 2010, and during that period of time, there is a continual review of service requirement. Equally, the service delivery model between – between services, will look slightly different. And again, will continue to evolve to ensure the needs of the community are best met. In terms of the service model that the NT Health Central Australia Region provides, it is a GP service, with support from remote call centre, here – based here in Alice Springs. So another GP, or a remote medical practitioner is available on-call. And equally, those specialist services provide specialist support into Yuendumu Community on a – on a routine or a cyclical basis.

Okay. But they've – it's probably my computer blocking me. It – but they wouldn't then be available to be first respondents, the GP, as they're only visiting services, would you agree with that?---The GP is not considered as part of on-call roster, no. So including the GP in resident.

Would you agree – this might be better, that with a base population of 800, it would ideal to have two general practitioners permanently based on the community?---I would need to work with expertise to understand those algorithms. Certainly, you know, as we've talked through today, it is about providing services, qualified services, into the community, to best meet the needs of the community.

Taking into account resources available, is that right? Is that the other part of the equation?---I think where we're – if I perhaps go back to 88, certainly we have funding available.

Yes?---And it is then about how do we recruit into those positions, again to support. But in addition to that, it's considering those visiting services across a spectrum of skill set, both allied health, nursing and medical staff providing those Outreach services into Yuendumu.

THE CORONER: But - - -

MS WILD: Okay - - -

THE CORONER: - - - can I just ask this question. The qualifications of the nursing staff in remote areas, have in fact improved, as I understand it – not – improved is probably the wrong word. Remote area Health nurses qualifications now enable them to do more services, is that correct?---Yes, your Honour. I will say that, and

we've heard this throughout the – the evidence, is that the remote clinics are nurse led clinics. They are led by remote area nurses, classified at the N4 level. So a comparatively senior level, reflecting the autonomy and the skill set of those nurses working in remote areas. They work using a – a remote area manual. So a guideline where that enables them to work against a set of guidelines to work independently, with of course, support. Now we have the advantaged, compared to 2010, of much stronger telehealth opportunities. Telehealth, telemedicine, are both through primary health care branch of the business, with our remote Outreach medical staff, as well as our emergency branch of the business, with medical retrieval services. So telehealth has certainly strengthened those opportunities for sure.

MS WILD: Would you agree though, with a proposition that if a GP is available to be part of the on-call first response team, then that would be of benefit to the community in an emergency situation?---Yes, absolutely. I'm – it's not my understanding that the GP has ever been part of that on-call roster, so I can't confirm that. But yes of course, more people on the on-call roster is great.

And prior to 2010, when NT Health took over, you're not aware of where there or not the two GPs that were in community with the Congress health service, were part of that?---No, I have no – no visibility of the model of service delivery with Congress with the two GPs. I'm not aware of what service they provided in community. I'm not aware of what service they may have had in terms of that telehealth access, back in those times, for both primary health support, nor for emergency support.

Thank you, Ms Heinrich. I'm going to turn to recruitment now. And you've certainly identified at length, that that is an area of significant challenge?---Mm mm.

For the Department of Health?---Yes indeed.

And you're trying to be creative about solving some of the challenges you face?---Yes indeed.

And one of those solutions would be to have a fly in/fly out model, is that right?---Yes.

And that would be considered a transitional model do you think? To have that fly in-/fly out - - - ?---Are you referring specifically to the concept of an eight week on, four week off model?

Yes?---It may be. So again, I think there's – what we've learned through NT Health, particularly post-COVID, and with the current and national and international shortages of staff, we need to be as flexible as we possibly can be. And I think it's about creating models that are industrially sound, of course. And we need to flexible to the needs of the individual. So it may be a transitional model that somebody does eight weeks on and four weeks off. They may decide at that point to move, on an ongoing basis, into community, or that model of rotation may – may actually work for

them. In which case, they would work permanently in that community, but take a break in a four week off model.

So, it could be that that model in fact produces greater longevity, are you saying?---Absolutely.

And that's the aim?---Absolutely.

Now, you would agree that it's ideal to have staff integrated well into a community?---Yes, definitely.

And that's important for a number of reasons?---Yes.

One for the longevity of staff in community?---Absolutely.

And also for the building of trust relationships - - -?---Yes.

- - - and who's identified?---Correct.

And you may have heard some evidence from the nurses in 2019 were not well-integrated into the community?---Correct.

And in fact, they felt it was too dangerous to walk around the community?---Yes.

Now, do you agree that such segregation could present a barrier to establishing trust relationships?---Yes, yes.

Now, obviously, this isn't common to health nurses in a lot of communities, is there a mechanism that could have triggered an interest by management that this was indeed happening in the Yuendumu Community at that time?---I can't say if there was a mechanism. Certainly, we have very strong support mechanisms for our staff. Staff have an opportunity to obviously work collaboratively within the clinic within that work environment, staff are encouraged to come back into Alice Springs to participate in various training forums and the like. So, there is an opportunity to communicate. Equally through our line, management function, we have a district manager attached to each of the services, so there may have been opportunity to identify those types of trends during that period of time. I can't comment, but certainly there are opportunities to communicate that. I think it's about working through to understand again what those issues were, what were the reasons and certainly, one of the strategies that we're employing is looking at how do we better collaborate. I referred earlier to the Central Australia Regional Coordination Group as an example of that collaboration. That is, of course, at the senior executive level, but nonetheless, that starts to demonstrate some role modelling of working collaboratively across agencies. The example that I used earlier about the visits through to Papunya and more recently, Harts Range, and indeed, Yuendumu today, gives that clear picture to staff out in communities that the agencies are collaborative. So, it does give that opportunity to see that role modelling behaviour of the executive departments across agencies and as such, encourage that at a

more local level.

So, you're hoping that the executive – you'll lead by example, effectively, and that will trickle down?---Ideally.

It does seem that some of these issues have really only been uncovered during this inquest. Would you agree with that?---Yes. And I would note that they were issues or inexperience at the time. I'm not aware of the circumstance at this particular point in time in those engagements at this particular point in time.

THE CORONER: The evidence this morning seemed to suggest that it hadn't changed very much, that the nurses still very much socialised together - - -?---Mm mm.

- - - and were not particularly integrated into the broader community?---Okay, thank you.

MS WILD: Thank you, your Honour.

And that was the question I was asking, is there a mechanism that would trigger that interest from the executive level so that in fact, we can find out what's happening on the ground in community, such that we don't end up in the same situation where we have nurses feeling they can't leave their own home and things escalate to the point of their withdraw.

MR HUTTON: Your Honour, I think the evidence of nurses feeling unsafe to walk around was limited to one nurse, Ms Wild might correct me.

THE CORONER: I don't think this morning's evidence was in relation to unsafe to walk around, what it was, I think, more directed to was there did not seem to be opportunities for deeper integration into the community. The nurses did feel that it was safe to walk to the shop during the day.

MR HUTTON: Yes. We've heard from Nurse Vanessa Watts gave her evidence about walking around the community with her son, for example, at the time. As I recall the evidence at least, it was - - -

THE CORONER: Other than Nurse Vanessa Watts, there doesn't – there has not been any real significant evidence of other nurses becoming – or other staff members, Kartiya staff members, becoming more integrated into the community other than at a very superficial level.

MR HUTTON: I accept that regarding integration certainly, your Honour. I don't understand that to – I don't understand the evidence to have been that that was a safety issue as presented by anyone other than Nurse Holland.

I think the evidence from Ms Starbuck, for example, was the nurse – fraternity of nurses was itself very social and very integrated, but certainly not more broadly than

that. But I think the way it has been put to Ms Heinrich, and apologies if I'm misunderstanding you, is that that's as a consequence of not feeling safe in the community. And I don't understand that to be the evidence.

MS WILD: Perhaps if I can, the evidence of Ms Holland, and she's the one that specifically spoke about not feeling safe, she indicated that the rest of them also didn't feel safe.

THE CORONER: Sure, that was back in 2019.

MS WILD: 2019.

THE CORONER: And the more recent evidence is that there wasn't really a question of safety about walking around the community during the daytime, but there didn't seem to be any real advancement in relation to socialising or greater connectiveness with other services or the community more generally. It seems to be quite an isolated cohort in the clinic.

MS WILD: Thank you, your Honour. The question then is, can you think of a trigger that would interest management if we had a particular culture in the staff in NT Health in the community that would trigger their interest?---I'm sorry, I'm not quite clear what you're asking.

