CITATION: *Inquest into the death of Pukumani* [2025] NTLC 3

TITLE OF COURT:	Coroners Court
JURISDICTION:	Darwin
FILE NO(s):	D0145/2021
DELIVERED ON:	14 February 2025
DELIVERED AT:	Darwin
HEARING DATE(s):	19-21 March 23-24 April 2024
FINDING OF:	Judge Elisabeth Armitage
CATCHWORDS:	**Bed Block in Joan Ridley Unit RDH; prolonged stay in Emergency Department RDH; Failure to monitor respiratory in Joan Ridley Unit; Failure to conduct CPR for 7 minutes; seclusion; managing medication change; Ketamine on CareFlight**

REPRESENTATION:

Counsel Assisting:	Beth Wild
Counsel for Department of Health:	Tom Hutton
Counsel for Family:	Hannah Donaldson

Judgment category classification:	A
Judgement ID number:	[2025] NTLC 3
Number of paragraphs:	166
Number of pages:	50

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

No. D0145/2021

In the matter of an Inquest into the death of

PUKUMANI
ON: 8 AUGUST 2021
AT: DARWIN

FINDINGS

"…We have a Bed Block issue. In any given time, there are five to ten patients … waiting for these high-dependency beds. We need more than just a short-stay unit. We need more beds . . . We don't necessarily need anything really fancy. We just need more beds…

The Northern Territory has 17 beds per 100,000… compared to every other state and jurisdiction, which has about 30, and the highest being about 36. So we have half the available beds of every other jurisdiction. It's a terrible narrative. We also have double the mental health burden.

… the way we treat our most vulnerable members of our community is the way our community is judged. People with a mental health issue, people from remote Aboriginal communities, are some of the most vulnerable peoples in our Australian community, and we are judged by the way we treat them."

Evidence of Dr David Mitchell, Chief Psychiatrist, Northern Territory

INTRODUCTION

1. Pukumani was called Jorrijorringa,[1] blue winged kookaburra, by her family on the Tiwi Islands. She was born on 20 February 1974 to parents, Dennis and Gabriella Alimankinni, and was the second eldest of her siblings. She was raised by her parents and extended family on the Tiwi Islands. She was 47 years old when she passed away. She is survived by her husband, four children and a grandson.

2. Her family were very involved in this Inquest, and it was clear to me that she was deeply loved and cared for and is greatly missed. On the final day of the Inquest members of her family sang and danced outside the court room to honour her memory. Everyone was invited to watch and participate, and I greatly appreciated the opportunity to join in this tribute to Pukumani.

3. At 2am on 4 August 2021, Pukumani was involuntarily admitted to the Royal Darwin Hospital (RDH), under s 39 of the *Mental Health and Related Services Act 1988* (MHRS Act). At 6.18am on 8 August 2021, she passed away in the Joan Ridley Unit (JRU). As Pukumani was an involuntary patient when she passed away, she was a 'person held in care' and, under the *Coroner's Act 1993*, and an inquest was mandatory.[2]

4. An autopsy was performed, and toxicological analysis of blood samples taken from Pukumani revealed the presence of Ketamine, paracetamol, and several antipsychotic and sedative medications, all administered in the treatment of her deteriorating mental health in the days before her death. It was the Forensic Pathologist's opinion that the cause of death was *"acute respiratory failure in the context of [Pukumani's] known underlying chronic obstructive pulmonary disease, obesity and administration of multiple antipsychotic and sedative medications"*.[3]

1 Statement, Nicole Intalui,11 March 2024 at [6]
2 ss12, 15(1) Coroners Act 1993 (NT)
3 Autopsy report, Dr Marianne Tiemensma, 4 November 2021

5. She passed away because her mental illness overshadowed her physical illnesses which were overlooked. Nurses failed to conduct the required observations, and her physical deterioration went undetected until it was too late.

6. On 28 January 2022, NT Health completed a comprehensive Root Cause Analysis (RCA). In addition to gaps in service provision, handover deficiencies and the multiple and high doses of antipsychotics and sedatives, the RCA identified two root causes for her death:

   (a) the failure to complete the required prescribed observations of Pukumani overnight; and
   (b) the ongoing bed block in the ED which prevented Pukumani from receiving care in a therapeutic environment.

7. Dr David Mitchell, Chief Psychiatrist of the Northern Territory, on behalf of NT Health said:

> "Pukumani's death was preventable. NT Health takes full responsibility for the shortcomings in the care that was provided to Pukumani and is committed to ensuring that systemic improvements are made in response to [her] death…On behalf of NT Health I would like to express my sincerest apology to Pukumani, her family and her community". [4]

IN HER COMMUNITY

Her background and involvement with the mental health system in the Northern Territory

8. Pukumani was not a well lady. She had multiple medical comorbidities including Chronic Obstructive Pulmonary Disease (COPD), Type 2 diabetes, hypertension, chronic renal disease and anaemia. She regularly smoked cigarettes and consumed marijuana and synthetic marijuana, known as Kronic.

4 Affidavit, Dr David Mitchell, 15 March 2024, at [8-9] and [385]

9. She first became known to mental health services on 12 November 1998, when she was admitted to RDH for a brief psychotic episode. Following this admission, Pukumani became a long-term patient of the Top End Mental Health Service (TEMHS). She received treatment and support for her schizoaffective disorder and her chronic illnesses during her various attendances at the RDH and admissions into Cowdy Ward (1998-2010). Otherwise, her care was primarily managed in her home community of Wurrumiyanga, Bathurst Island, by the Darwin Remote Mental Health Team (DRMHT) and by the Julanimawu (Nguiu) Primary Health Care Centre (the Nguiu clinic). She also received NDIS support and participated in NDIS activities provided by the Wellbeing Centre. Both the Department of Health and NAAJA (on behalf of her family) submitted that despite the inherent challenges of remote health care delivery, she was well-cared for by the remote services staff. [5]

10. An experienced Community Mental Health Registered Nurse with the DRMHT (the Mental Health RN), provided health care to Pukumani from 2014[6] and this Mental Health RN was held in high regard by her family. She explained the DRMHT and her role in it as follows:

> "During the period I was involved in Pukumani's care, I was a Community Mental Health Nurse with the Darwin Remote Mental Health Team (DRMHT). The DRMHT provides a specialist mental health service to the Central Top End Health Primary Health Centres (or clinics) using a Consultation Liaison Model of Care. The DRMHT is a multi-disciplinary team. In 2021, it was comprised of a consultant psychiatrist, psychiatry registrars, a pharmacist, and seven nurses: a Team Manager (N5), a Nurse Practitioner (N6), and five Mental Health Nurses (N4s), of which I am one." [7]

11. In 2020 the Mental Health RN found it increasingly difficult to locate Pukumani in the community. She was reluctant/resistant to attending the clinic for her anti-

5 Oral closing submissions of NAAJA and written submissions, NT Health at [24] citing Root Cause Analysis at p 5. Affidavit, Dr David Mitchell, 15 March 2024 at [61].
6 Affidavit, Mental Health RN, 11 March 2024 at [49]
7 Affidavit, Mental Health RN, 11 March 2024

psychotic injection on its due date or to visit the Wellbeing Centre for review,[8] and the Mental Health RN noticed a general deterioration which she described:

> "Over time, and particularly from early 2021 onwards, Pukumani's capacity to manage her financial affairs, sustain health and dietary needs, and sustain good relationships with family, community members and the clinic deteriorated, despite support from the NDIS." [9]

12. On 26 October 2020, the Mental Health RN reviewed Pukumani and reported her concerns to Dr Kane Vellar, DRMHT Senior Psychiatry Registrar Rural Outreach, who was regularly visiting the community about once or twice a month.[10] The Mental Health RN reported that Pukumani was increasingly refusing her antipsychotic medication, was resistant to engaging with the clinic, her self-care was deteriorating and there was obvious Tardive Dyskinesia.

13. Tardive Dyskinesia is an antipsychotic-induced hyperkinetic movement disorder which encompasses a wide range of abnormal and involuntary movements. It is a serious disorder that can be irreversible and lifelong. It can be disfiguring and disabling, and it can have major negative impacts on psychological health and quality of life. It can also result in a loss of motor functioning.[11]

14. On 8 December 2020, Pukumani was reviewed by Dr Vellar, the Mental Health RN, and a clinic nurse. Dr Vellar was concerned that her physical health was at significant risk from the negative side effects of taking Zuclopenthixol decanoate for many years. The negative side effects that were already apparent included:

    (a) Her EPSE (Tardive Dyskinesia) which was at high risk of becoming chronic.
    (b) Her evolving metabolic syndrome, an umbrella term for a cluster of conditions (high blood pressure, high blood glucose levels, increased body mass index and elevated cholesterol) that increased her risk of heart disease, stroke, and diabetes.

8 As referred to paragraph 25 of closing submissions from NT Health citing Additional Folio 16; Affidavit, Mental Health RN, 11 March 2024 at [80]
9 Affidavit, Mental Health RN, 11 March 2024 at [80]
10 Affidavit, Dr Kane Vellar, 12 March 2024 at [39]
11 Affidavit, Dr Usman Khalid,12 March 2024 at [38] – [39]

(c) Her obesity.
(d) Her presentation was older than her stated age.

15. To address those serious health concerns Dr Veller considered that it was necessary and appropriate to lower her dosage of antipsychotic medication and, ideally, change her antipsychotic to one with a lower propensity for metabolic syndrome. This plan was discussed with Pukumani, the Mental Health RN and, on 20 December 2020, with Dr Usman Khalid, DRMHT Consultant Psychiatrist. The plan agreed upon was: [12]

(a) Regular Zuclopenthixol decanoate 300mg to be administered every 3 weeks (reduced from fortnightly).
(b) Metabolic screening as it was thought she may benefit from the addition of Metformin (though adherence was noted as a likely concern).
(c) An annual ECG for review by Psychiatry so that her medications could be adjusted.
(d) After a period of stability on the lower dose, a plan to change her antipsychotic to Aripiprazole in the new year.
(e) Routine follow-up by DRMHT to monitor mental state / assess for EPSE+.

16. Pukumani presented to the clinic on 22 December 2020, 12 January 2021 and 2 February 2021 and received her reduced dose of Zuclopenthixol as scheduled. In February the Mental Health RN observed a 'well and settled' mental state on her reduced depot medication.

17. On 23 February 2021 Dr Vellar attended Wurrumiyanga and visited Pukumani's home. She was having difficulty breathing and was brought into the clinic for further respiratory management and she received her scheduled Zuclopenthixol depot. Her respiratory condition did not improve, and she was hospitalised from 26 February – 5 March.

18. On 24 March 2021 she was seen by a DRMHT Registrar. He considered her mental state was stable on her reduced depot dose. On 26 March, an Aboriginal Mental

12 Affidavit, Dr Kane Vellar, 12 March 2024 at [55]

Health Worker recorded that Pukumani had refused her depot injection, but this was able to be administered on 29 March.

19. Between 19 and 30 April 2021, two Aboriginal Mental Health Workers and the mental Health RN made daily attempts to assist Pukumani to the clinic so that she could receive her depot. Pukumani refused transportation to the clinic and said she would attend later. Pukumani was "*noticeably occupied with the card games*". Pukumani was asked whether she no longer wanted the depot, however "*she did not inform this was the case, merely that she would attend the clinic the following day*". At approximately 5.00pm on 30 April, two Registered Nurses were able to administer her depot in the community as she refused to come to the clinic. She was looking well.

