ATTORNEY-GENERAL

Parliament House
State Square
Darwin NT 0800

GPO Box 3146
Darwin NT 0801

REPORT TO THE LEGISLATIVE ASSEMBLY

Pursuant to section 46B of the *Coroners Act 1993*

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

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Pursuant to section 46B of the *Coroners Act 1993* (the Act), I provide this Report on the findings and recommendations of Local Court Judge Elisabeth Armitage, Territory Coroner, dated 14 February 2025, regarding the death of Ms Rita Alimankinni, also known as Pukumani (the Deceased) (Attachment A refers).

This report includes the response to the recommendations of the Territory Coroner by Mr Chris Hosking, Chief Executive Officer, Department of Health (DoH) (Attachment B refers).

The Deceased, a 47 year old female who died at the Royal Darwin Hospital on 8 August 2021 due to acute respiratory failure in the context of her underlying chronic obstructive pulmonary diseases, obesity and administration of multiple antipsychotic and sedative medications. As the Deceased was a person held in care, an inquest into the death of the Deceased was mandatory under section 27 of the *Coroners Act 1993* (the Act).

Recommendations of the Coroner

The Coroner made the following formal recommendations at paragraphs 163 to 166 in regards to the death of the Deceased:

'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.'

Response to Coroner's recommendation

A copy of the Coronial Findings was provided to Mr Hosking on 19 March 2025, in accordance with section 46A(1) of the Act.

A written response was received from Mr Hosking dated 5 June 2025, as required by section 46B(1) of the Act. The response was as follows:

1. In relation to recommendation 163 of the Coronial Findings – NT Health recognises the importance of maintaining effective clinical handover processes that ensure necessary patient information is communicated when patient care is transferred between healthcare settings and care providers. This includes current and historical patient medications including any adverse drug reactions. Clinical handover communication processes are assessed as part of NT Health's hospital accreditation against the National Safety and Quality Health Service standards.

   NT Health is participating in work being led by the Department of Children and Families to develop information sharing arrangements with the NDIA to capture demographic and performance related information. However, this information will not be sufficiently detailed to support patient care.

   NT Health recognises the critical role that NDIS service providers play in supporting their clients to maintain medication regimens. While it is not practical to have formal information sharing arrangements with individual NDIS providers, NT Health agrees to undertake a review of existing mental health clinical handover policies and processes to identify opportunities to facilitate better communication of patient information between NT Health and NDIS providers.

2. In relation to recommendation 164 of the Coronial Findings – NT Health currently engages with CareFlight to conduct bi-annual audits of the patient retrieval and handover process to hospital admissions. These audits, undertaken jointly by CareFlight staff and the Chief Psychiatrist, include a review of current practices regarding the use of Ketamine during patient transport. Consideration is given to clinical safety, risk management, and best practice guidelines in consultation with medical and mental health professionals across both services.

   CareFlight is responsible for the safe transfer of patients to definitive care. NT Health and CareFlight ensure that any position on the use of Ketamine is clearly documented in the patient records of each service and communicated to mental health doctors at handover of the patient from CareFlight to NT Health to support informed decision-making in patient care.

3. In relation to recommendation 165 of the Coronial Findings – NT Health recognises the critical need for increased inpatient mental health capacity to address the need for high dependency beds. However, hospitalisation is only one component of mental health service provision. The NT Government is constructing a 24 bed Mental Health Inpatient Unit at the Royal Darwin Hospital, which will increase the ratio to 24 beds per 100 000 population.

The uniquely dispersed nature of the NT population requires more focus on prevention of hospitalisation through early intervention, outreach and investment in sub-acute and community managed beds. It is not possible to provide acute beds in all regional areas, but it is possible to provide appropriate therapeutic supports, in culturally appropriate contexts. As shown in the table, the NT is outperforming other jurisdictions in this regard.

In 2022-23:

	Australia	NT
Public specialized mental health hospital beds	27 per 100 000 population	17 per 100 000 population
Residential mental health beds	10 per 100 000 population	19 per 100 000 population
FTE staff	149 per 100 000 population	170 per 100 000 population
Supported housing places	17 per 100 000 population	19 per 100 000 population

4. In relation to recommendation 166 of the Coronial Findings – NT Health acknowledges the importance of ensuring that mental health inpatient staff have the necessary skills to identify and respond effectively to patient deterioration.

The NT Government's MyLeaming platform includes the Detecting Deterioration, Evaluation, Treatment, Escalation, and Communicating in Teams – Foundations training module (DETECT). This module has been developed for and recommended to multidisciplinary teams (including doctors, nurses, midwives. and allied health professionals) to support the identification and management of patients showing signs of deterioration. NT Health Clinical Learning Education and Research is working with the mental health team to incorporate specific mental health scenarios into the training, which means all staff undertaking DETECT will then be trained in these scenarios.

Furthermore, NT Health is updating the recognising and responding to acute clinical deterioration guidelines which will now focus on both physiological and psychological deterioration. This will be accompanied by an implementation and communication plan.

I am satisfied that the Chief Executive Officer of the Department of Health has considered the recommendations of the Territory Coroner and that they have responded to the recommendations.

DATE:
03 JUL 2025

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MARIE-CLARE BOOTHBY