THE CORONER: First of all, do you think that's a problem, if you've got a cohort of – or the clinic really sticks together and doesn't have broader connections into the community or with other agencies in the community?---Yes, ideally, I think there's a loss of opportunity, if I might, in relation to that isolation within your own cohort, and I make reference again to the Regional Coordination Group where we're working very actively to work across agency groups to develop that much more coordinated and perhaps inclusive and collaborative approach in those services. So, yes, I agree that there's a focus through the Regional Coordination Group, that is the work that we're leading to look at stronger integration and collaboration.

And would you expect that people who – or staff who are more broadly integrated into the community may well – that may assist retention?---It may. We equally have experienced that individuals choosing to work in a community, much like individuals choosing to work in a hospital, some people prefer not to socialise; some people prefer to have that quiet time after work. Again, I think we need to be flexible to meet the needs of individuals and ensure that individuals' needs are met. And for those people who prefer to socialise, then yes, that's important that they have ways to socialise, but I acknowledge that there are others who would choose not to socialise.

MS WILD: Thank you, your Honour.

Ms Heinrich, I want to turn to Indigenous employment now, and you've identified
- - -

THE CORONER: Just before you do.

So, what Ms Wild was asking was, is there a mechanism for hierarchy in NT Health to kind of assess what is happening in a clinic and, you know, determine whether or not, you know, there are opportunities for people to be integrated into the community if they would like that because there did not seem to be - and does not seem to be - those opportunities at the moment in Yuendumu?---I believe that the mechanisms are through line management, so again through the clinic manager, through to the district manager and as I mentioned, staff do attend forums in Alice Springs, so there's an opportunity to talk across those communities as well and that is the forum where people can raise - raise those concerns and management certainly can take on any of those recommendations around their concerns. Equally it would be about understanding the barriers to that communication, so what might those barriers be and if that was assessed as, you know, something important then what are the opportunities. If we think about socialising in Alice Springs itself perhaps, it's thinking about that we might go to a restaurant with a colleague. In Yuendumu that - there's not an opportunity for that. We might go to a movie with a colleague. There's not an opportunity for that. We might - I think we talked earlier to sporting events. We might participate in a sporting event and there are limited coordinated sporting events, so they are the sorts of things that yes, I agree, we can have a look at from NT Health with out neighbouring agencies to consider are they the types of things that staff are interested in. In my experience we have recently - at least in the las two years - undertaken a survey of our remote area nurses and it's not an issue that was raised, but I am happy to investigate that further.

MS WILD: Thank you. Indigenous employment I would like to turn to now?
---Yes.

The primary - you've identified that this is an area of priority within NT Health and a great deal of work seems to be put in to the recruitment of Indigenous staff?
---Yes.

You would agree with that? And can you articulate why this is so important to service delivery?---Yes, absolutely. Certainly employment of Aboriginal people into our health service is essential, given the population that we serve here in Central Australia. Clearly in the remote communities the very large majority of the population that we serve are Aboriginal. Equally in the acute care sector the population of people that we serve are largely Aboriginal. The inpatient population of Alice Springs being approximately 85 percent Aboriginal. As such it is important that we recruit Aboriginal staff who have a cultural awareness, a cultural understanding and can engage well with people that they are serving.

And as well as being a priority, you would agree that it is also a challenge for NT Health?---Indeed.

And in fact, the latest statistics they looked at which it was less than 10 percent Indigenous employment in Central Australia?---Yes, yes, that's correct.

And by contrast, Congress has 57 percent Indigenous employment with about 200 out of 380 staff or thereabouts, we'll hear tomorrow the exact current numbers being Indigenous. Can you address as to what would account for that very significant difference?---I would have to say this is somewhat anecdotal because I'm not aware of Congress' data specifically, so I am - again this is anecdotal information. I would anticipate that the health service of Central Australia employs a large number of medical and nursing staff. I think we heard evidence earlier referencing that the balance of staff employed at Congress tends to be those people not in those medical ad nursing roles. In Central Australia we have a very large number of those roles, noting that we run a hospital and have a very significant proportion of FTE in those qualifications. Having said that, we are acting working towards - as I talked to earlier, the cadetship program as an example, to support people to work towards that level of qualification in nursing and medical roles as an example.

One of the models that Congress use is employing staff that are called "Malpis" (?) and that is the Indigenous healthcare workers that might not have the nursing qualifications but they work in tandem with the people who do, so that would likely increase their Indigenous staff?---Yes, yes, it may, yes.

And it seems that having such a significant portion of staff that they - you would have to agree that they are better at recruiting Indigenous staff?---Again, I think it is looking at the professional groups that we are recruiting to and the challenges of recruiting into that. We equally have an Aboriginal Health Worker role that we recruit to. They are people with a Certificate II. I can't comment on the Congress position but we certainly do recruit into that Certificate II as an entry point into health service with that opportunity, similarly, to work alongside of potentially remove area nurses, potentially Aboriginal health practitioners, so again those Aboriginal health workers, as an example of entry point, can - can identify perhaps their preferred career pathways and we can again work to support people into ongoing career pathways as a measure of retention.

So you wouldn't regard it as an advantage that Congress have the priority that you place on cultural safety, for example, in recruiting Indigenous staff?

THE CORONER: I don't know that this witness can comment on that because I don't know that she would be aware of what is done in Congress in relation to cultural safety.

MS WILD: Okay. That's a fair point, your Honour.

You've talked about the local health advisory group?---Yes.

Now, is that the group that has been establishes as a result of the recent reforms? ---No. The group that has been established as a result of the reforms are government-wide by the office of the Chief Minister and Cabinet is the remote safety worker subcommittee, which is the subcommittee of the regional coordination group and that is established or stood up where there is a risk identified to a particular community again to support coordination collaboration across agencies to manage

and - manage a circumstance. The health advisory group has been a group and they are established in remote communities and the intent of those groups is that they provide an opportunity for member of the community to work with members of the health staff in community to identify opportunities for improvement in the health service of community members making, I guess, comment or perception of, in short, what is working and what is not working in that community and what those communities would prefer to see more of.

Now, I couldn't find this in the affidavit, but who makes up the local advisory group? ---It incorporates both community members and health staff members. The general manager of the primary health care branch of Central Australia also attends those.

Okay, and the local heath advisory group hasn't been able to meet recently? Is that right?---No. Despite efforts both of course on behalf of the health service including, as I mentioned, the general Manager of primary health care who has more recently been working with the Chief Minister and Cabinet representative in Yuendumu to assist in the development or the establishment of those meetings. Those meetings have not gone ahead. Some have been schedule but not gone ahead on the day and there has been some challenge in re-establishing those meetings.

And in part you've attributed that failure to some unrest in the community, is that right?---At times, yes.

We have heard evidence from Superintendent Nobbs in these proceedings about something he regards as "meeting fatigue" and that is that the same people on community are expected to attend many meetings and in an unpaid capacity. Do you think that might be affecting your ability to get the local health advisory group to meet?---Its not something that has been reported to me through either my general manager of primary health care nor our representative of the Chief Minister and Cabinet, nor of the community itself but certainly would be worth considering if that was an issue, yes.

Yes, and it's the government representative that is in charge of getting that group to meet, is that right?---They are facilitating. So that's a relatively new role in Yuendumu that was established following the incident to work on that collaboration of agencies in Yuendumu. So that position has been more recently recruited to. Health have utilised that position accordingly, to support and facilitate that – that coordination.

THE CORONER: What is the name of that position again? Approximately?---It's Karl Hampton. He's the representative of the Central Australia Chief Minister and Cabinet team.

MS WILD: So he is also responsible for the local decision making group, is that right?---The Health Advisory Group?

No, he's got the local decision-making group too, Mr Hampton, as part of CCM. So he is organising that as well as the Health Advisory Group, is that right?---He's not

organising the Health Advisory Group. He's a representative in community. As we talked to, we work closely with our agency colleagues, and it's about working with Carl, as he will have an understanding of you know, what might be happening in community, and might we best work with people, what the availability of people in community might be.

THE CORONER: Just for your information, Superintendent Nobbs also said that he had, or there was difficulty engaging with Elders in some of the police arranged meetings?---Mm mm.

But I think he reflected that there was a council meeting where attendance was remunerated, and they had much greater buy in?---Mm mm.

And there has been a discussion in these proceedings about whether or not people who are providing expertise to these kinds of meetings, should have that expertise reflected by some form of remuneration. Particularly for example, given that all the participants from Health, for example, are remunerated for their contributions?---Yes. Yes and that's certainly something to consider.

MS WILD: Thank you, your Honour.