A change of medication

20. The Mental Health RN discussed her continuing concerns about Pukumani's disengagement with the service and a deterioration in her wellbeing with Dr Vellar. On 19 May 2021 Dr Vellar conducted a further review of Pukumani and considered that she demonstrated a stable mental state and an absence of psychotic symptoms on her reduced depot dose. However, Dr Vellar was concerned that "*she did indeed have clear tardive dyskinesia with oro-buccal smacking movements intermittently, facial grimacing (dyskinesia) of upper extremity of her face*". Her extremities were also affected. In the circumstances, Dr Vellar considered it appropriate to change her antipsychotic medication (as previously planned) to Aripiprazole. Although Dr Khalid has no independent recollection of discussing this with Dr Vellar, he confirmed he supported this plan.

21. On 24 May 2021, Pukumani attended a consultation with a Rural Medical Practitioner at the Nguiu clinic and her medication was changed to Aripiprazole. She was to receive 3 days of oral Aripiprazole at which time she would be reviewed for a known side effect, akathisia. On 27 May 2021, Pukumani was reviewed by a Registered Nurse at the Nguiu clinic and received her first Aripiprazole 300mg depot. She was prescribed oral Aripiprazole for 14 days (as recommended when

switching to this long acting injectable) and was to receive depot Aripiprazole every four weeks thereafter.

22. On 28 May 2021, Pukumani commenced respite care in Darwin. With Pukumani's consent, a Registered Nurse from the Nguiu clinic wrote to the respite provider, notifying them of her current health concerns and medications, including her oral Aripiprazole prescription.

23. On 9 June 2021, a Case Review was completed by the Mental Health RN and Dr Vellar. The review documented that her self-care had deteriorated over the last six months, and she was at a chronic, moderate risk of psychological deterioration in the context of delayed psychotropic medication administration. Support and contact with the NDIS was identified as a protective factor for Pukumani. However, NDIS had advised local services that they would not facilitate Pukumani's access to respite care in Darwin unless she was up to date with her mental health treatment. There was no plan to discharge Pukumani from the DRMHT at that time. Rather, regular review was recommended.

24. On 28 June 2021, a Registered Nurse from the Nguiu clinic received an after-hours telephone call from St John's Ambulance, who advised that a male had reported his "*nanna is feeling unwell*". A driver from the Nguiu clinic went to four different addresses, including the address provided, but was unable to locate Pukumani. On 30 June 2021, an Aboriginal Mental Health Worker recorded that she had been to three different houses to collect Pukumani for her depot, but she had "*refused from yesterday and today*".

25. On 2 July 2021, Pukumani was reviewed by a Remote Area Nurse at the Nguiu clinic and was administered her Aripiprazole 300mg depot. Other regular medications were also provided, and tests were completed to monitor Pukumani's chronic conditions.

26. On 27 July 2021, Pukumani attended the Nguiu clinic after hours, following an altercation at a local card game. A family member had struck her repeatedly across the back. Pukumani reported experiencing shortness of breath. She was observed to have significant bruising but there was no evidence of underlying lung issues. Pukumani's vital signs were taken, as was a Blood Glucose Level test, and a neurological assessment was completed. Pukumani was given Panadol and Diazepam to help her settle. A mandatory report to police was made.

27. On 28 July 2021, Pukumani was reviewed by a Remote Area Nurse at the Nguiu clinic. The welts on Pukumani's back were reviewed and had improved. Pukumani stated it was "*all ok now*" with her family, and she was "*safe, as she had said sorry to family*". The Remote Area Nurse monitored Pukumani's vital signs, and administered her depot at approximately 3.00pm, two days ahead of schedule but approved by the Mental Health RN. Additional appropriate health interventions were offered and health checks, including Pukumani's BMI, skin, ear, oral and vision tests were completed.

28. Pukumani was subsequently seen by the Mental Health RN, after hours, outside the Nguiu clinic. Pukumani was observed to have a "*settled manner, demeanour*," though she became "*visibly upset initially when talking about her recent assault and family relationships which she describes as not good, currently relaxing and becoming more animated as the conversation progressed*". Pukumani reported that she gets "*cranky*" with her family when she needs her medication and when she has no cannabis. Pukumani acknowledged being upset by the assault. She denied experiencing any changes or concerns with her new medication. She reported ongoing regular use of cannabis, and that she was still enjoying her card games. No symptoms of EPSE were identified. The impression formed was of an "*[a]symptomatic mental state, slightly labile mood related to current family issues*". The DRMHT was to continue to review Pukumani.

Pukumani is taken into care

29. At 2am on Monday 2 August 2021 Pukumani's family contacted the Nguiu clinic requesting assistance. Police and clinic staff attended and found Pukumani naked outside and her family in a commotion. Her sister said that Pukumani had not slept for 4 days, and her family were exhausted. Pukumani was provided medication to help her sleep.

30. The next day she was seen at the clinic, and it was decided to continue to monitor her health in the community. A nurse attended her home at 10.15pm and administered Olanzapine and Diazepam.

31. However, the next morning (3 August) at 10.30am police called the clinic requesting assistance. Pukumani had been found topless and pacing in the street. She was rambling and hearing voices. With police assistance she was coaxed into the ambulance and taken back to the clinic.

32. At the clinic she remained very agitated, but family members assisted clinic staff and throughout the day she was administered Diazepam, Olanzapine, Midazolam, Panadol and IV Haloperidol. The Mental Health RN formed the impression that she was in relapse and presenting with symptoms of hypomania and psychosis. Dr Vellar was consulted, and she was made an involuntary inpatient under the MHRS Act[13] with a plan for her admission to the inpatient unit at the Royal Darwin Hospital.

33. She was administered Propofol and Ketamine before boarding a CareFlight. She arrived at RDH at 12.50am and at 3am on 4 August 2021was admitted as an involuntary patient for up to 24 hours. At 9.10am she was reviewed by Dr Vellar and admitted as an involuntary patient for up to 14 days.[14] He considered she was suffering from a mental illness, namely, acute agitated psychosis.

13 Form 9 and s 39
14 Form 10

34. Given the level of her psychosis and agitation she should have been urgently moved to JRU. However, as there were no beds available in JRU, she remained in the Emergency Department (ED) until the afternoon of 6 August 2021. This was far from ideal, and increased the likelihood that additional medications and sedation, would be used. I will return to her time in ED and the problem referred to as Bed Block later in these findings.

Was the decision to change her medication a causal link to her relapse?

35. The decision to change Pukumani's medication, how the change was managed, and whether the change contributed to her relapse were issues that were scrutinised in the Inquest.

36. Concerning the change of her antipsychotic medication to Aripiprazole, Dr Richard Furst, Forensic Psychiatrist, initially provided this opinion:

> "In my opinion, the decline in [Pukumani's] psychiatric condition in late July-early August 2021 was entirely caused by that switch of medication as Aripiprazole proved to be an ineffective replacement antipsychotic medication for [Pukumani]. Unfortunately, Aripiprazole is well tolerated and has a favourable metabolic profile but is one of the least effective antipsychotic medications currently available in Australia [even though such lack of efficacy may not be obvious from the FDA data/published literature]. In any case, measures to improve the safety of such transitions/switches of depot medications are required and I would endorse the recommendation by the pharmacist reviewing this case in that respect, including the need for oral cover [additional oral medication] during the transition phase when the new depot medication is building up to a steady state."
>
> "It was also unclear as to why Dr Vellar chose a dose of 300mg every 4 weeks, as the standard adult dose for Abilify Maintena is 400mg IM every 4 weeks. Overall, I am of the opinion that the amount of daily antipsychotic medication provided to [Pukumani] throughout June and July was both insufficient and ineffective in controlling her schizoaffective disorder, causing her relapse and ultimately necessitating

> the episode of acute care at the Royal Darwin Hospital in the first week of August that proved fatal."[15]

37. Dr Mitchell did not entirely agree with Dr Furst, and he provided this opinion:

> "…Dr Furst's views on the medication change solely causing Pukumani's decline neglects the more likely formulation of multiple exacerbating factors leading to relapse. In addition to medication change, this would likely have included cannabis use, social stresses, and physical health. The material and relative contribution of each of those factors is now impossible to determine. I would suggest a move away from a dichotomous approach of all or nothing, to one that identifies and respects the myriad of confounding variables that contribute to a deterioration in a patient's mental health."[16]

38. During his oral evidence Dr Furst was provided with some additional information and he slightly relaxed his opinion. While he remained of the opinion that Aripiprazole was generally a less effective antipsychotic, given the serious side effects she was experiencing he was not critical of the clinical decision to trial Pukumani on this medication. He conceded that it may have worked for her and there was no way of knowing until it was tried.[17] Additionally, he accepted that stress from the assault on 27 July may have triggered a psychotic episode in a vulnerable person, and her deteriorating physical health and use of cannabis may have also contributed to the deterioration in her mental health.[18]

39. The RCA Medication Review[19] referred to by Dr Furst specified that an adequate trial before commencing depot Aripiprazole is two weeks (or more) to assess efficacy, whereas Pukumani was only trialled for three days (to assess tolerance and adverse side effects). Further, it also indicated that the normal starting dose is 400mg IM (to be reduced if there are adverse side effects), whereas Pukumani was commenced on 300mg IM. The Review noted that steady state Aripiprazole

15 Expert Opinion, Dr Richard Furst, 31 October 2023, pp 17-18; see also impression of Psychiatry Registrar on her admission into the RDH ED, Progress Note 4/8/21 at 3.27 "…would suggest that transition off her normal Zuclopenthixol to Aripiprazole has contributed to this admission as her last admission was in 2007".
16 Affidavit, Dr David Mitchell, 15 March 2024, at [382(d)]
17 T 131
18 T 130, 134
19 Additional Document Folio 5

concentrations are reached by the fourth once-monthly dose and Pukumani had not reached this stage. Accordingly, I accept that there were concerns as to whether there was sufficient coverage by the new medication to manage her mental illness.

40. Another concern was whether the additional oral coverage was received. Although prescribed and provided, it could not be established that Pukumani had received her 14 days oral coverage while she was in respite. In his oral evidence Dr Vellar agreed that if Pukumani failed to take the 14 days oral coverage it would be a risk factor.[20]

41. It was clearly not ideal to commence her medication change immediately before a period of respite when she could not be monitored by her usual health team, and it could not be confirmed that she was receiving her medication as prescribed. Ideally, the introduction of the new medication should have occurred when it was planned for Pukumani to remain in community and Dr Mitchell agreed with the general proposition that remote teams need to be more proactive in monitoring patients in the community if they are engaging in a significant medication change.[21]

42. The divergence in expert opinions was, however, largely resolved by the oral evidence in the proceedings. I agree with Dr Mitchell that it is not possible to determine an exact causal link between her change in medication, the reported assault on her, her use of cannabis and/or Kronic, and her relapse and it is likely that all those factors in combination, and possibly further unknown factors, played a part. However, giving appropriate weight to the NT Health Medication Review, while I do not find that her change in medication caused her relapse, on balance I am satisfied it was one of the contributing factors.