The – the local decision making then, that Mr Hampton is involved in, seems to be working with the Local Health Advisory Group, would you agree with that? If I use the word with but you say, supporting it?---Yes, I – I'm not familiar with the detail of the local decision making group.

The – I'll then turn to your annexure, which is annexure five?---Mm mm.

Which is Pathways to Community Control?---Yes.

Now that document – it's from 2009, but perhaps take it from me, it's similar to the local decision making documents and works which have in its framework, the aggressive movement to greater levels of community participation?---Yes.

Is that right?---Yes, that's right.

Now, this - - -

THE CORONER: Can I – can I just – I've got annexure MH5, which is entitled Pathways to Community Control.

MS WILD: Yes.

THE CORONER: That's the one we're talking about?

MS WILD: Yes.

THE CORONER: Right, okay, thank you.

MS WILD: Now that document, in its executive summary states that it provides a framework that supports local Aboriginal community control, and planning and development and management of primary health care, in a manner that's commensurate with capabilities. Is that right?---Yes.

And it acknowledges – importantly, the framework contemplates progressive movement skills, greater levels of community participation?---Yes.

The – now we know that the primary health care transitioned back from Congress to the NT Government in 2010, is that right?---Yes.

Now other than the local advisory group, are you aware of any other transition towards community control that's happened of the service delivery of health in Yuendumu, since 2010?---In – in Yuendumu, specifically, my understanding is that through the – and the document refers to the NT Aboriginal Health Forum as being the governance body that oversights transition of community services. And I'm not a member of the NT Aboriginal Health Forum. The Chief Executive of NT Health is the member and the representative for Health. My understanding is that there has been some early indication of a – a request for transition of community services, inclusive of Yuendumu. There are a number of communities within that region that are being considered. As the very initial phase of that suggested interest. My understanding is that the NT Aboriginal Health Forum have contracted a consultancy firm to undertake that initial consultancy with members of the community. And my understanding is that there is a consultancy paper that is due to be finalised, and will be tabled, when finalised, at the NT Aboriginal Health Forum.

Sorry, when's that?---I don't have a date. It's when the consultancy firm complete their paper.

There are a variety of ways that we could – could transition, into having that community control. Do you agree with that?---Yes, there's an opportunity for a community to express their interest. Which there is an early indication that that may in fact be the direction. Once that expression of interest has been forwarded to the NT Aboriginal Health Forum, and if it is assessed against the criteria as meeting the criteria, then – and certainly if that is, you know, the supported direction, then by all means, a transition steering group is established. NT Health would be part of that steering group, if it was in fact an NTG service that is led. There are currently three communities across Central Australia, that we are working collaboratively to transition from NTG, or NT Health Services, to Congress. And a transition steering committee has been established to support that transition. And we would expect all three of those communities to transition across this financial year. The last being at the end of the financial year.

And in addition, there are a couple of communities, namely Ntaria and Wallace Rockhole that have a joint model of service delivery?---Yes, that's right.

Is that right?---Yes.

Whereby, NT Health supports Congress in delivering that service?---Yes, that's right.

So that is something that (inaudible) - - - ?---There are, yeah there are definitely alternate models. And I think certainly the NT Aboriginal Health Forum and the pathways to transition, or the pathways to transition to community control, certainly advocate for that flexibility of service delivery. And again, it is about meeting the needs of the community. And it is a collaborative approach. I think that's the key, is that it is definitely a collaborative approach between services.

And the model of the Aboriginal controlled organisations, including Congress, has – that there is a board made up of local members, and auspice agreement that allows Congress to deliver their service, at the direction of the board. Is that your understanding?---I can't comment on Congress.

Do you know of any impediments towards transitioning to an Aboriginal controlled health organisation, in Yuendumu?---I'm not aware of anything, no.

Thank you.

Those are my questions.

THE CORONER: Yes, Mr McMahon.

MR MCMAHON: Thank you, your Honour.

XXN BY MR MCMAHON:

MR MCMAHON: Ms Heinrich, just while it's relatively fresh in our mind. I might just go back to this question of health advisory group. And the idea of meeting fatigue was put to you. And as I understood it, you said that's not an expression or a concept that you're familiar with?---It's not been raised to me in relation to the Yuendumu Community, no.

Do you understand the concept?---Yes I do.

Presumably used, also at the executive level of public service?---Yes I think we experience it, yes.

I just want to grapple with that at the moment. And you'd only been in the job, according to your affidavit, for about 14 or 15 months?---In the Regional Executive Director position, since the transition to the *NT Health Services Act* in 2021, yes.

And you're affidavit is – is full of ideas and energy. So obviously I don't want you to take any of the comments or questions that I'm asking to be personal criticisms?---Sure.

But just looking at this Health Advisory Group for a moment. The – as I understood what Mr Hutton said today, I might have misheard, but he – I thought he said that Mr Reeves had been out something like six times out to Yuendumu, to meet the people involved in the Health Advisory Group, but unsuccessfully managed to get a meeting together?---Perhaps I could just clarify that.

Yes?---There has been attempts since – since the return to business as usual from COVID. So again we had to pre-COVID, post-COVID, there have been approximately six attempts to arrange a Health Advisory Group. On occasions, Dr Reeve has attended Yuendumu, on the assumption that an Advisory Group had been agreed and scheduled, to find that community members were not available.

All right. So it's not the Dr Reeves aspect that I'm interested in at all. It's the fact that there have been six attempts, and they haven't worked out. So it's not a criticism. It's just a question. Doesn't it jump from the page then, when you say that, that the processes involved in doing that, are failing?---Yes.

And so given that it seems, from what you're saying, and I could be wrong, it seems from what you're saying that the process of calling together such a meeting, is driven by NT Health?---Yes.

So that begs the question of what is NT Health reflecting on, on how to change the process, to make it more successful? Something quite significant needs to happen, it would seem, in terms of process and that seems obvious, doesn't it?---Yes.

And it that happening?---Yes. As I mentioned, there has been a coordination. So with the implementation of the role from the Chief Minister's and Cabinets Department, Carl Hampton, in Yuendumu, there's an opportunity then to work with a stakeholder in community to facilitate that. So that's – that's certainly a path to say, actually if it's not NT Health, can we use our colleague to facilitate scheduling. In addition of course, as I mentioned, we've got the regional coordination group in community today. As I mentioned, Dr Reeve has attended that group on behalf today. And I would anticipate, and hope, that there is feedback from the community today, similarly to how there has been in the other communities that we've visited as a regional coordination group, indeed about how we could do things better. What are the barriers. What are the gaps. So I would anticipate that we have some information out of that – that collaboration today.

In those considerations of what are the barriers. Is one of the matters that you consider, the question of on the one hand, an external agency, such as NT Health, coming into community and trying to set up something, in this case, the Health Advisory Group meeting. And on the other hand, what's missing from that equation, which is the level of local community controlled ownership and generation of the idea and process?---Mm mm.

And where does that reflection lead you, as an entity? I don't mean you personally, but as an entity?---I – I think again if we refer back to the transition framework, there is opportunity for – for that framework. So it is about, as we heard, about the

progressive engagement, the progressive movement towards stronger engagement. That they can be models that look quite different. And certainly we understand in the Yuendumu context, that there is a consultation in place currently, to assess the community's interest in moving towards community controlled transition. And of course, we would be supportive of that, should that be the expressed interest of the community. Have you examined why there used to be, from the evidence, it seems to be the case, more regular meetings of the Health Advisory Group, whatever it was called, prior to five or six years ago, compared to now?---Not specifically. But I do note that during the COVID period, and again, I apologise, I don't have the level of detail. But I do note that during the COVID period where NT Health was required, of course, to have strong regular engagement with the community, because of the changing profile of COVID, the changing health needs, interactions, outcomes and the like, there – there was a good engagement from community. So again, I – they're things that we will need to consider. Again, during COVID, post-COVID, what has changed.

All right. The – if I may say, reading your affidavit, and considering what you say, perhaps two things a bit striking. One is that – firstly there are a lot of ideas in there for what's planned for the future. But on the other hand, there is something of a perhaps a sense of crisis in terms of the problem of recruitment and retention. And that seems to be a problem that has been a long time in the making from reading your material, and the annexures to your material. Would you agree that that problem of having an adequate pool to call from, and adequate number of people who you can employ, is a term – is a very long-term problem. Or is that something that you see more as a problem only emerging in the last few years?---I - - -

And perhaps before you answer that, I should have introduced myself?---Mm mm.

I'm acting for the Parumpurru Committee of Yuendumu. So it's the Justice Committee of Yuendumu, which was put together for this inquest. And so we're looking at the future. We're not really interested in – when I say not interested, it's not about – focused on some of the minutiae or blame or anything like that in what's happened in the past. We're trying to look for recommendations for future improvement in community?---Mm mm.

Which is the basis of my question?---Yeah, great. So coming back to your question. I'm going to say it's both, if I can. I think what we have seen is that during and post-COVID, we have seen some unexpected changes. And I suspect, if you were talking to any manager of any health service, they would say the same thing, based on the information that we see, is that certainly there have been some unexpected changes in terms of a deterioration of recruitment/retention capabilities. So certainly, you know, that is the evidence available to us. In Central Australia specifically, remote area nursing, so if we come to a remote area, or a primary health care area, there have been challenges in remote area nursing for a period of time, yes. I - - -

Could you just quantify that please?---A period of time?

Yes?---I'm – again, I can probably really only talk to my time in this role. So I acted in the Chief Operating Officer role since December 2020. Which transitioned to the Regional Executive Director in July of last year. So during that period of time, I can comment. I can talk to you about the hospital, if you like. But certainly from that period of time, what I would say is that there have been challenges. I think this – this comes back to what is the role of the remote area nurse. How do we attract into the role of the remote area nurse. It's a fairly unique role for people who are not exposed to this type of work. So if you're a nurse in Sydney, the role of a remote area nurse would look significantly different to something that you would normally sort of undertake. So yes, I think there are some challenges in that role. And we've talked to how do we attract nurses in those roles to live in community. We've talked about the challenges of living in community. Potentially the challenges of relocating family with you to live in community. The challenges of the social aspect of – of community, and the likes. So - - -

Sorry, you've listed a lot of that in your affidavit?---Mm mm.

In – in much of society, when you talk about a unique or a particularly challenging role, the other half of the equation often might be remuneration?---Yes.

And you said earlier today, if I heard you correctly, that you need the remuneration to be equivalent to other jurisdictions, which I understood you to be saying, that your people, the remote area nurses in this case, may well be not be getting paid adequately, compared to the national market place, which is one of the reasons you're having trouble recruiting?---I think there's certainly a challenge where during this crisis, as you say, in terms of recruitment and retention of nursing, there is a level of competitiveness across jurisdictions. So we see that other jurisdictions are investing significant funds into health care staff, particularly nursing staff. So we see that in the media. How those – how those allowances or payments might be scheduled for other jurisdictions. My - - -

So if we can just deconstruct it a bit?---Yeah.

You're saying the same nurses might get paid more if they went somewhere else?---I think we're competing for the same pool of nurses. So it is about how do we compete for the same pool of nurses across Australia, given that we do have a national challenge around recruitment. So it is about, what is it that we have here in the Territory, and specific to remote area nurse, how is it that we remain competitive. And certainly salary allowances are a component of that.

Certainly, the other component is the marketing component that this is equally a very significant opportunity to work in a remote area to – you know, to have the privilege of working in a community is something that certainly, we need to consider. But yes, we are in a competitive market.

Is there a single place – I don't want you to go far with this answer, but is there a single place where someone like me can go and study the schedules of payment across the country?---There are – if you choose to focus on nursing alone, I would

encourage you to have a look at the enterprise agreements of each of the jurisdictions for nursing. Having said that, there may be other schedules of payment outside of the lease, yeah.

I understand, I'm happy with that. I was just hoping there'd be a one-stop shop?---I'm sorry, no.

If you need to search in seven jurisdictions, it's a lot of button pressing. The – you were asked a little bit earlier about the FIFO model, fly-in/fly-out, which you're working on and you spell it out in your affidavit. I don't want you to go through all of that. It's set out there. And in one of the attachments, I think it's attachment 16 probably, you've set out the program for the fly-in/fly-out model. And one of your answers about that suggested the obvious objective that you're looking to achieve longevity in retention of staff, but – and as I say, we're speaking for Parumpurru Committee here, but the model – I just want you to comment on this, because the thing that struck me about the model is that once you say you were talking about putting your staff in for eight weeks and out for four weeks, you're really creating a very limited – well, a much more limited pool of potential candidates, because so many people who would want some stronger form of domestic – and arrangement where they didn't have to travel back and forth, eight weeks in one place and four weeks in another. Can you comment on that. I mean, is the FIFO idea the last best idea that you have got for this - - -?---Never the last best.

Yes?---There's more to come.

I know, that's not what I'm talking about, at the moment it's one of the strongest ideas that you've got in order of your documentation as a way of - - -?---Yeah.

- - - recruiting and retaining. But on the other hand, it seems that it's almost destined not to retain people, because it's a young person's – or a person who is happy to move on, come in and go out model?---The aim is the opposite, but I appreciate your feedback. I think, for me, it is actually around responding to that need for young people. So, the idea is that, not all staff would be allocated in a community on that model, so we would have a range of models. Again, not – there is not a "one size fits all" for all staff, there would be ideally staff who are recruited permanently on a Monday to Friday type schedule.

Okay, so that wasn't so clear to me, because in your documentation, you talk about how every nurse there at the moment is an agency nurse at Yuendumu?---Historically, not today, of course, but yes.

I thought that was at the time of your affidavit?---Yes. So, again, I think what we have to understand is that recruitment into communities will change dramatically.

Well, that's the - - -?---The goal - - -

Yes, I understand that?---Yeah. And the goal is that we have models that meet the needs. I would be looking, in essence, at a number of people picking up a FIFO

model, so that you could have a consistent staff, a group of staff members to enable a small portfolio of staff to have that presence, the constant presence in community while one of the team members was on their four weeks off, that four weeks off enables that nurse to perhaps go home to another jurisdiction, wherever they might come from, visit family, socialise with family. But rather than move on to a different community as they might with an agency, they come back into the community after their four week off. Then the person who I might be partnering with will take the four weeks off. So, it is about a model that indeed does support that return to community, that consistency, but respond to the needs of some nurses who have raised that they do need to go home, their preference is to go home and spend time with family.

All right. The final matter I wanted to raise with you is something which is briefly touched on in your affidavit. Have you got your affidavit there?---I do.

It's at par 107 – 106 actually and it also is – what you said there in 106, which is one of the issues you have to deal with is with regard to – in relation to recruitment, is delays associated with necessary criminal history checks and Ochre cards and prospective staff may be unable to deal with some of that. Now, some of the evidence we've heard is that the form-filling required by Aboriginal community – did you hear that evidence?---Yes, I did.

Yes, the form-filling required by Aboriginal community members to get to the point of being employed at the Yuendumu Clinic is not only difficult, but actually and full and complete barrier prohibition top working there. And since you heard the evidence, I won't go through it all now with you, but you've mentioned the need to be creative. I don't remember now whether you said it or I read it, but you can understand and you raised the notion of then creating an imaginative in dealing with these problems. Are you able to tell us now, having heard that evidence, whether there is something constructive and productive that you can do to get rid of this prohibition or strong barrier, or are you constrained by a whole government approach?---In part, but we're working on it. So, certainly, yes, it is a criteria that we are required to meet. I can certainly indicate that we are advocating for a change in that, so we are working - - -

Sorry, I missed that?---Sorry. We are advocating for a change in some of that process, so we are working within our own constraints to advocate for a process change. However, as an interim, there has been the recruitment of the Aboriginal recruitment officers that I have spoken to by district. Their role is indeed to support people to facilitate that process where possible. So, again, having somebody who can work with a potential candidate to complete the paperwork, so to speak. Equally, I would think through the establishment of the recruitment hub that I spoke to you earlier, there would be supports more generally with those processes. So, I think it's a couple of avenues, acknowledging that, yes, it is laborious, it is - - -

Is that a problem you were working on, obviously prior to hearing the evidence?---Yes.

Yes. Is part of the solution being considered putting at least part of the form, or

much of the form, in Warlpiri language?---That hasn't been raised, but certainly could be considered, absolutely.

I think that's my time, thank you.

THE CORONER: Thank you. Are there other questions?

MS WILD: Not for me.

THE CORONER: Ms Dwyer – Dr Dwyer?

DR DWYER: I note the time, your Honour, might we have the afternoon break before I finish off.

THE CORONER: Sure. All right. A 15-minute break.

ADJOURNED

RESUMED

THE CORONER: Yes, Dr Dwyer.

DR DWYER: Thank you very much.

NAOMI HEINRICH:

THE CORONER: Sorry, I'm out of order.

Yes, Dr Dwyer.

DR DWYER: Thank you, your Honour.