20 T 53
21 T 237

43. The Medication Review contained recommendations concerning switching antipsychotic medications as follows:

> 1. A switch between antipsychotics in the community should have a clear plan documented;
> a. Reason switch is being considered (e.g. unacceptable weight gain and metabolic risks)
> b. Include trial of tolerability and response to new antipsychotic (if they have responded or trialled an antipsychotic, this should be referenced and the reason for the re-trial)
> c. Initiation plan (e.g. oral coverage)
> d. Monitoring (both for mental state and side effects) during the change
> e. Plan if switch wasn't successful
>
> 2. Administration record in the community (remote)
> a. Administration should include;
> i. Patient identification check
> ii. Medicine name
> iii. Dose
> iv. Route
> v. Batch/expiry if possible
> vi. Second check if possible
> vii. Site
> viii. When next depot is due

44. When Pukumani's medication was changed the plan was not as detailed as that recommended and there was no documented plan in case of deterioration. Importantly a trial as to the efficacy of the new medication was not conducted (but a short trial was conducted to assess for side effects). And the administration of her medication was not documented as recommended in the Medication Review. These are areas for improvement in the future.

45. Pukumani had received considered, appropriate and compassionate mental health care in her community for many years and her mental health had been well maintained. By 2021 she was experiencing dangerous side effects arising from her long-term medication, and I accept that it was appropriate to try her on new medication in the aim of reducing those side effects. In hindsight, it is possible to see that all the circumstances of her medication change were not ideal. However, I

wish to clearly acknowledge the practical difficulties of delivering remote mental health care. In my view, the doctors and nurses (and other staff) involved in her remote care were delivering quality care. While ideal circumstances may be hard to achieve in remote communities, I accept that there are benefits to undertaking medication changes in community as compared to requiring a person to be hospitalised, away from home and family and over a period, to monitor a medication change.

Role of NDIS

46. Pukumani was a recipient of NDIS. From July 2020 Ms Judy Carne was her NDIS Support Co-ordinator through Sacred Business Service. Ms Carne's role was to facilitate referrals to other providers, organise respite care, assist with appointments such as occupational therapists, and report back to the NDIS.[22]

47. Under her NDIS package Pukumani was entitled to access respite care in Darwin twice each year. The approved respite service provider was BDMS Community Services. The service agreement specified that BDMS would provide "*assistance with integrated support for self-care, accommodation, food and activities*".[23]

48. A care worker with BDMS remembered Pukumani. She explained that back in 2021 when Pukumani was in respite, BDMS maintained paper files which included medication records. Although they had searched the paper files, Pukumani's file could not be located. There was, therefore, no record as to whether she had taken her medication during respite in May 2021. I was informed that BDMS now has an electronic records system.

49. Concerning her medication, Ms Carne explained that the respite provider was not required to report on whether Pukumani was taking her prescribed medication, but

22 T 251
23 Additional folio 29, BDMS Community Services NDIS Service Agreement issued 1 July 2020

on reflection she thought that it would be preferable if there was such a requirement.[24]

50. I expect that NDIS service providers generally recognise the importance of their clients taking their medications which are necessary to support their physical and mental health. I consider that it would be preferable if there was formalised arrangement for recording and sharing this information between case workers, service providers and health providers. NT Health suggested that to ensure there are appropriate and sufficient records and communication, a review could be conducted by the Director of Allied Health of the current arrangements between NT Health and NDIS service providers that are funded by NDIA, to identify and, if considered necessary, to formalise and strengthen those arrangements.

CAREFLIGHT

CareFlight and the use of Ketamine

51. The RCA Medication Review identified that during her CareFlight evacuation Pukumani received Ketamine 150mg IV and Propofol 600mg IV and commented, "*Although this combination is often used during transport for mental health evacs, I am not sure if the final study from CareFlight has been completed and published. In general, Ketamine can exacerbate schizophrenia*".

52. Dr Vellar shared that view. He said:

> "Ketamine in itself can cause an exacerbation of psychosis. But not only that, it has an unusual phenomenon whereby there is a post administration withdrawal effect which can create behaviours that are consistent with or exacerbate psychosis. So that's one reason why it is not commonly used for patients who are acutely psychotic…I wouldn't entertain the idea of utilising that agent for a patient with an existing major mental illness such as schizophrenia".[25]

53. Similarly, Dr Khalid opined:

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24 T 260
25 T 60-61

> "I've seen multiple cases who are transferred by CareFlight and being given Ketamine and I've seen enough cases that concern me that there is an emergence of acute behavioural disturbance after Ketamine. I've come across a number of patients who are well known to me for many years, and I've seen them unwell. I've seen them psychotic. So I have a fair understanding of how they will present when they are unwell or well. After Ketamine I've seen a number of cases that present who are totally different and unpredictable. And I've got concerns about Ketamine use during CareFlight. And I've expressed this on a number of forums, and I've spoken to CareFlight, especially when [they] ring me about a transfer of patient to discuss the mode of transfer. …. In recent years, after a number of discussions at departmental level or my level, there is less use of Ketamine in CareFlights in the last few years…
> There is evidence on Ketamine use in schizophrenia and often it is even quoted as contraindicated in patients with established psychosis or established schizophrenia. Because there is prolonged emergent syndrome…that can mimic very much like psychosis, acute agitational state, behavioural disturbance and delirium like picture.
> …
> The picture we were seeing in [Pukumani] was quite different, how agitated, driven and pacing and extremely difficult she was…It's difficult to point out only one factor in this case. There are a number of factors. And one factor I still have to think about is whether Ketamine use was appropriate."[26]

54. Following this evidence a statement was provided by Dr James Hooper, NT Medical Director and Medical Retrieval Consultant, CareFlight, and a Specialist Anaesthetist at RDH. The statement was prepared with "*input from Dr Toby Fogg (CareFlight National Medical Director) and Ms Jodie Mills (CareFlight NT General Manager)".*[27] This statement referenced trials and reports concerning the use of Ketamine in medical retrievals and identified the benefits of Ketamine compared to some other types of sedatives in this context. In particular:

> "Respiratory: Ketamine is well known to preserve respiratory drive, even in large doses. Therefore, despite sedation, patients will normally continue to breathe effectively which makes it a very favourable drug as the negative side effects are rarely encountered. In 1-2% of cases laryngospasm (involuntary closure of the glottis) may occur, resulting in inability to breath normally. This is typically transitory and rapidly responsive to assisted ventilation (Alotaibi et al. 2023)"

26 T 93-94
27 Additional Documents Folio 32

55. Dr Hooper's statement also referred to an unpublished study undertaken by CareFlight:

> "Between September 2016 and September 2020, a clinical trial was undertaken at CareFlight NT to examine the safety of Ketamine and Propofol for the sedation of acutely unwell patients with psychiatric symptoms or psychosis. One hundred and twentyfive patients met the inclusion criteria and were administered either Ketamine or Propofol sedation.
> Key outcomes were:
> • There was no suggestion of post flight complications
> • An airway manoeuvre was required for 16 patients, of which 13 had received Propofol
> • In-flight complications were minor and all managed effectively. These included a reduction in blood pressure or oxygen saturation, and these were slightly more prevalent in the Propofol cohort."

56. Dr Mitchell, who has been an air retrieval officer, considered that while there were both pros and cons concerning the use of Ketamine in patients with psychosis, there are reported articles on its safety profile.[28]

57. That there were genuinely held concerns about the use of Ketamine in psychiatric retrievals was only clearly identified as a potential issue during the oral evidence. In those circumstances there was insufficient opportunity to fully investigate the matter. Based on the limited information available to me, I agree with Dr Vellar who considered there should be further discussions between NT Health and CareFlight as to whether and, if so, when it is appropriate to use Ketamine for the transport of schizophrenic and/or psychotic patients.

THE EMERGENCY DEPARTMENT

An extended stay in the Emergency Department

4 August 2021

28 T 219

58. After being transported by CareFlight, Pukumani arrived at the RDH ED at 2.00am on 4 August 2021 and she was admitted to a resuscitation room. Her medical notes indicated that she had received Propofol and Ketamine sedation during her CareFlight and that she suffered from schizophrenia and COPD. A psychiatric review was requested.

59. At 2.30am she was seen by the on-call Psychiatry Registrar. His plan for her management was admission to the Mental Health Inpatient Unit, the allocation of a 1:1 Personal Care Assistant, and for observations to be completed every 15 minutes. The Psychiatry Registrar completed a Form 10 Examination and admitted her as an involuntary patient on the grounds of mental illness.[29]

60. Involuntary mental health patients in ED are allocated ED based security provided by and referred to as MSA. There are also hospital-wide security staff, referred to as security. There are also Personal Care Assistants referred to as PCAs. I understand that PCAs are available for mental health patients in inpatient units. I understand that in the ED it is more likely an involuntary mental health patient will be allocated one or more MSAs. Sometimes a 1:1 is referred to as a "*security special*".

61. It was very difficult in ED to manage and provide appropriate care in response to her challenging, mental ill-health driven, behaviours. According to her nursing Clinical Progress Notes[30] at:

    - 5.20am she fell from a wheelchair on her way to the toilet. The Mental Health treating team were notified.
    - 6.06 she was distressed and agitated++, and not following directions.

29 Folio 19 Medical records PDF p 60

30 Times noted are taken from the clinical progress notes which should reflect the time the note was made, not the time of the event

- 6.25 a duress alarm was activated when she got out of bed, over the handrails. She was returned to her bed with the assistance of security. They remained by her side.
- 6.55 she was very distressed and needing to go to the toilet. Because of her high falls risk, she was offered a bedpan which she refused.
- 7.50 she was elevated and shouting and believed staff were trying to kill her. There were three security present.
- 9.10 there were two security present.
- 10.45 she was alert, agitated, pressured but settled.
- 12.30pm she ate a sandwich, was calm and somewhat cooperative.
- 1.50 she was calling for family but easily distracted and she remained relatively calm until 4.12pm when she became increasingly agitated, aggressive and yelling. She could not be adequately de-escalated.
- 4.53 she got out of bed. Because there were concerns about falls, nurses and an MSA "*assisted her to the floor*" where she was verbally de-escalated. She was assisted to a red chair and settled during dinner.
- 5.27 she suddenly threw her plate and walked through the ED looking for family She was able to be partially guided back to the Resuscitation Room but "*pulled away when MSA went to stabilise patient*" and she fell onto the ground. Multiple security and MSA assisted to lift her onto a bed. She was verbally de-escalated and ate a sandwich.
- 6.11 the duress alarm was activated by an MSA as she was trying to get out of bed. Two security officers were present.
- From 7.45 until the next morning, she slept. (Which must have been a great relief to her, the staff and other patients in ED.)

62. From time-to-time members of her Mental Health team attended ED to make plans for her admission, care and medications, to assess her and to assist in calming her. Throughout her time in ED, Dr Vellar was her treating psychiatrist, and he spent

lengthy periods of time with her de-escalating her behaviours and encouraging and supporting her to receive medication and permit observations.

63. At 8.15am a clinical team meeting was conducted with the plan of inpatient admission confirmed. At 9am her case management was transferred to the Red Team, so she was under the care of Dr Vellar and Dr Khalid who knew her well, and a Management Plan for Mental Health Outliers (Mental Health Inpatients who did not have a bed in a mental health ward) was completed. At 9.10am Dr Vellar documented the plan to:

> (a) Admit her under section 39(3) of the *Mental Health Act.*
> (b) Admit her to the Joan Ridley Unit (JRU) (priority admission).
> (c) Normal Psychiatric observations in JRU. Security Special whilst in ED.
> (d) Vital observations as charted, namely, requires ongoing monitoring of vital observations hourly for 4 hours, then 2nd hourly for 8 hours, then QID [4 times a day or every 6 hours] observations thereafter given psychotropic load.
>
> [Emphasis added]

64. Although she was identified for priority admission to the JRU there were no beds available. She therefore remained in ED as a mental health outlier. The impact of Bed Block on her care will be considered in further detail later in these findings.

65. At this early juncture and throughout her time in ED, Dr Vellar was aware and documented that Pukumani was receiving high doses of multiple medications to manage her acute psychosis. This was of concern. Dr Vellar factored this 'psychotropic load' into her vital observation schedule and recognised that her medications needed to be carefully considered and managed. This critical aspect of her care will also be considered later in these findings.

5 August 2021

66. On 5 August 2021 the challenge to provide appropriate care in ED continued, at:

- 7.50am she was woken for breakfast, she swore, spat, kicked and punched staff. She was incoherent, rambling and not responding to verbal or environmental de-escalation. A Code Grey was called, she was deemed to be unsafe to herself and others and was moved to the resuscitation bay and partially sedated.
- 8.30 she was agitated ++++, rambling+++, making no sense and repeating "*Fxxk off*". She refused observations and this behaviour continued through to 10.55 when she fell asleep briefly. When staff attempted to monitor her breathing she woke, swore and was agitated.
- She calmed down a little over lunch from 12.13pm but her agitation returned at 2.10.
- She was moved to the Oleander Room with two security officers present. She shouted and swore and refused her observations.
- 4.20 she was seen by the after-hours psychiatric coordinator in the Oleander Room with 2 security officers present.
- 7.45 she was seen by the on-call Psychiatric Registrar agitated, lying in the corridor and disruptive to ED. She returned to the Oleander Room but did not go to sleep.
- 10.15 she was agitated, escalating and "*banging on the door*," she refused medication and appeared "*groggy on her feet*".
- 10.45 she was increasingly agitated and asking for water. "*When door of room opened [patient] pushed past security + nurse. Taken back into Oleander Room by 3 x security. Not for IM this time*".
  [Oleander Room emphasis added]

67. Both her time in the Oleander Room, and her medication throughout the day, will be discussed further, later in these findings.

68. Similarly to 4 August, from time-to-time on 5 August she was reviewed and/or assessed by members of the mental health team. At about 9am Dr Lehmann-Waldau, Consultant Psychiatrist, reviewed her file and medications but he did not

see her. He noted that her acute psychosis was treatment resistant and questioned whether she had a medication induced delirium. He planned to discuss her treatment with Dr Vellar and noted that she needs a JRU bed.

69. At 11.50am Pukumani was reviewed by Dr Vellar, who observed that: "*[Pukumani] presents with florid psychotic spectrum symptoms; delusions & persecution, auditory hallucinations, disorder & thought stream…"* and noted "*ongoing extreme behavioural disturbance requiring psychotropic management*". He documented that she required "*firm boundaries*" due to "*underlying antagonistic personality traits, which require firm direction (due to entitlement and demanding behaviour)".*

6 August 2021

70. On 6 August the challenges in ED continued for Pukumani and the ED staff, at:
    - 2.20am she was banging on the door (presumably of the Oleander Room) but failed to respond to nursing staff and she refused observations. She was walking around (I infer in the Oleander Room).
    - By 6.27 she was a little more settled and sitting on the bed but when approached she started yelling and refused medication and was left to calm down.
    - 8.30 she refused medication, and she was kicking at the door, she was verbally and physically aggressive.
    - 8.40 she forced herself past 3 MSA guards at the Oleander Room. The security caught up to her and she fell. She refused the efforts of nurses to get her to return to return to the Oleander Room and the security officers assisted her to her feet and took her back to the Oleander Room.[31]
    - 9.00 her file was reviewed by Consultant Lehmann-Waldau who noted she was in the Oleander Room with security present, in seclusion, and seclusion forms needed to be done.

31 Affidavit, Dr David Mitchell, 15 March 2024, at [259]

- 10.00 3x Security were present and Pukumani was expressing frustration at her prolonged seclusion in the Oleander Room. The MHET team started the seclusion section paperwork. It seems she may have left the Oleander Room as it is noted she lay done in the CIN area and was irritable +++ and unable to be redirected.
- 11.30 Security gave her an intramuscular injection and she was briefly more settled.
- 12.56 a duress was activated as she was exit-seeking and security attended.
- 1.40pm she was trying to leave room but sat back on the bed when given sandwiches. Her risk assessment was 4 (Code Grey) but as she was "*apparently re-directable*" she was only to be watched closely.
- 3.00 a bed finally became available in JRU.

71. Similarly to the previous days, from time-to-time Pukumani was assessed by members of the mental health team. At 9.00am Dr Lehmann-Waldau noted she was in seclusion in the Oleander Room and the seclusion paperwork need to be done. At around 10:30am the MHET Senior Registrar contacted Dr Khalid concerning her medication, and Dr Khalid asked Dr Vellar to review her and determine the appropriate further management options. At 11.05am Dr Vellar documented that he had reviewed Pukumani in the Oleander Room. Dr Vellar observed that she was "*posing significant management difficulties due to behavioural disturbance secondary to her psychotic relapse*". It was noted that she was refusing medications that day and was "*very difficult to persuade*". He determined that Pukumani "*require[d] ongoing intermediate acting antipsychotic due to difficulty with medication administration*". Dr Vellar's impression remained of "*Acute psychosis*", and his plan for Pukumani's management was as follows:

    (a) continue section 39(3) under MHRSA
    (b) security 1:1 whilst in RDH
    (c) urgent JRU bed
    (d) Zuclopenthixol acetate (indicated). Note ECG adequate on 5/8/21. 100 mg IMI stat
    (e) Re-direct – use positive reinforcement strategies for behaviour concordance.

Was Pukumani secluded in ED?

72. At about 2.10pm on 5 August Pukumani was given a bed in a sparsely furnished single room attached to ED called the Oleander Room. It contained a mattress on the floor[32] and a couch. There are two doors to the room which require swipe cards to operate, and the third main door (opposite the Resuscitation Bay) cannot be locked and is normally left open. As I understand it, the doors have windows so a person outside the room can see into the room even when the doors are closed. It is quieter and provides a less stimulating environment than a bed directly in ED. Accordingly, it is a room that is regularly used for mental health patients who would benefit from a less stimulating environment.

73. Normally patients are free to come and go from that room and the main door is left open. At least initially, this seems to have been the case for Pukumani. For example, at 7.45pm she was lying in the corridor of ED and being disruptive and was redirected back to her bed in the Oleander Room. However, a question arose as to whether at some point her liberty was curtailed. The question arose as to whether, and if so, when, she was placed into seclusion.

74. Seclusion is a specific word with a specific meaning for mental health patients. It is defined in the MHRS Act as "*the confinement of the patient at any time of the day or night alone in a room or area from which exit is prevented*". Section 62 provides that patients must not be kept in seclusion except in accordance with this section and approved procedures. Very briefly, seclusion may only be used when no other less restrictive method of control is appropriate and it is necessary for the purpose of medical treatment, to prevent injury, to prevent the persistent destruction of property or to prevent absconding. Its use must be approved by an authorised psychiatric practitioner, or in an emergency, by the senior registered nurse on duty. If implemented there are requirements for review and

32 T 282, Registered Nurse

documentation and the patient must be released from seclusion without delay when it is no longer necessary.

75. As noted earlier in these findings, during the evening of 5 August 2021 Pukumani was given the bed in the Oleander Room. At 10.15pm she was banging on the door (and I infer it was closed). At 10.45 she asked for water and when the door of the room was opened (and I infer it had been closed) she pushed past security and the nurse, she was taken back into the room by three security (and I infer she was not free to move around ED and there were security standing at her closed door). At 2.30am on 6 August 2021 she was banging on the door (and I infer it was closed) but refused to answer questions. At 6.27 she was sitting on the bed, yelled, and was left to calm down. At 8.40 she forced herself past 3 MSA security and when she refused to return to the Oleander Room the security took her back (and I infer she was not free to leave the room or remain in the greater area of ED). These are not simply my inferences; they are consistent with the reviews conducted by the MHET Senior Registrar and Dr Vellar who reported her seclusion to Dr Khalid, and Dr Khalid's own review of the notes.[33]

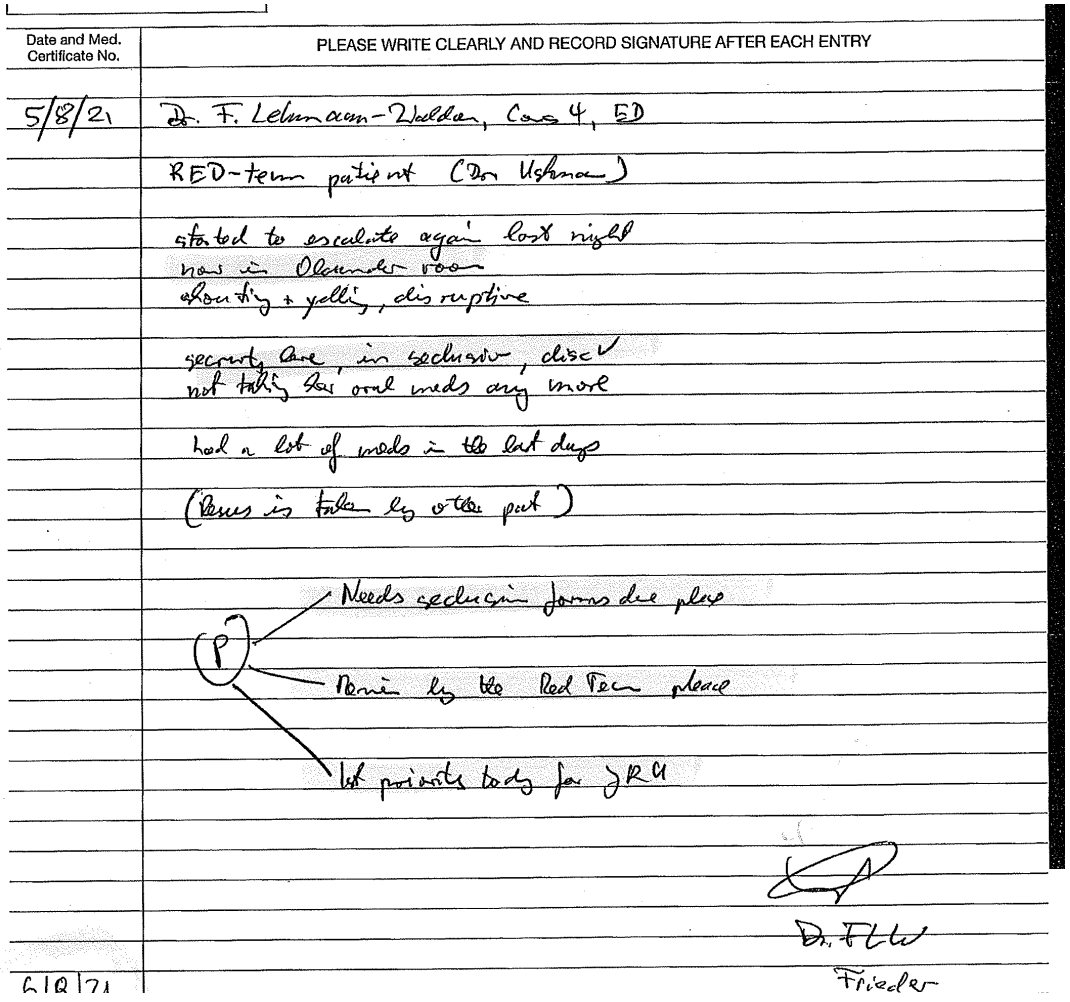
76. The nurse who made those Clinical Progress Notes provided an affidavit, some three years later, in which she said that she had no independent recollection of the events but that she understood "*that seclusion is when a patient is held within a room and is unable to leave, for example because the door to the room is locked, or because staff physically stop the patient from doing so. Seclusion cannot occur without the authorisation from a psychiatry registrar, and I am aware that paperwork must be completed if seclusion is authorised*". Relying on the notes in the medical records she was of the view that "*there is nothing in my notes that indicates to me that Pukumani was secluded that evening, and I expect I would remember a seclusion if it had occurred. I would also have had to complete paperwork in relation to it. I do not believe Pukumani was secluded while I was*

33 T 101; as to my inferences they are drawn from a full review of the notes and evidence, I am not persuaded by alternative explanations such as proffered in Additional Documents Folio 28, Affidavit, Dr Andrew Wren, 2 April 2024, at [29], [39]

present in the Emergency Department".[34] In light of her lack of independent recollection, this nurse was not called to give further oral evidence.