XXN BY DR DWYER:

DR DWYER: Ms Heinrich, I'm going to start by just finishing off some questions about the root cause analysis, would you like a copy of it in front of you or do you have it there?---A copy would be lovely, thank you.

I'll see if I can get that up for you. It sits behind your letter if 31 August 2022.

I might just ask Bec to put the page on there.

And then that might be easier, you can follow it.

I'm going to put, for the benefit of my friends, the following: page 6 of the root cause analysis.

And the court officer will have that up for you. In relation to the root cause analysis, you gave evidence earlier that you signed off on it, effectively?---Yes.

You're reliant, aren't you, on the report writers in terms of giving you the factual basis for the report?---Yes.

And in terms of giving you their critical analysis based on the facts?---Yes.

At page 6 of the report, there are some conclusions expressed in the introduction and par 3 reads, "After consultation with all staff members via teleconference, the consensus was that they were not feeling safe to stay within the community and the decision was made to withdraw the health staff from Yuendumu. As a result of the reduction of services to Yuendumu, it was arranged that all emergency calls were to be triaged and attended by the neighbouring Yuelamu Community Health Centre. A police escort was available for these Yuelamu Health Centre staff if attending Yuendumu afterhours." I just wanted to stop there. Are you now aware that in fact, a police escort was not available for Yuelamu staff?---Yes.

That Sergeant Frost in fact expressed to Lorraine Walcott that that would not be

possible, due to limitation of staff resources?---Yes, that's my understanding.

So, it's disappointing, isn't it, to see that factual statement made when it's not correct?---Yes.

That introduction goes on to read, "The above arrangement was made in consultation with the local police sergeant --", that is the decision – the arrangement for the police escort, "was made in consultation with the local police sergeant, community Elders, other Yuendumu stakeholders and the on-call PHC management." When you read that, did you read that to mean that before the clinic staff were removed temporarily from the community, there was consultation with the police, community Elders and other Yuendumu stakeholders?---It does infer that, yes.

And by – firstly starting with the other Yuendumu stakeholders, who did you envisage had been spoken to prior to the decision to remove the clinic staff?---My understand was that it was members of the Yuendumu Community.

I see. Well, how does that change to – how does that differ from community Elders?---I think the broader population across the community.

You didn't envisage that it involved speaking, for example, to the aged care facility or to Purple House or to the teaching staff or to other service providers?---Not necessarily, given that it was on a Saturday and many of those service providers are not open on a Saturday.

By "consultation", I take it that you infer that that meant that there was discussion, dialogue, negotiation, debating, acting genuinely, engaging in discussion about the decision?---Yes.

Rather than just telling people on the way out that you were going?---Yes.

Do you now come to know that in fact there was no consultation with the police before clinic staff made the decision – or before management made the decision that clinic staff would be removed?---Yes, that's my understanding from witness statements.

And there was no consultation with the community Elders or broader community before the staff moved out. Do you agree?---That's correct.

Can I suggest to you that it is extremely disappointing to see that factual inaccuracy in a root cause analysis when you've got to sign off on it?---Yes.

Are you prepared to give that feedback to the authors of the root cause analysis?---Yes, absolutely.

It puts you in an embarrassing position doesn't it, can I suggest, to sign off on it? ---Yes.

And at a management level do you agree that there was a failure to ensure that there was appropriate consultation with those - with the police and the community? ---Yes.

I anticipate on the basis of all the information that we have heard this week and from - including from yourself Ms Heinrich, to be submitting to her Honour the following - please tell me if the is anything that you disagree with. Firstly, that the attempted break-ins of the nurses houses did create a risk to the staff?---Yes.

That every effort should have been made to manage that risk without resorting to leaving the community, if possible?---Yes.

That leaving the community was - may in some circumstances be necessary but is a drastic conclusion to reach?---The decision was based on that assessment and yes, it is a significant decision.

And given the significance of the decision it needs to be the last resort in terms of managing risk, do you agree?---Yes.

And I anticipate submitting to her Honour that in circumstances where there was no consultation with the police and no consultation with community elders or other stakeholders it was not clear that it was the last resort prior to the decision being made---I think at the time the decision was made based on the information available by those staff on the ground and those management staff. In hindsight we have learned that the consultation was not as thorough as it might have been.

Well, in hindsight we've learned that the consultation was wholly inadequate? ---Correct.

Because the staff moved out, do you agree?---Correct.

Police told clinic staff that they were responding with more staff, into more police, into the community and that should have been factored into the risk assessment, I think you have already conceded that?---Yes, yes.

And the failure of a written risk assessment in terms of - well I withdraw that. I will just go to the point you've been taken to previously is that there - at page 15 it notes that "There are two primary and competing concerns in relation to a risk assessment. One is the safety of health workers and the other is the safety of the community"? ---Yes.

And I don't diminish for a moment the importance of the safety of health workers? ---Absolutely.

But you would say, wouldn't you, that the safety of the community is at least equally important in balance of concerns?---Absolutely. It's a combination of both risk assessments.

And in these circumstances where there is no written evidence of any risk assessment in relation to the safety of the community, it's not possible to conclude that there was a risk assessment done?---That's fair, yes.

And the importance of formalising a risk assessment on the day was to ensure that nothing was missed, in part, do you agree? No opportunity was missed?---Yes, and I think in relation to the risk assessment as we discussed earlier, while it was not documented, I have a full understanding that the staff involved because of their experience will have undertaken that risk assessment , the gap is the documentation.

I just want to test that for a moment. We know now that nurse Cassandra Holland was - her evidence is that she was happy to stay, that nurse John Alton was happy to go to Yuelamu to provide back-up services for the community, so that if he'd had an emergency in both communities at the same time, that would have been of enormous assistance with Mr Alton, do you agree?---Yes.

And given that those two nurses at least, were content to stay, one in either community, that should have been factored into the risk assessment, shouldn't it? ---Yes, it's not clear when that information came to light in terms of the decision.

Doesn't that underscore the importance of making a written record of what everybody thinks?---Yes, absolutely.

Do you think that fatigue might have played a role in the failure to properly record the decision-making?---Quite likely. Fatigue plus external workload. We understand that the manager on call will have taken multiple other calls in terms of primary health care activity and the like in addition to the Yuendumu incident.

Do you mean by that Helen Gill?---Yes.

So in terms of the responsibility to formalise the risk assessment on both sides, to the nurses and to the community, did that lie with Helen Gill?---With Helen Gill and her senior executive team at the time.

Has Helen Gill and her senior executive team been provided with feedback in relation to the paucity of documentation about the risk assessment?---Certainly we've had that discussion, yes, in terms of the risk assessment and our review post that and I refer to the changes, I guess since COVID where we make our requirement to assess risk routinely, consistently in a changing profile and we have indeed reviewed those documentation processes.

One failing I am going to suggest to you in relation to the consultation prior to moving out was a failure to adequately consult with the Aboriginal staff to see whether or not there was anything they could suggest before moving to the position with clinic staff in the dark?---Yes.

Do you agree with that?---Yes, absolutely.

Moving to a different topic. In 2018 my review of media resources suggest there were some criticisms of the Yuendumu clinic at the time. Were you familiar with an article published by the ABC to that effect?---No, I am not familiar with that, no.

Do you know after there had - whether or not there was a review of the clinic services that followed on from some criticism of the police in 2017/2018?---No, I am not aware of that.

In order to find that out, who are we best placed to ask?---I would work through the general manager primary health care.

And who is that?---That is David Reeve at the time. At the current time.

Within that article there is a suggestion that community members were not being adequately transported to the clinic in order to access services. That is something that we can ask the current clinic manager, but has that ever been brought to your attention?---I'm actually aware that from recent - we call them "consumer surveys" undertaken in the Yuendumu clinic, one - that was one of the more recent pieces of feedback as well and I've seen a flyer indicating that the staff are working to improve that transport to the clinic. So yes.

Is there a service providing transport to the clinic?---No. I imagine it would be through the clinic staff themselves, perhaps the Aboriginal health worker who would assist in that process. As well as - sorry - there is a gardener - gardener/driver role that is recruited into the clinic that may assist with those functions as well.

And that is a position currently open, is that right?---Yes.

Is the clinic accredited, as far as you're aware?---Yes, it sits under the AGPAL accreditation and all of the Central Australia community clinics are accredited under AGPAL.

Can you explain what that acronym stands for?---I'm sorry, I can't right now.

Well you take that on notice?---I certainly will. Helen Gill will certainly be able to help with that tomorrow.

Thank you. And am I best placed to ask Helen Gill about the process of accreditation and what that involves?---Yes, yes.

Have you been aware of any complaints being made about allegations of bias towards - or racism towards members of the community either unconscious bias or unconscious racism or actual complaints of racism?---I've not received any complaints, no.

Would they come to you do you feel?---We have a process, so certainly complains would likely go through - again depending on where the complaints are coming from, potentially through the clinic manager, maybe to the district manager, maybe to another leadership role within primary health such as the Director of Nursing and potentially then through to the general manager, primary health care. Where there is a significant incident of investigation it may well be that that is raised with me as the delegate for various processes.

No doubt that is something that we can ask Ms Gill when she gives evidence tomorrow, but if there was, for example, or if there was a level of engagement between staff and community where the community could give the staff feedback about things that they were not - about certain behaviours that they were concerned about, you'd welcome hearing that wouldn't you?---Of course.

Have you heard any complaint about Aboriginal people being made to stand outside the clinic rather than being allowed indoors?---I've not heard that complaint, no.

During COVID there was obviously a need for changes in some of the protocols so that people would not risk infecting others. Are you aware of any kind of standardised protocols or procedures that were introduced across clinics?---We established a large number of protocols across remote clinics and in the hospital itself. They were in line with largely national standards around managing – or preventing the spread of COVID.

Did they involve one patient being in the clinic at a time?---I couldn't confirm the detail, but likely it was all about restricted impact towards each other. So again, looking at those concepts of social distancing to minimise exposure to other people. The wearing of PPE, protective equipment, and the like. So it may well have evolved – involved a reduction of access to the clinic at any one point in time.

Are those social distancing protocols still in place in – in regional – in remote clinics?---There is a component, where by yes, we support, across our health clinics again, social – social distancing, as there should be in all places.

Do you agree that that needs to be balanced, as – particularly given where we are now in October 2022?---Yes, absolutely.

(Inaudible) pandemic. It needs to be balanced with behaving in a way which is culturally appropriate?---Yes, absolutely.

And so you would welcome any feedback from the community, wouldn't you, as to whether or not, the community feels that staff are getting that balance right?---Yes of course.

Are there performance indicators in place so that somebody in your position can assess the performance of the Yuendumu Clinic, as opposed to other regional clinics – the remote clinics?---Yes we have a suite of key performance indicators that are identified under the Service Delivery Plan. That Service Delivery Plan is set out by

the system manager in – in my situation, that's the Chief Executive of NT Health, in terms of the performance of the communities. At a high level that looks at the communities collectively, so it's not necessarily that each of the communities are stepped out. That responsibility would sit, unless there was an issue of course, that responsibility would sit with the branch, or the division of primary health care to investigate those particular matters. Which is why we work to a district model to ensure that there is good opportunity to look at the performance within those particular clinics.

So is that an issue that I should take up with Ms Gill tomorrow, in terms of the function of the Yuendumu Clinic?---She may be able to provide a response, in terms of those safety and quality indicators, yes. Alternatively, of course, the General Manager for Primary Health Care may provide information.

Who is David Reeves, is that right?---Mm mm.

So I'm thinking, just to make sure that I am structuring my questions adequately to the right people. For example, we heard from Dr Rosser I think, about the high rates of rheumatic heart disease in Yuendumu. And we certainly heard that from a nurse yesterday. In terms of the rates of compliance with regular echo screening for patients with rheumatic heart disease, are statistics kept about comparisons of Yuendumu to other communities?---I can't comment specifically. That is not one of the KPI's in the Service Delivery Plan currently.

Do you think it should be?---I – I would assume that there are data kept on that, but it's not part of the Service Delivery Plan. There is a suite of designated KPI's that belong within that Service Delivery Plan.

What about the rates of attendance out outpatient clinics for patients from Yuendumu, compared to other communities?---At outpatient clinics in Yuendumu - - -

Yes?---Or in Alice Springs?

Well let me start with Alice Springs then?---Certainly we monitor attendance rates of people in the Alice Springs Outpatient Department, and for example, to other appointments such as elective surgery. By and large, that is not by community, it is by the individual. And working to meet the needs of that individual.

What about chronic disease screening?---Yes. Again, the rates that I would look at are the rolled up rates for Central Australia, not necessarily by clinic. That would sit with the – again, the District Manager and teams within those areas.

But those figures are certainly kept as a KPI so that you can look across the communities?---Yes, yes.

And similarly, rates of staff turnover?---Yes, we collect some of that turnover data, yes.

Would you be concerned to know the reasons for, for example, if you had a much higher rate of staff turnover in Yuendumu than Tennant Creek, you might – you would interrogate that?---Yes.

Is that right?---Yes.

Because you might – there might be reasons for that, which include anything from poor performance of the clinic, to Tennant Creek being an easier place to live?---Yes.

Is that right?---Yes.

And there might be lessons to be learned across that spectrum, for somewhere like Yuendumu, is that right?---Yes.

Whose responsible then for reviewing that?---Again I think – I think it's a broad team in the primary health care branch. We have a number of people who look at that. As an example, the recruitment of nursing, and the turnover of nursing might fall within the – the portfolio of the Director of Nursing, through primary health care.

So am best – well let me just ask you then in relation to Yuendumu. Are you currently aware of whether Yuendumu has a higher rate of staff turnover than clinics like Tennant Creek?---Not specifically, no.

If we – but those figures are kept?---Yes.

Someone will be aware of it?---Yes.

Likely David Reeves, is that right?---Yes.

Is there a general physician who visits Yuendumu?---Dr Rosser – sorry a - - -

A general physician, so a consultant?---Yes we have. I can't say who that is, but certainly we have a cycle of – a rotation of general physicians into community. As I referred to earlier, we try to ensure that the general physician again has repeat visits into that community to ensure again some continuity, and a development of relationships. But I can't tell you who that general physician is.

Does attendance by a general physician depend on the number of referrals that are made by the clinic staff?---There is a cycle of scheduling. So there's a scheduling program of general physicians. Equally, there is an opportunity for the general practitioner to make contact with that general physician. So there is equally opportunity to do that.

It must be an important way to skill up your GP's as well, to give them some access to specialists?---It's certainly important, like for any GP to have access to specialist services, yes.

Sure. So do you know whether or not statistics are kept on the rate of referrals by GPs in Yuendumu to specialist physicians, as compared to referrals in other communities?---I imagine yes we could gather that data.

Again, David Reeve - - - ?---Yeah.

- - - is the right person to talk to?---Yeah, and we're very happy to take these questions offline too.

I'm grateful, thank you very much. Overall, how do you tell then if clinically, and I ask this not to be critical - - - ?---Mm mm.

- - - but to work out whether or not there are ways to support remote area clinics. How do you tell if one clinic is underperforming clinically, as compared to another clinic, and therefore needs greater support?---Again, this is perhaps not directly within my portfolio, but I would imagine that again, the governance structure of primary health care with the – the relevant managers, would be able to identify that very readily. Much like we would in a hospital, with the relevant managers identifying gaps in service delivery. That may be through things like the KPI's that you've referred to. It may be through consumer or customer feedback. There may be a number of avenues of feedback to assess that. That is the role of the manager to understand what is working in that community, and what is not, and what needs to be addressed. That's the role of a manager. As I mentioned, we have a District Manager, who has oversight of a number of communities. And equally with reporting lines for clinical expertise through to a Director of Nursing, or indeed a medical practitioner.

It sounds like that's something that I can take up with David Reeve or Helen Gill, is that right?---Yes.

On a related, but slightly different topic. I was referring to you in – discussing with you in a break, a book called "Illness is a weapon" which is a book written about the Warlpiri people in Lajamanu. One of the points taken from that book, which – and I anticipate some of it may be in evidence shortly. It talks about the importance of having male staff members, so that – that health staff can work within Warlpiri cultural norms, where there are expectations that male clinic staff will work with male members of the community. Are there specific efforts made by NT Health, to attract sufficient numbers of both male and female staff members, so that we can work within those cultural expectations?---I would have to say that recruitment is of course a key. Recruitment of – of all disciplines, gender and the like is a key. In terms of the management of ensuring appropriate gender for cultural needs, certainly that is taken into account in terms of allocation. So how a person may – may be allocated care on the day, by whom, would be the most appropriate. That would include in – in relation to the Warlpiri and Yuendumu, utilising men's visiting services so the men's assessment service as well, to support some of that – that aspect.

If – I'm going to put a scenario to you?---Mm mm.

If you heard from Warlpiri Elders and emerging leaders, that in fact there was some cultural norms that were not – Warlpiri norms that were not being respected by the Clinic, because for example, there were not sufficient male staff, you'd be really interested to hear that, wouldn't you?---Yes, absolutely.