77. I am not persuaded that the existence or otherwise of seclusion paperwork is determinative of the question as to whether Pukumani was secluded. That there was no paperwork might indicate that she was not in seclusion, or it might indicate that the required paperwork was not completed.

78. Sometime around 9am on 6 August 2021[35] Dr Lehmann-Waldau attended ED and made the following notation in Pukumani's medical records:



Date and Med. Certificate No.

PLEASE WRITE CLEARLY AND RECORD SIGNATURE AFTER EACH ENTRY

5/8/21 Dr. F. Lehmann-Waldau, Case 4, ED

RED-term patient (Dr Usman)

started to escalate again last night
now in Observation room
shouting + yelling, disruptive

security are in seclusion, discr
not taking for oral meds any more

had a lot of meds in the last days

(Issues is taken by other part)

P

Needs seclusion forms due please

Remain by the Red Team please

1st priority body for JRC

Dr. F Lw

Frieder

6/8/21

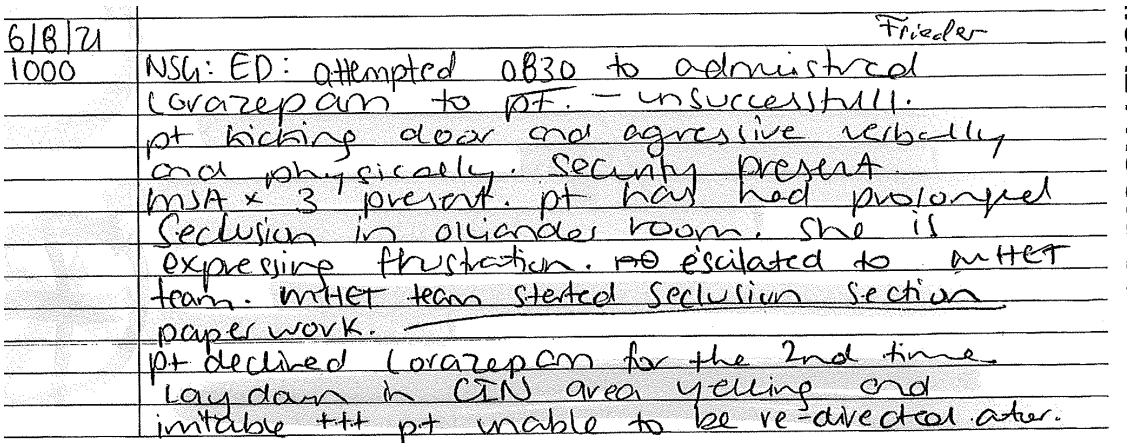
34 Affidavit, Registered Nurse, 18 April 2024 at 56,58.59], Additional Document Folio 30

35 T 318, it is accepted that the date of 5/8/21 in the records is wrong and the correct date was 6/8/21

79. Dr Lehmann-Waldau provided an affidavit dated 21 March 2024.[36] He could not recall Pukumani or the events of 6 August 2021 but interpreted his and other medical records. He said, "*seclusion is when a patient is put in a confined space and prevented from leaving (for example, locking a door or physically preventing someone from leaving)".* It is usually used to de-escalate an aggressive patient. It is an intervention of last resort. He attached the hospital policies and procedures concerning seclusion to his affidavit.

80. Concerning his record (extracted above) he said that Pukumani had been secluded in the Oleander Room prior to his arrival in ED. He did not see Pukumani but discussed her with the nursing staff and recorded what they were reporting to him. Because it was unusual for someone to be secluded in the Oleander Room, he noted that the Resuscitation Room was taken. He noted that the seclusion forms were missing and reminded the nursing team that they needed to be completed. He said that scenario was "*not uncommon, because if you are in the drama of doing stuff...patient comes first, paperwork comes second".*[37] He could not recall the nurse or nurses that he spoke to. I consider that it was clear from his records and his evidence that the lack of paperwork did not cause him to doubt that Pukumani was in seclusion.

81. At 10am a registered nurse made this notation:


6/8/21 1000

Frieder

NSG: ED: attempted 0830 to administered Lorazepam to pt. – unsuccessfull. pt kicking door and agressive verbally and physically. Security present. MSA x 3 present. pt has had prolonged Seclusion in oliander room. She is expressing frustration. ~~no~~ escilated to MHET team. ~~MHET~~ team stated Seclusion section paper work.

pt declined Lorazepam for the 2nd time. Lay down in CTN area yelling and irritable +++ pt unable to be re-directed atm.

36 Additional Document Folio 27
37 T 319

82. This nurse provided an affidavit dated 23 April 2024[38] and gave evidence. In effect she explained that at that time she was a junior nurse and did not appreciate the technical difference between involuntary patients and patients in seclusion. She said that in these notes she should have used the word 'admission' instead of 'seclusion'. Given the time that has passed, while I accept that this nurse was doing her best to assist me, I do not find this explanation persuasive. For example, where she recorded "*MHET team started seclusion paperwork*" becomes nonsensical if 'seclusion' is replaced with 'admission'. Pukumani had been admitted a full 2 days earlier.

83. At about 10.30am the MHET Senior Registrar contacted Dr Khalid about "*ongoing management of [Pukumani] who was reportedly very unsettled and agitated in the emergency department (and had required seclusion over night due to her acute agitation)".* [39] The Senior Registrar asked if additional medication could be administered, and Dr Khalid said he would ask Dr Vellar to review her urgently. When the MHET Senior Registrar reported to Dr Khalid, I am confident that she well understood what seclusion meant and was using the term with precision.

84. Dr Vellar attended, and he also reported to Dr Khalid that Pukumani "*had been inappropriately secluded in the Oleander Room of the Emergency Department with behaviour escalating over the preceding night and presented significant management issues for staff and patients (in a code yellow) situation*".[40]

85. In his evidence Dr Vellar explained that when he attended ED, he reviewed the file and discovered that Pukumani had been secluded overnight and was still in the Oleander Room. He said:

> "I immediately advised staff…that that was inappropriate and … that we'd open the door, and I went in and reviewed her…

38 Additional Document Folio 33
39 Statutory Declaration, Usman Khalid, 16 November 2021 at p 3
40 Statutory Declaration, Usman Khalid, 16 November 2021 at p 3; T 61, Dr Vellar

> It's my understanding that one of the mental health workers or nursing staff opened the door and I came some moments later.
> I found a very distressed lady who'd been secluded, but who was actively responding on account of her psychopathology…"[41]

86. Dr Vellar further explained:

> "For the process of secluding a patient there is a requirement under the Mental Health Act to inform – to be signed by a doctor – a designated medical practitioner, who will then inform the treating team that that's occurred, so that ongoing checks of the patient can occur whilst they are in seclusion. It's my belief that staff within the Emergency Department were unfamiliar with that because she was in the Oleander Room, which is a room for patients with mental illness…There's two doors there, and its my understanding both of those were closed with the security officers outside. So that technically means she's secluded. So she has no way of coming out of the room if she chose to". [42]

87. The question of seclusion was not addressed in the RCA, nor in the institutional response of Dr Mitchell.

88. In its submissions, NT Health reminded me of the relevant standard of proof in accordance with *Briginshaw v Briginshaw*[43], submitted that the evidence was insufficient to conclude that Pukumani had been secluded, and strongly cautioned me against such a finding. While I accept there is some divergence in the evidence, I was comfortably satisfied that the evidence of the mental health practitioners established that she had been secluded, even if this had not have been properly understood as seclusion on the night by the ED staff. Her seclusion was contemporaneously reported to and accepted by Dr Lehmann-Waldau who noted it in her medical records and "*reminded*" the nursing staff that they were required to complete the appropriate documentation. It was contemporaneously reported to Dr Khalid by a Senior Psychiatric Registrar who attended on Pukumani, spoke to staff and reviewed her records. It was contemporaneously reported to Dr Khalid by Dr Vellar who attended, reviewed her records and spoke to staff. Ultimately it was

41 T 59-60
42 T 57
43 [1938] HCA 34

he who directed that the door be opened. Where the evidence of the mental health practitioners differs from the ED nurses, I prefer and accept the evidence of the mental health practitioners.