And one creative way of working around that might be to see if there's a male position available, then you have them attend more regularly to Yuendumu, to make sure that that Warlpiri culture can be better respected?---Yes, absolutely, using vising services differently, mm mm.

So that underscores, doesn't it, the great need to hear from Warlpiri people about what their expectations are about service delivery?---Yes, absolutely.

And you're saying, and I'm particularly thinking about anybody who's listening now in to the live stream now or later, or listening to our Warlpiri summary which goes up at the end of the week, you welcome feedback from the community about that?---Yes, absolutely.

And you welcome participation by Warlpiri members of the – or by all members of the community, about how this health service can be provided in a way that is more culturally respectful - - - ?---Yes.

- - - if there are shortfalls?---Yes, absolutely.

I want to ask you some questions about Purple House. We understand that Purple House is the Tanami Regional Dialysis Unit, or includes that service - - - ?---It includes that, yes.

And that that service according to their website, began operating in 2010, and enabled Warlpiri people from Yuendumu, and nearby communities, in Yuelumu, Willowra, and Nyirripi, to receive dialysis on country?---In Yuendumu, yes.

And the delivery of that service is overseen by the Tanami Regional Dialysis Committee?---I can't comment on that, sorry.

In Yuendumu, are you aware that they now run the Non-residential Aged Care Program?---I am aware, but not deeply associated that, yes.

You don't attend the local advisory board, am I right?---That's correct.

Can you remind us who does, from NT Health?---Yes, amongst the health staff located in Yuendumu, David Reeve, General Manager, Primary Health Care, attends.

Do you know whether or not Purple House also attend that local advisory group?---I can't confirm that. I'm not sure.

That's a matter for – I can add that to my list for Mr Reeves?---Mm mm.

In relation to the meeting that you do attend, the stakeholder meeting – am I right that you do attend the stakeholder meeting?---No I don't attend the stakeholder meeting.

Are you aware then, you've spoken about the stakeholder meeting, do you know whether Purple House attend the stakeholder meeting?---No I'm not aware.

Are you – David Reeve attends the stakeholder meeting, is that right?---Certainly members of – of the health service would attend the stakeholder meeting. I think that's the one chaired by the Department of Chief Minister.

Yes?---Yes.

We can – and Mr Hampton is on our list of witnesses - - - ?---Mm mm.

- - - so we can ask him about that?---Mm mm.

But you would certainly expect them to attend a stakeholder meeting, or – is that right?---Purple House or - - -

Yes?---I – I don't have oversight of that stakeholder meeting, I'm sorry.

Let me ask you a different question then?---Mm mm.

From your position - - - ?---Mm mm.

- - - within NT Health, it's important to have good relationships with the staff of Purple House providing that dialysis service, do you agree?---Yes, absolutely.

Do you know what the relationship is like, currently, between Yuendumu Clinic staff and Purple House?---I can't specifically say what that relationship is. But certainly, the clients who are attending the dialysis clinic in Yuendumu, run by Purple House, would be receiving dialysis care from Purple House. But maybe receiving chronic – chronic disease care and emergency care through the NT Health Service Clinic. So certainly there is an overlap in terms of that care service, and so communication between the teams is – is important, yes.

You're not aware, currently, whether that communication is – whether there's room for improvement in that communication?---No I'm not aware.

I assume, given your position, you would welcome some feedback in that regard, if there is a way to – if there is a shortfall in communication?---Yes, yes.

Are you aware of whether or not they have the same issues of retaining – or of attracting or retaining staff, that NT Health have?---Again, I don't have the detail in terms of recruitment and retention for Purple House or Western Desert. I do know that they have had some challenges. For example, recently, needing to temporarily

close a rental dialysis service, due to staffing challenges. Those patients were relocated to Alice Springs, to the NT Health Services.

Which was that community?---Utopia.

They haven't closed services in Yuendumu though, is that right?---I'm not aware that they've closed services in Yuendumu, no.

In – we heard from the nursing staff this week, that in terms of their socialising just with each other, and not with other stakeholders, they did not for example, socialise with the staff at Purple House.

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Which was that community?---Utopia.

They haven't closed services in Yuendumu though, is that right?---I'm not aware that they've closed services in Yuendumu, no.

In – we heard from the nursing staff this week, that in terms of their socialising just with each other, and not with other stakeholders, they did not for example, socialise with the staff at Purple House. I suggest to you that it was a missed opportunity when the clinic staff moved out in 2019 to at least speak to Purple House to see whether those nurses might be available to provide any emergency care?---Again, I'm – in terms of emergency care, I'm not aware of the skill set of the dialysis nurses. They are qualified to provide dialysis and may not have emergency skills of a remote area nurse, remembering that a remote area nurse undergoes particular training and qualifications to provide that emergency response.

Sure, but isn't the point that the staff there didn't know and neither did management what were the skills of the Purple House nurses at the time?---Nor indeed the number of nurses present in community at that particular point in time.

And it would have been worth finding out?---Possibly, yes, yes.

Does it surprise you that nurses living in the same community, a small community of less than a thousand people, don't communicate with each other before such a significant decision is made?---I think it depends on the circumstance at that particular point in time. The nurses were communicating with each other in relation to their particular concerns around safety.

I anticipate submitting to her Honour that there needs to be an urgent look at whether or not relationships between all the stakeholders can be improved so that you have better communication in relation to any sort of crises. Do you agree with that?---Yes, certainly, you know, there's – as we've talked through those opportunities to share information, either in a meeting circumstance where there is opportunity to do that and, from my perspective, the introduction of the role of Karl Hampton in community is definitely around that better communication coordination in community. So, one would assume that that will continue to improve with his presence and role in coordination.

Do you think from the perspective of NT Health that, if you're going to have an orientation for staff members when they come into the community, it might be useful to have an orientation on a monthly basis for all staff from all different stakeholders that's provided by Elders and emerging leaders?---That could be an idea.

It's a way of getting stakeholders together on a regular basis?---Yeah, possibly.

And getting them engaged with community members, including Elders?---Yeah, possibly.

Okay. Well, imagine you're in a position of a nurse going out to a community for the first time, I'm going to suggest to you that it would be a positive thing to be able to meet with other service providers on a monthly basis in a less formal setting where you're working with Warlpiri leaders and Elders to learn culture?---Yes.

And similarly, language classes. Can you see the value in staff in a clinic learning Warlpiri or learning as much Warlpiri as they can?---Yes, and I think some of our witnesses have referred to the fact that they have learnt some language.

Might one way of getting stakeholders together be to have language classes together?---It could well be, yes.

In relation to the issue of the gap in service delivery which you're trying to fill to meet unmet needs, a significant need is counselling and specifically trauma counselling. Do you agree with that?---Yes.

Yuendumu in particular, I'm going to suggest to you, has a history which means that many people have been impacted severely by trauma. Do you agree with that?---Yes.

Are you familiar with the Coniston Massacre that occurred in 1928?---Yes, I am.

And I suggest to you that the impact of colonisation generally creates enormous trauma that needs to be addressed?---Yes.

And there were riots in 2010 that led to 100 people leaving the community. That's likely to have created significant trauma - - -?---Yes.

- - - across all age groups?---Yes.

That young people in 2010, many of the young people in 2010 are teenagers now who might have ongoing behavioural issues related to trauma?---Yes.

And so, although all communities might call out for counsellors, Yuendumu has a particular need. Do you agree?---Yes.

And we've heard that there is a need to provide male and female counsellors. Do you agree with that?---We need to have a gender balance, yes.

And in addition to the counselling services, a psychologist should be provided?---So, under the Social and Emotional Wellbeing program funded by the Commonwealth through the NTPHN, there is a psychologist position funded. I think the witnesses have referred to those people who have filled those positions previously.

Yes?---We have noted that that position is currently vacant, despite recruitment efforts. And we are certainly that we can recruit into that position in the early new year. We also have, as I mentioned earlier, that AOD aftercare worker, who again, we have historically been able to support a gender balance between those two positions.

I'm going to suggest to you that it's not enough to just have that one funded psychologist position, or the AOD. That there needs to be counsellors, in the community, male and female, to help address the unmet need in relation to trauma. Do you agree with that?---I think everybody has a role, and I think it's looking at what those – what those positions are. Again, nursing staff have a role in counselling. Medical staff have a role in counselling. We have the Social, Emotional Wellbeing Program with the psychologist. We have the AOD social worker, and we have visiting services that support that. But indeed, we can look at additional positions to support that.

Do – we heard from nursing staff yesterday, that they thought there was a very significant need for counsellors based in the school. Male and female, to support young people between the ages of five and 15, because they are not seeing them in the clinic to provide any services?---That's something that I have not had addressed directly with me. Interestingly, given that we've got our Regional Coordination Group in Yuendumu today with the executive lead of education, that – that may indeed be something that's addressed today in Yuendumu.

Given it came from one of your nurses yesterday - - - ?---Mm mm.

- - - and in fact it's – we've heard similar evidence from more than - - - ?---Mm mm.

- - - witness, are you prepared to take that up, in terms of the unmet need?---Yes, I would need to talk to education to understand what the resources are in schools.

But that's certainly an issue that should be addressed at the stakeholder meeting, do you agree?---Again, I'm not a member of the stakeholder meeting, but yes, it should be a point of discussion.

Do you know currently, whether there are any counselling services provided by WYDAC?---I can't comment specifically. I understand there has been work with – through the Commonwealth to provide funding to WYDAC. But I can't confirm where that discussion is at.

Would you have an expectation that David Reeve, for example, would know about that, because he's attending the stakeholder meeting?---Yes he – he may be aware of that more closely.

In terms of – well, particularly given the recruitment challenges in a community, it's just vital, isn't it, for stakeholders who are – who are capable of providing some of the similar overlap services, like counselling, to be able to know what each other's capacity is. Do you agree?---Yes, which is certainly again, something that's being worked through, for example, from a visit today through regional co-ords.

And do you agree that stakeholders need to support each other to the extent possible?---Absolutely.

I'm going to ask you about – about attracting staff firstly. You make a point, in terms of Yuendumu, it's a community that's hot and dry, and there are some challenges. It's not by the beach, for example. But can I suggest to you that in terms of recruiting, people need to understand that working in Yuendumu is an amazing opportunity to work with Warlpiri people?---We've done our best through a recent recruitment campaign to – to do exactly that. To offer through people being filmed about their experience. To talk about what drew you to a remote area. Not necessarily specifically Yuendumu, but into remote communities. So we've certainly used that to understand what is it that draw people into communities. Because people are drawn. And that definitely has been the theme of the campaign, to understand what is it that draws you into a community, and how might we attract others, based on what we've learned from staff.

When was that campaign rolled out?---July 2022. That's the Local Central Australia Campaign that I refer to in my affidavit. There is further campaign to be – expected to be rolled out in early 2023, through the NT Health Program. What we've done in that campaign though, is definitely to draw on the experiences of people in community. Equally, people working across other parts of our service, to tell their story. To share their story. So that we don't market palm trees and beaches. That we're marketing what is real to Central Australia.

In terms of what is real to Central Australia, and the opportunities provided?---Mm mm.

Is it part of that campaign to get the message out, that one of the great strengths of working as a nurse in a place like Yuendumu, is that you get to be autonomous, to a larger extent, than you would in a city?---Yes.

That it's nurse led care for much of the time in community?---Yes.

That you get to engage with a community?---Yes.

And that you get an opportunity to engage in a broader practise - - - ?---Yes.

- - - that you would – than you would do in the city?---Yes.

So if – working in Yuendumu, is an opportunity that can foster your career?---Yes, and certainly they're certainly some of the tag lines we've used in our recruitment campaigns.

Has it so far borne fruit that you can see? The July campaign?---I think it's early days, to be honest. And again, no one strategy is going to resolve recruitment. We certainly have had some strong feedback. In fact, only this week, that a magazine, and I'm sorry I don't know which magazine, has made contact, literally based on one of our remote area nurse You-Tube videos. That they are very interested in – in the nurse that was in the video, and keen to provide a magazine article. So for me, it's about how do we get that message out there. Having loaded a number of these recruitment videos on You-Tube, and starting to market that, it's a multi-pronged approach to ensure that that message about those opportunities is – is relayed. Equally as important, is retention. So that we are supporting staff when they arrive, both through on-boarding, and ongoing professional development and the like.

No doubt you are interested to reflect on what staff has said in this inquest, as to what are the strengths and challenges in – for them, in working in Yuendumu?---Yes, absolutely.

One of the consistent themes, might I suggest to you, is housing?---Yes.

That the Colorbond fencing, which was well intentioned - - - ?---Mm mm.

- - - has not had a positive impact on the staff, at least that gave evidence, for a number of reasons. One is that it doesn't make them feel safer. Because in fact people can get over the yard without them seeing?---Mm mm.

And secondly, that in fact has the effect of cutting them off from each other, in terms of socialising?---Yes.

And thirdly, that some staff felt it cut them off from the community and made them feel more – is that something that NT Health is now prepared to look at in terms of

perhaps reusing that – or removing that Colorbond fencing, at least as it's currently positioned?---NT Health does not have management over the private – with the leased houses. That's a communication through to NT Housing, and certainly that communication can be had, yes.

I anticipate getting some more feedback from stakeholders as to what would assist in terms of making life more comfortable in Yuendumu and making life – and also helping them to integrate with the community that they care about. Can I suggest to you some low hanging fruit and see if you agree with me?---Yeah, sure.

One idea that has been proposed is the pool opening for longer hours so that – and perhaps a gym being provided so that people feel that they can maintain their mental and physical health?---Yes.

Another is a social hub or café potentially attached to the pool and gym so that people feel that they've got somewhere to congregate?---Yes.

And you're aware, aren't you, that the pool is something that's really popular with the community?---Yes.

And so that actually making everybody feel comfortable there is a good way together?---Yes.

If we could – well, I'll withdraw that. Have you recently engaged in any survey work with staff to see what would assist them in terms of making them – that is, helping them to stay longer in community?---Yes, I mentioned earlier that we have undertaken a remote area nurse survey that was led by our nursing office, I believe that was in the last two year period, to understand the preferences of staff, yes.

And have any of those preferences been acted on?---There are a number of preferences that are being considered. One of the examples is access to fresh foods and the like. We are looking at campaigns around how we can support that differently, perhaps through a click and collect program and again, looking at how we engage people through our wellness programs. So, those activities are being assessed. Equally, we know that professional development is very important for staff.

Is one – have you looked at, in terms of staff getting some respite from community as opposed to a model where they come out of community for four weeks, a model where you can come into Alice Springs, into accommodation on a more regular basis, say once a month, once every six weeks. Yes, my understanding is that that occurs.

Is that – is the accommodation then funded when staff gets some time out?---It's available through NT Health, yes.

Do you know how often staff have that option?---I'm not 100 percent sure, but certainly, we're looking in our accommodation guidelines at the moment. That is a

broader aspect of our recruitment and retention program. We are currently looking at the completion of a new accommodation build in CBD Alice Springs and thinking equally about how we might utilise some of that new build for staff who are looking to retreat from remote areas in addition to attracting staff into urban Alice Springs. So, a combination of the use of that service. We're changing some of those protocols in terms of accommodation management. We have a large accommodation portfolio, given the vast FTE within our portfolio within our portfolio and we're looking to centralise the management of that accommodation portfolio, so that we have a greater oversight and a better utilisation of those services.

Final topic, Ms Heinrich, is the idea that has been raised with you previously about socialising with other stakeholders. I appreciate your evidence is that you have – people have different personalities and some might be more social than others, but do you agree with the principle that stakeholders can be an important support for each other?---Absolutely.

And that it's important to break down any barriers that currently exist so that those staff who want to take up opportunities to get to know each other, can do?---Yes.]

And there might be a need for stakeholders like NT Health to be proactive about that, particularly after COVID?---Yes.

If – are you aware of any survey that's been done of current service providers in Yuendumu outside of NT Health or inclusive of NT Health as to what might help them to develop their relationship?---I'm not aware of any such survey.

Would you welcome that being done?---Yes, of course.

Thank you.

THE CORONER: Mr Hutton, did you have anything else?

MR HUTTON: No, your Honour.

THE CORONER: Look, thank you very much for providing your time, your detailed affidavit and all the documentation attached to that. We appreciate the effort that you've gone to, to provide detailed information to this inquest?---Thank you, your Honour.

We can – sorry, Mr Mullins.

MR MULLINS: Sorry, your Honour. Just one last matter while we reflect on these important matters, can I just observe from the family's perspective with Ms Ferandez-Brown in court, that today would have been Kumanjayi Walker's 22 birthday.

Thank you, your Honour.

THE CORONER: Yes. We will adjourn until tomorrow at 9:30.

WITNESS WITHDREW

ADJOURNED