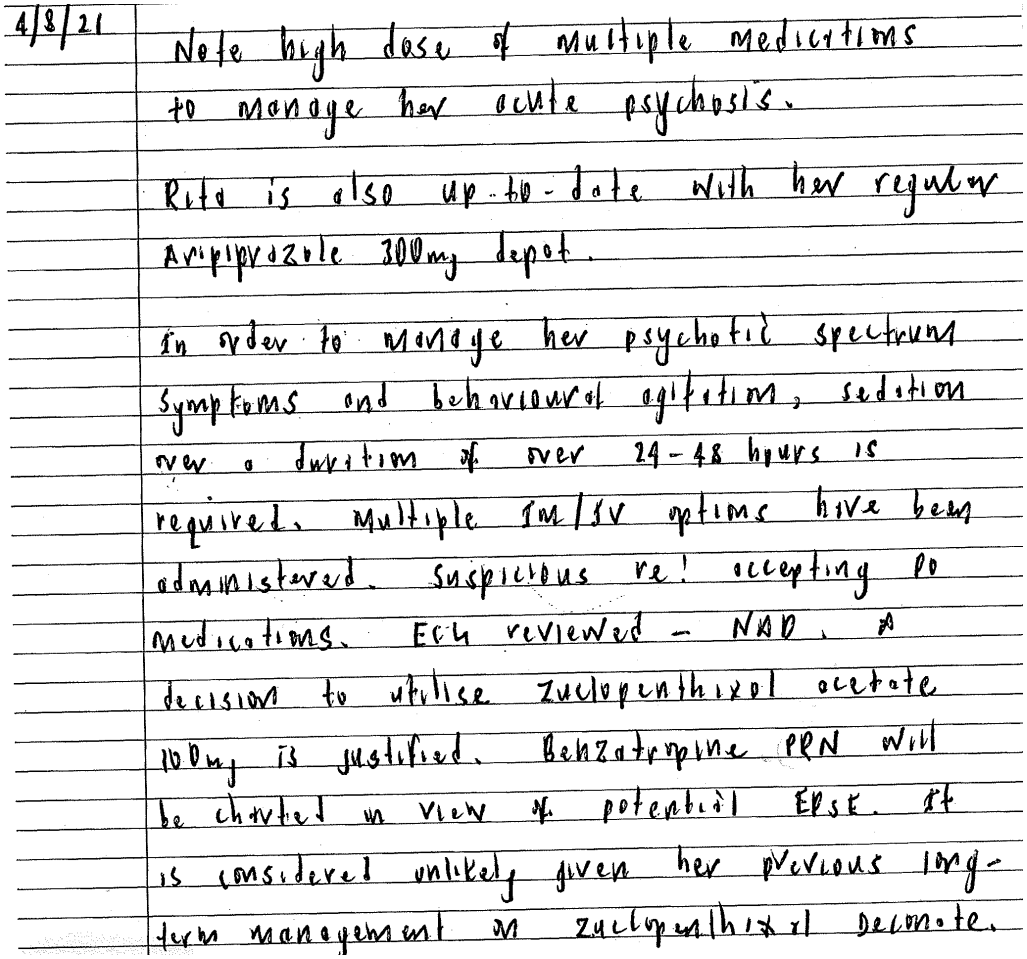
89. I am satisfied that she was, in practical effect (and whether this was understood by the ED staff), secluded in the Oleander Room and was not free to leave it from approximately 10.15pm on 5 August 2021 when she was banging on the door, until sometime around 10am on 6 August 2021 when Dr Vellar directed that the door be opened. I note that at 10am there is an entry in the Clinical Progress Notes that she lay down in CIN and refused Lorazepam, and I accept that she was not in seclusion when that occurred, and the door must have been opened by then. However, given that the notes record the time a notation is made rather than the time the event occurs, I cannot determine with any precision the time that her seclusion ceased. Confusion about when it started and ceased was because seclusion paperwork was not completed.

90. While I make no findings that the seclusion was inappropriate per se, the evidence establishes that her seclusion did not comply with the requirements of s62 of the MHRS Act, and it did not comply with RDH policy and procedures. I was unable to determine who made the decision to effectively impose seclusion or whether they appreciated that was the legal effect of what they were doing. It is possible that her seclusion arose almost organically from a combination of decisions and decision makers. However, I accept the evidence of Dr Vellar that the breach of the legislation (and concomitant policies and procedures) likely arose from a lack of knowledge and training as to the definition and requirements concerning seclusion among the staff in ED on 5 and 6 August 2021.

91. I find that seclusion was not a contributor to her death, but instead provides further evidence that her prolonged stay in the ED was not only terribly inappropriate for her quality of care, but her circumstances also placed unreasonable, and at times seemingly unmanageable, burdens on the overstretched ED staff.

Medications in ED

92. When Dr Vellar first assessed her in ED at 9am on 4 August 2021, he was acutely aware that she had been receiving "*high doses of multiple medications to manage her acute psychosis*" and he attempted to reconcile her medications to date (including from her time at the Nguiu clinic and during her CareFlight). This was part of his first entry into her notes at 9.10am:


4/8/21

Note high dose of multiple medications to manage her acute psychosis.

Rita is also up-to-date with her regular Aripiprazole 300mg depot.

In order to manage her psychotic spectrum symptoms and behavioural agitation, sedation over a duration of over 24-48 hours is required. Multiple IM/IV options have been administered. Suspicious re! accepting PO medications. ECG reviewed - NAD. A decision to utilise Zuclopenthixol acetate 100mg is justified. Benztropine PRN will be charted in view of potential EPSE. It is considered unlikely given her previous long-term management on Zuclopenthixol Decanoate.

93. Sometime before 10am on 5 August Dr Lehmann-Waldau questioned the possibility of a differential diagnosis of medication induced delirium.[44] This was discussed with Dr Vellar and it was decided to stick with her medication management plan and, if additional sedation was required, to utilise the Rapid Tranquilisation Protocol.[45]

44 T 313

45 Clinical Progress Notes, 5 August 2021 at 11.50am

94. The treating doctors understood that Pukumani was receiving high dosages of multiple medications and that this had to be managed over a prolonged stay in ED. This was being actively discussed and monitored. But it was challenging to identify and reconcile all her multiple medications which were administered by the Nguiu clinic, CareFlight and then in the ED. And it was challenging, if not nigh impossible, to manage her condition and driven behaviours in ED without medication. But this approach gave rise to additional medication-induced risks.

95. Following autopsy and the receipt of the toxicology report, it was the Forensic Pathologist's opinion[46] that Pukumani passed away from acute respiratory failure in the context of chronic obstructive pulmonary disease and multiple antipsychotic and sedative medication administration. She strongly recommended a clinical review considering the following:

> • Toxicological analysis of a hospital admission blood sample showed the presence of multiple sedatives (midazolam and diazepam), anti-psychotics (olanzapine, aripripazole, and haloperidol), Ketamine, paracetamol, and a cannabis metabolite; and a post-mortem blood sample, collected 1 day after death, showed the presence of anti-psychotic (zuclopenthixol, olanzapine, haloperidol, and aripripazole) and sedative (lorazepam and diazepam) medications.
>
> o Zuclopenthixol was measured at a high, and potentially toxic, concentration in the postmortem blood sample. Manifestations of zuclopenthixol toxicity include prolongation of the QT interval and induction of cardiac arrhythmias. However post-mortem redistribution may occur with zuclopenthixol, and the drug concentration has to be interpreted with caution, as it may just be an indication of recent therapeutic exposure. In this case, the post-mortem interval was short (1 day), and the body was refrigerated soon after death. There is a warning against the use of zuclopenthixol in patients with chronic obstructive pulmonary disease.
>
> o Anti-psychotic use is associated with an acute and dose-dependent increased risk of acute respiratory failure in patients with chronic obstructive pulmonary disease, and caution should be exercised when prescribing anti-psychotics to patients with chronic obstructive pulmonary disease.
>
> o In addition, the use of benzodiazepine receptor agonists is a significant risk factor for respiratory failure in patients with chronic

46 Dr Marianne Tiemensma, Post-Mortem Examination Report for the Coroner, 4 November 2021, pp 2, 3

obstructive pulmonary disease. A known adverse effect in the use of benzodiazepines is respiratory depression, which may worsen sleep related hypoventilation, especially in patients with underlying pulmonary diseases.

[References excluded]

96. As referred to earlier, a thorough Medication Review was prepared for the RCA. These reviews identified that between the Nguiu clinic, CareFlight, ED and the JRU, Pukumani had received over 60 discreet medication administrations. Both CareFlight and ED attempted to reconcile her medications when she transferred into their care. However, both failed to consider her Aripiprazole long-acting regular depot medication (received in Nguiu) and ED failed to consider the Ketamine received during CareFlight.

97. On 2, 3, 4 and 5 August 2021 she received combinations of high dose antipsychotics, and her cumulative dose was well above the recommended maximum dose. Her day of highest risk was on 4 August 2021 when she received four different antipsychotics (Aripiprazole, Droperidol, Olanzapine and Zuchlopenthixol acetate), and three different benzodiazepines (Diazepam, Lorazepam and Midazolam). The Medication Review contained this warning:

> "The benefit of using high dose or multiple antipsychotics have not been demonstrated by robust literature (except in the instance of clozapine in combination). The risk of high dose, multiple antipsychotics and the potential for adverse events is well known. During my review, I have used the definition that 'High dose' can result from the prescription of either: a single antipsychotic in a dose that is above the recommended maximum, or two or more antipsychotics that, when expressed as a percentage of their respective maximum recommended doses and added together, result in a cumulative dose of >100%.
>
> There is no firm evidence that high doses of antipsychotics are any more effective than standard doses. This holds true for the use of antipsychotics in rapid tranquillisation, the management of acute psychotic episodes, chronic aggression and relapse prevention.
>
> The majority of side-effects associated with antipsychotic treatment are dose related. These include EPS, sedation, postural hypotension, anticholinergic effects, QTc prolongation and sudden cardiac death. High-

> dose antipsychotic treatment clearly worsens adverse effect incidence and severity.
>
> The decision to use high dose should include ongoing close physical monitoring, including ECG's. The documentation of reason for using high dose and descriptive targeted symptoms should be noted."[47]

98. In the detailed Institutional Response prepared by Dr Mitchell,[48] he described the numerous reviews and updates of RDH policy and procedure concerning the administration and reconciliation of medications for TEMHS patients. Of note, the Lead Pharmacist at TEMHS has undertaken to review relevant NT Health wide policies, with the author of the Medication Review, to ensure that the learnings are incorporated into TEHMS and TEHS (Top End Health Service) policies and procedures.

99. Dr Mitchell also identified that the Medication Review advocated for a pharmacist to be included in discussions with the treating team on risks, co-morbidity considerations, interactions and alternatives. There was only one pharmacist dedicated to providing inpatient and outpatient assistance to TEMHS patients when Pukumani passed away. This has now been increased to three, and I am told there is now considerably more capacity for pharmacist engagement with TEMHS patients. I am advised that a pharmacist is now included in the weekly inpatient multidisciplinary meetings which provides an opportunity for practitioners to raise complex cases and for pharmacists to provide individualised advice.

Bed Block in the JRU

100. Everybody involved in Pukumani's care absolutely understood that she could not get the most appropriate care in ED. Dr Mitchell said this:

> "Best practice when admitting a known mental health patient into treatment, following a deterioration in their mental health, is direct admission to the least restrictive inpatient unit or facility, appropriate to their current level of risk.

[47] Additional Document Folio 5, Medication Review, p 10
48 Affidavit, Dr David Mitchell, 15 March 2024, Additional Document Folio 23

> Where an Emergency Department admission is required, until a bed in an Inpatient Unit becomes available, that admission should not extend ideally beyond four hours. Most hospitals monitor admissions against a four-hour National Emergency Assessment Target (NEAT), an eight-hour target and a 24-hour target.
>
> An Emergency Department is not an appropriate location for the management of mental health patients, beyond an initial medical and psychiatric assessment, because the physical environment and activity that occurs within that Department is not conducive to a therapeutic engagement. Emergency Departments are potentially highly stimulating and disorientating environments where there is the risk of exacerbating psychiatric illness and can, by their nature, be further traumatising."[49]

101. During her ED admission the ED was overwhelmed, as described by Dr Mitchell:

> "Pukumani's care on 5 August 2021 was provided against a background of 11 other mental health patients waiting for admission into the Emergency Department, as well as eight patients double bunked within that Department. The Emergency Department was described as "critically overcrowded… with multiple patients awaiting admission overnight, this resulted in extremely long wait times e.g. 2-3 hours for assessment of CAT 2 patients."[50]

102. Part of the reason for the ED being overwhelmed and the reason Pukumani remained there for so long was because of Bed Block in the JRU. The JRU was full and there were no beds available in an inpatient unit for either Pukumani or the 11 other mental health patients stuck in ED or general wards as Mental Health Outliers. Regrettably, this is not uncommon.[51] There are simply never enough inpatient mental health beds. In oral evidence Dr Mitchell said:

> "…We have a Bed Block issue. In any given time, there are five to ten patients … waiting for these high-dependency beds. We need more than just a short-stay unit. We need more beds . . . We don't necessarily need anything really fancy. We just need more beds…
>
> The Northern Territory has 17 beds per 100,000, … compared to every other state and jurisdiction, which has about 30, and the highest being

49 Affidavit, Dr David Mitchell, 15 March 2024, at [290-292]
50 Affidavit, Dr David Mitchell, 15 March 2024, at [294]
51 Similar evidence was heard in the *Inquest into the death of Xysz Tacdliwaazy @ Josh Ngalarina @ Mayinaj* [2024] NTLC 3 at [47]

about 36. So we have half the available beds of every other jurisdiction. It's a terrible narrative. We also have double the mental health burden. It's about 14 percent of total disease burden…these are well known facts, and this has been the case for years. On top of that, we also have bed flow issues of just the general population. So we have 50 to 60 older-age patients that are sitting within the Royal Darwin Hospital - a 350-bed hospital – that if moved, would immediately relieve and deliver to hospital 50 to 60 beds. And I don't say this to be someone that complains, because I'm truly someone that's prospective and looks forward to the solutions. But I say this because I think the public needs to be aware of the incredible stresses that our frontline workers experience day to day, and leadership at all levels - at my level, and above me, and below me. We need to be working towards the solutions, and we need to be advocating to all levels of government. To the Commonwealth, and all levels of government, that this is a really important issue…

And I'll say finally… the way we treat our most vulnerable members of our community is the way our community is judged. People with a mental health issue, people from remote Aboriginal communities, are some of the most vulnerable peoples in our Australian community, and we are judged by the way we treat them."[52]

103. I am advised that construction works are currently underway to increase TEMHS inpatient capacity from a current total of 31 to 55 beds. These bed numbers are likely capable of addressing the current Bed Block issues provided the beds are operational – that is, provided there are sufficient staff to support additional patients. Whilst the funding has been provided for construction, a budget for staffing has not yet been committed to (and will be difficult to raise), and assuming funding is provided, it is anticipated that recruiting sufficient skilled staff (in the context of a current national and global shortage) will be difficult. While frankly acknowledging that there is much work to do to alleviate Bed Block, Dr Mitchell said that he is committed to continuing the effort.[53]

JOAN RIDLEY UNIT

Transfer and Handover to JRU

52 T 221-222
53 Affidavit, Dr David Mitchell, 15 March 2024, at [353]

104. At 3pm on 6 August 2021, some 62 hours after she arrived at RDH, Pukumani was finally transferred to the JRU. She was escorted to the JRU by two security officers and a nurse. Dr Vellar and Dr Khalid also attended the JRU to discuss and plan her continuing treatment and to ensure she was settled in. Although Dr Vellar and Dr Khalid were discussing Pukumani in the nurses' station, they were not directly responsible for this, and did not pay particular attention to, the handover which was conducted by the nurse from ED to a nurse in JRU.

105. I understand that the handover involves the physical transfer of the patient, her belongings, her medical records file and, importantly, a verbal handover from nurse to nurse highlighting the significant issues. The nurse receiving the handover recorded the handover information in an Inpatient Admission Note.

106. The RCA investigated the handover process. It identified that in the Inpatient Admission Note there was no record of her COPD. The panel were unable to determine through the available documentation if [Pukumani's] history of COPD had been 'handed over' by the ED nurse to the JRU nurse. The JRU nurse interviewed by the panel did not recall that it was, and she believed Pukumani had been medically cleared to be in the JRU and that she did not have any other underlying health conditions.[54]

107. It also appears that there was no clear handover concerning the requirement for ongoing QID (4 per day or 6 hourly) vital (physical) observations "*given her psychotropic load"* as directed by Dr Vellar on 4 August 2021. Dr Vellar considered[55] and NT Health accept[56] that this should have occurred as part of the handover.

108. The information that was likely missed during the verbal handover was available in her medical records, and it is expected that nursing staff will familiarise

54 RCA p 21; Ex 5 Clinical Progress Note 6/08/21 at 1500hrs; Inpatient Admission Note p 2
55 T 70
56 Submissions, NT Health, 17 May 2024, at [164]

themselves with a patient's medical records. However, in practice there is significant reliance placed on verbal handovers at admission and between nursing shifts[57] because patient care workloads may make it difficult for staff to thoroughly read all patient files. The nurse who did the handover from day to night shift on 6 August 2021 gave frank evidence on this point. She had the challenging task of settling Pukumani into the ward and explained:

> "Between 3 o'clock and 8 o'clock I had two admissions [one from the prison] and a discharge. So for me to be able to sit down and read the notes, to be honest, I didn't. Because immediately after this admission…there was another admission…[also] I've got the patients in the ward… to look after… I have to make a handover for everyone …so to be honest with you, it was too hectic.
> …
> To be honest with you, on that day, instead of finishing at 9, I finished at half past 10.00, and I had to come back the following day. Because I haven't finished with her admission, and I haven't finished with the other ones. So just to make sure I finished everything. So, reading the notes, I should have done it. I know, and I'm sorry I didn't. I wish I had done. That's my mistake." [58]

109. The RCA "*considered a recommendation to improve the system of handover or critical information for long stay mental health patients in the Emergency Department*". However, having reviewed the relevant policies and templates, they considered they adequately addressed the handover process.

110. While the policy and procedures concerning handovers are considered by NT Health to be adequate and sufficient, the JRU Inpatient Admission Note for Pukumani omitted a significant medical condition, her COPD, and the QID direction. Those matters should have been 'handed over' and documented. While there is an expectation that nursing staff will read patient records, the evidence I received was that the exigencies of the working environment do not always permit this to occur in a timely or complete way. In those circumstances, the importance

57 T 144, RN J
58 T 177, RN M

of a comprehensive, thorough, and well-documented handover cannot be understated.

JRU Observation Policy and directions from the treating doctor

111. In the JRU nursing staff are required to make and record visual observations of patients. The Inpatient Unit Role and Function TEMHS Guideline[59] specifies that the Unit Team Lead is to regularly check that visual observations are being done. The frequency and manner of visual observations are described in the Category of Observations TEHMS Procedure.[60] Pukumani was placed on routine 15-minute observations, which meant she had to be sighted at a minimum of 15-minute intervals during the day and night and each observation had to be recorded on her Visual Observation Chart.[61] The Visual Observation Chart provided coded options to assist with documenting observations which included abbreviations, such as, A = Awake, S = Sleeping, Sn = Snoring, and R = Restless. There was a column headed "Behaviour Observed / Document Staff Intervention" which was filled in and included observations which included "sitting", "watching tv", "talking", "walking", "pacing" and "S" (for sleeping).

112. There is a separate policy for Night Shift Procedures,[62] which provides further instructions for Observations Overnight, including:

> **Check breathing on all clients** that are sleeping/resting and record on the chart (taking note of changes in position, snoring, restlessness. **If difficult to assess properly, request** a senior staff member to check as well.

113. Additionally, and as already discussed, when Pukumani was admitted to the JRU she was also on QID vital (physical) observations. If she had not been on these, the fallback position for physical observations set out in the Inpatient Unit Role and Function TEMHS Guideline required them to be conducted at least once daily.

59 Additional Document Folio 8, approved 6/4/21
60 Additional Document Folio 13, Approval Date 4/11/21
61 Ex 4
62 Affidavit, Dr David Mitchell, 15 March 2024, Annexure 4, Approval Date 25/3/20

6 - 8 August 2021

114. According to her Visual Observation Chart, during the afternoon of 6 August, Pukumani was moving around the JRU and her behaviours remained disorganised and challenging. But by 10pm she was in her bedroom sleeping and she remained there until 10am on 7 August 2021.

115. During Saturday, 7 August 2021, her behaviours remained challenging. From time-to-time she was banging at the door, yelling and screaming, demanding to leave, and sometimes she tried to push past staff, apparently trying to abscond. Her thoughts were disorganised, and she was responding to unseen stimuli. She was uncooperative. She was noted to be at times irritable, agitated, pacing and talking to herself.[63]

116. At about 1pm, there was an attempt to follow the general TEMHS procedure to take physical observations (once per day) but Pukumani refused. [64]

117. On the evening of 7 August 2021, Nurses J, O and M were on shift and they were each allocated two-hour blocks to complete the visual observations for the patients who required them overnight. Pukumani's Visual Observation Chart records, and CCTV footage shows, that she was awake and watching television in the lounge until 9.15pm. But by 9.30 she had fallen asleep on a beanbag. At 9.30pm all three nurses tried to wake her to give her her scheduled Lorazepam, but she was difficult to rouse, and they did not persist. Except for Nurse M giving her a blanket at 11pm (when she closed the lounge), no staff entered the loungeroom where she was sleeping between 9.30pm and 5.43am on 8 August. However, her Visual Observation Chart was completed during the night, with each observation being noted as "S" for sleeping.

63 Ex 5, Clinical Progress Notes 7/8/21; Ex 4, Visual Observation Chart 7/8/21
64 T 145, Nurse J

118. All three Nurses stated that visual observations of Pukumani were completed using the CCTV monitors located in the nursing station and they did not conduct the respiration checks specified in the nightshift procedures. Nurse J said he was not aware of the requirement to conduct respiratory checks. He was not aware of the nighttime policy and nor had he been inducted into this requirement when he started working in JRU.[65] He said that it was normal for observations to be done by looking through a window without entering or via CCTV, this had never been corrected by a Team Leader, and he was not aware of the requirement to monitor the respiratory rate.[66] None of the other nurses on duty conducted the stipulated respiratory checks either, but Nurse M acknowledged that a patient's respiration rate cannot be adequately assessed over CCTV.[67]

119. Additionally, Nurse J said that he did not receive any handover and nor was he aware of the requirement for QID physical observations. Again, this was not an isolated failing, as the QID physical observations were also missed by all other nurses and Team Leads during Pukumani's time in JRU.[68]

A failure to follow JRU Observation Policy and the treating doctor's directions, and the steps taken to rectify this

120. Neither the respiration check nor the QID physical observations were implemented by any of the staff caring for Pukumani in the JRU and those failings were not identified or corrected by any of the Unit Team Leads. NT Health accepted that this was a systemic failure that had become the norm.[69] Dr Mitchell said that the failure to take good respiration observations was not simply a deviation from policy by one or more individual nurses, rather, "*three nurses are the tip of the iceberg…they're the unfortunate people that are in the spotlight… and this catastrophe could have been any number."* He referred to the observation failings as "*an ugly culture and we don't want that".*[70]

65 T 160
66 T 141, 142, 149
67 T 198, Nurse M
68 T 139, 145
69 T 142, 160, Nurse J
70 T 229

121. To correct these failings, NT Health have made changes to their policies and procedures. The Category of Observations TEMHS Procedure[71] and Visual Observation Chart TEMHS[72] now both clearly include a requirement for respiratory rate to be observed and documented as an integral component of visual observations across all shifts. Nurses are now required to enter a patient's room to check on them if they are asleep and monitor their respiration rate (by observing their breathing, taking note of changes in position, snoring, or restlessness). An escalation process is expressly outlined if a patient's respiration rate is difficult to assess, or they appear to have difficulty breathing. All respiration observations and escalations are to be documented on the patient's observations chart, in addition to their progress notes. Additionally, Dr Mitchell advised that observations of respiratory rate are now included in the JRU Orientation Checklist, to ensure that all new staff to the ward are aware of the requirement.[73]

122. Dr Mitchell reported that in January 2024, two spot checks were conducted of the patient files in the Inpatient Unit. All staff were using the updated forms, and respiratory rates had been recorded for all clients that were resting at the observed time.[74]

Pukumani passes away

123. As discussed earlier, Pukumani was difficult to rouse at 9.30pm on 7 August 2021. The nurses chose not to wake her for her Lorazepam and left her sleeping in the lounge area to minimise disrupting her and other patients.

124. A review of the CCTV of the loungeroom records her last independent movement at 2.58am on 8 August 2021.

71 Affidavit, Dr David Mitchell, 15 March 2024, Annexure 6, Approval Date 31/5/23, and under further review
72 Affidavit, Dr David Mitchell, 15 March 2024, Annexure 8
73 Affidavit, Dr David Mitchell, 15 March 2024, at [318]
74 Affidavit, Dr David Mitchell, 15 March 2024, at [319-320]

125. At 5.43am Nurse J entered the lounge to check on Pukumani. He could not hear her breathing, and he saw some secretions coming from her nose and mouth. He fetched the other nursing staff, and they entered the loungeroom. They discovered her unresponsive, warm to touch, and it was difficult for them to get a pulse. A duress alarm was activated which called an additional nurse and at 5.46am Code Blue was called.[75]

126. 7 minutes after she was found unresponsive, CPR was commenced by Nurses J and O, but their CPR efforts ceased before the arrival of the Code Blue team.[76]

127. At 5.53am the Code Blue Team arrived. All attempts at resuscitation failed. CPR was ceased and Pukumani was declared deceased by the Code Blue team at 6.18am.

128. The Code Blue Registrar noted that there was no phone number listed for next of kin and an Aboriginal Liaison Officer and Social Worker were required to assist with notifying the family. Dr Khalid attended at 8.30am and spoke to the staff. He too noted that there was no phone number for Pukumani's next of kin. However, as he was very familiar with Pukumani, he contacted the Nguiu clinic, and the clinic nurse gave him the phone number for Pukumani's daughter who was living in Darwin. He tried to call her but there was no answer.[77]

Why did she pass away?

129. Firstly, Pukumani was not identified as a deteriorating patient in the period preceding her death. It is likely that her confronting mental health presentation took complete priority and overshadowed her physical health concerns. But as Dr Mitchell said:

> "In the population we look after, we have so many other physical heath issues in addition to the mental health needs, we can't afford to ignore them."[78]

75 Ex 5, Clinical Progress Notes 8/8/21 at 5.40
76 Ex 5, Clinical Progress Notes 8/8/21 at 6.30
77 Ex 5, Clinical Progress Notes 8/8/21 at 8.30
78 T 231

130. The RCA identified that 9.30pm on 7 August 2021 was the first point in time when possible physical deterioration ought to have been considered. When the three nurses found her "*very difficult to rouse*" the RCA found that this was "*a significant change from her behaviour handed over prior to the night shift and may have been a missed opportunity detecting her deteriorating condition*".

131. The next face to face interaction occurred at 5.45am when she was found unresponsive. Respiration checks had not occurred overnight, and they should have been conducted. Dr Mitchell frankly conceded that:

> "Staff did not conduct visual observations appropriately, contrary to what is expected when caring for an unwell patient. Had visual observations been conducted face-to-face instead of via CCTV, it is likely that Pukumani's deteriorating condition would have been recognised and critical intervention could have been commenced that may have prevented her death."[79]

132. I note that the QID vital/physical observations had also not occurred or been attempted. No vital sign observations had been taken in the 48 hours before her passing.[80] The Forensic Pathologist, Dr Tiemensma, agreed that appropriate visual and/or vital observations would likely have identified her deteriorating condition. She explained that fluid built up of in Pukumani's lungs overnight and her oxygen saturation fell, ultimately resulting in respiratory failure. As the fluid built up, respiratory changes could be detected such as snoring, wheezing, sharp intakes of breath, or abnormal breathing rate. These changes could have been identified visually or by stethoscope or oxygen monitor.[81]

133. Many of the policy changes that have been implemented to ensure appropriate observations are carried out have been already addressed and I will not repeat them here. There is, however, one additional reform which is significant. I am advised

79 Affidavit, Dr David Mitchell, 15 March 2024, at [283-284]
80 Ex 5, Clinical Progress Notes, 8/8/21, 6.30am
81 T 196

that the Mental Health Inpatient Unit now has an After-Hours Nurse Coordinator who provides leadership to all three inpatient wards (JRU, Cowdy and YIP (Youth Inpatient)) and who is responsible to ensure that there is consistent, high quality care during evenings and weekends.[82]

134. Secondly, CPR was commenced 7 minutes after Pukumani was found unresponsive and ceased before the arrival of the Code Blue Team (when it was recommenced). This delay was considered a root cause for her death in the RCA[83] and the reason for it was not easy to understand. Although the mental health nurses were up to date with their CPR training, it was rare for them to use these skills in practice. Nurse J had only one previous experience and frankly admitted that "*there was a bit of panic",*[84] and this was Nurse M's first emergency in JRU. She explained that in effect the risk of having to deal with a medical condition was avoided because, if a patient has a medical condition "*we send them back".*[85]

135. In response to the failure to identify Pukumani as a deteriorating patient, NT Health advise that a mental Health Deterioration Simulation Workshop has been developed to assist staff to identify and respond to patient deterioration. The training is for Mental Health Nurses, PCAs, Aboriginal Mental Health Workers and security staff who provide outlier mental health care. Additionally DETECT training (Detecting Deterioration, Evaluation, Treatment, Escalation and Communicating in Teams training) which is currently provided to acute care multidisciplinary teams, is being developed specifically for mental health staff.

FAMILY CONCERNS

136. Pukumani's family were gracious in the midst of their great sorrow. They listened to and accepted the apologies that were offered. They made it clear that they did not blame anyone for Pukumani's passing away.

82 Affidavit, Dr David Mitchell, 15 March 2024, at [324]
83 Additional Document Folia 1, RCA, at p 17
84 T 166, Nurse J
85 T 201

137. They were, however, distressed to learn that while she was in RDH, Pukumani was calling for and looking for family. They wanted to know what had been done to identify family who might be able to support her and provide comfort to her. Senior staff from RDH were present and listened to these concerns.

138. Dr Vellar and Dr Khalid acknowledged the importance of family and explained that efforts were made to identify if anyone from her home community could join her to provide support, but these were unsuccessful.[86] Additionally, although another female family member was an inpatient at the time, given both patients' respective care needs, it was not appropriate at that time for contact to be facilitated.[87]

139. It was not clearly documented in the records for this hospital admission that one of her daughters was living in Darwin (although on other admissions this was documented) and her NDIS coordinator was also based in Darwin. The family thought that perhaps more could have been done to contact these supports for Pukumani. Perhaps so, and I do expect that additional efforts would have been made as her mental health improved. Tragically, that opportunity did not arise.

CONCLUSION

140. Pukumani had been well cared for, physically and mentally, over many years, by her treating teams, family, and community supports. However, she was suffering serious side effects from her long-standing antipsychotic depot medication. These side effects were so serious that it was appropriate that her medication be reduced and, ideally, changed. Management of the medication change was not perfect and the medication change, together with a confluence of other factors, contributed to Pukumani's relapse and subsequent hospitalisation. The Medication Review identified improvements for managing such a medication change and for recording

86 T 76-77, Dr Vellar; T 119, Dr Khalid
87 T 119, Dr Khalid

the delivery of depot medication in community. I endorse and adopt those recommendations.

141. Her relapse was severe and some RDH doctors considered that part of her extreme presentation might be attributable to the use of the sedative Ketamine during her CareFlight. CareFlight does not agree and has conducted an unpublished clinical study which seemingly does not support these concerns. I consider that this is an area of divergence and further work should occur between NT Health and CareFlight to explore whether there should be any limitations on the use of Ketamine as a sedative for patients with a history of schizophrenia or psychosis.

142. I agree with Dr Mitchell's succinct summary of the impact of Bed Block on Pukumani's care. He said:

> "The ongoing Bed Block …prevented Pukumani from receiving care in a therapeutic environment. Given an Emergency Department is not an ideal setting for managing an acutely unwell person suffering psychosis, the prolonged period in this environment, lasting days, may have even exacerbated Pukumani's distress. This potentially added to the need for further medication and sedation. The accumulative effect of this was catastrophic."[88]

143. NT Health is acutely aware that there are insufficient inpatient beds for mental health patients in the Northern Territory and the construction of expanded facilities is under way. However, funding for staff to support additional patients is still to be resolved. This critical work must continue as we are judged by the way we treat our most vulnerable citizens.

144. When she finally secured a bed in the JRU her medical conditions were overlooked as her mental health presentation took priority. That should not have occurred. Even so, as a mental health patient her care was not of the expected standard. Shortcuts were taken with her visual observations, and her QID observations were completely missed. In those circumstances, her physical

[88] Affidavit, Dr David Mitchell, 15 March 2024, at [273(b)]

deterioration went undetected until it was too late. It should have been detected up to 8 hours earlier and, if it had been, interventions could have been commenced which may have saved her.

145. When she was discovered unresponsive, the mental health nurses failed to commence CPR in a timely manner, and this may have contributed to her fatal outcome. Whilst they were up to date with CPR training, they lacked experience in effectively responding and further training should be implemented to strengthen this capacity in the inpatient units.

146. Had she received the appropriate level of care in RDH, Pukumani's death was preventable. The RCA identified failings and made recommendations to improve care which have been accepted by NT Health, and which have been, or are in the process of being, implemented. Many, but not all, of these changes have been mentioned in these findings and as such, it is unnecessary for me to repeat them as recommendations.

FORMAL FINDINGS

162. Pursuant to section 34 of the *Coroner's Act 1993*, I make the following formal findings:

(1) The identity of the deceased is Rita Alimankinni, born on 20 February 1974 in the Northern Territory of Australia.

(2) She passed away at 6.18am on 8 August 2021.

(3) The place of death was the Joan Ridley Unit, Royal Darwin Hospital.

(4) The cause of death was acute respiratory failure in the context of her known underlying chronic obstructive pulmonary disease, obesity and administration of multiple antipsychotic and sedative medications.

RECOMMENDATIONS

163. **I recommend to NT Health** that they conduct a review of the current arrangements with NDIS service providers that are funded by the NDIA, to formalise and strengthen arrangements for the exchange of information particularly concerning the management of client medications.

164. **I recommend to NT Health** that, together with CareFlight, they jointly consider whether, and in what circumstances, it is appropriate to use Ketamine when transporting mental health patients to hospital. Any position on the use of Ketamine, and the basis for that position, should be clearly documented and made available to NT Health mental health doctors.

165. **I recommend to the NT Government and NT Health** that adequate funding is prioritised and allocated to ensure that there are sufficient beds and mental health staff to remove Bed Block in mental health inpatient units. At a minimum, sufficient funding should urgently be allocated to ensure that the current 17 gazetted mental health beds for every 100,000 population is increased to 30 - 36, in line with other states and Territories.

166. **I recommend to NT Health** that they develop and deliver mental health specific DETECT training to mental health inpatient staff who provide care to, or who supervise, patients.