CITATION: *Inquest into the death of Kumanjayi Johnson [2026] NTCC 10*

TITLE OF COURT:	Coroners Court
JURISDICTION:	Darwin
FILE NO(s):	D0144/2024
DELIVERED ON:	3 September 2026
DELIVERED AT:	Darwin
HEARING DATE(s):	24 March 2026
FINDING OF:	Judge Elisabeth Armitage
CATCHWORDS:	**Death of child in care; Sepsis; Adequacy of health care; Failure by the Department of Children and Families to actively prioritise contact between the child in care and his biological family, culture, language and country; Inadequacy of family viewing facilities at the mortuary.**

REPRESENTATION:

Counsel Assisting:	Fiona Kepert
Counsel for NT Health and Children and Families:	Tom Hutton
Counsel for Family – Desley Campbell:	Kathleen Heath

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

No. D0144/2024

In the matter of an Inquest into the death of

KUMANJAYI JOHNSON

ON: 6 JUNE 2024
AT: PALMERSTON REGIONAL HOSPITAL

FINDINGS

Judge Elisabeth Armitage

Introduction

1. Kumanjayi Johnson was born on 1 June 2021, at about 25 weeks gestation. From his premature birth Kumanjayi had many health complications. He spent over 4 months as an inpatient in the neonatal intensive care unit and the paediatric ward at Royal Darwin Hospital, and he was required to have surgery in Adelaide and Darwin. Kumanjayi was diagnosed with cerebral palsy, global developmental delay, and hydrocephalus requiring the insertion of a shunt. These conditions made it difficult for him to feed and gain weight, and he suffered from hearing deficits and retinopathy of prematurity.

2. Child protection notifications were made to Territory Families, Housing and Local Government (**the Department**)[1] almost immediately following Kumanjayi's birth. Kumanjayi's mother was unable to meet his complicated care needs. The first protection order application was filed on 7 July 2021, and interim orders were made granting daily care and control to the Department. A short-term protection order was made on 29 July 2021 with a direction that the CEO of the Department have parental responsibility. Kumanjayi Johnson's parents were represented in the proceedings, and the orders were made by consent.

[1] Now the Department of Children and Families

3. On 7 April 2022 long term protection orders were made placing Kumanjayi Johnson under the care of the CEO until he turned 18. When he passed away on 6 June 2024, Kumanjayi was in care, as defined in the *Care and Protection of Children Act 2007*, and an inquest was mandatory.

Kumanjayi's Family

4. Although Kumanjayi's parents were unable to look after him they loved him. When they spent time with him, the Departmental notes record their love and warmth towards him. The first time Kumanjayi's mother saw him outside of hospital there were smiles and giggles, and his mother rocked him to sleep in her arms.

5. His mother attended the inquest and provided a written statement. Her statement contained information about her background, how much she misses Kumanjayi, and the importance of her children being connected to their country. Kumanjayi's mother's history, both as a child and in her adult life, helped me to understand the barriers that made it difficult for her to maintain greater contact with Kumanjayi. Kumanjayi's mother loved him very much and she asked if the Department would provide her with more photos of her son, as she only had a few.

Kumanjayi's Carers

6. On 22 October 2021 Kumanjayi was discharged from hospital and he commenced living with VK and her family. This was an out of home care placement arranged through Kentish Community Services. Kumanjayi stayed with this family for the rest of his life. VK and her family, like Kumanjayi's biological family, remain devastated by his death. Both families have suffered the grief and pain of losing a child.

7. Kumanjayi's mother acknowledged that VK and her family looked after Kumanjayi well, "I know they loved him."[2] The Department acknowledged the love provided by VK and her family, "It is widely recognised… that [VK] provided exceptional care

[2] Exhibit 2 [29]

for Kumanjayi Johnson", Kumanjayi "live[d] a rich life, which was full of love, care, and support."[3]

8. The evidence established that VK and her family loved and cared for Kumanjayi as they would their own child. VK and her family supported Kumanjayi through a vast array of medical and allied health appointments, met his complex needs at home, and he was part of their family. In VK and her family, Kumanjayi Johnson received not only diligent support for his medical needs, he was also part of a family who cared about his emotional and social wellbeing. They facilitated regular contact with his siblings and cousins who were also in care, and no doubt would have supported increased contact with his parents and extended family and participated in opportunities to meet his cultural needs, if that had been arranged by the Department.

Kumanjayi's passing

9. At the end of May 2024 and in the first few days of June 2024, all of VK's household became unwell. First, another child living in the home was required to be hospitalised and shortly after Kumanjayi Johnson developed flu like symptoms. VK and her sister became sick and tested positive for Covid. VK's husband also became ill.

10. On 3 June 2024 VK had a telehealth appointment with a general practitioner (**GP**). The appointment was for VK but at the end of the appointment VK asked for advice in relation to Kumanjayi.

11. The GP was satisfied that Kumanjayi Johnson was not critically unwell, she provided VK with advice on caring for Kumanjayi and guidance on when to come back to the clinic or to attend at a hospital.

12. For the next 2 days Kumanjayi seemed to be showing signs of improvement. Although he continued to have a fever and vomited after food, he was able to take on liquids and slept well. Late on the night of 5 June 2024 the sound of Kumanjayi Johnson's breathing changed and Kumanjayi woke in the early hours of the morning and was unsettled. Being concerned that his health was deteriorating, VK arranged

[3] Exhibit 1 - 5.5 [83] and [169].

for her sister to take Kumanjayi Johnson to the Palmerston Regional Hospital (**PRH**) and VK followed very shortly after.

13. Hospital records show that Kumanjayi Johnson arrived at 5.06 am on 6 June 2024. He went into respiratory arrest at 6 am and despite all efforts staff were unable to save him and he passed away at 7.13 am.

14. A careful post-mortem examination was undertaken and there was no evidence of significant injury, skeletal injuries or neglect. On 17 June 2024, following receipt of results from toxicology, microbiology and serology testing, the post-mortem examination report was finalised. The results indicated: viral pneumonia with features of a systemic septic process; mixed respiratory viruses observed on nasopharynx and lung swabs; Streptococcus pneumoniae observed in cerebrospinal fluid; Streptococcus pyogenes (Group A) and Staphylococcus aureus observed in blood cultures and cerebrospinal fluid. Sepsis was confirmed as the cause of death. The forensic pathologist also noted that Kumanjayi's cerebral palsy and complications of prematurity were contributing factors.

Sepsis

15. Kumanjayi Johnson was clearly very unwell by the time he arrived at PRH. His tragic passing reminds us of how quickly sepsis can progress, particularly in children.

16. Sepsis Australia reports that 84,000 Australians are affected each year by sepsis, and of those, 12,000 die. By way of comparison around 1,200 people have died each year in the last 5 years as a result of road fatalities,[4] and around 9,000 people die each year in Australia from lung cancer, which is the leading cause of cancer death.[5]

17. Although sepsis affects people of all ages, those at higher risk of death are the very young, the very old, and Aboriginal and Torres Strait Islander people. I heard evidence that children can often compensate well when they are very sick and it is

[4] https://datahub.roadsafety.gov.au/progress-reporting/monthly-road-deaths
[5] https://www.canceraustralia.gov.au/research-data/data-and-statistics/cancer-australia-statistics#deaths

common for children to have fewer specific signs of sepsis when compared to adults. I assume this makes it more difficult for parents and health professionals to recognise sepsis.

18. Community education has been important in Australia to reduce the prevalence of sepsis deaths. Parents and carers need information and support to understand the risks and symptoms, and to feel comfortable seeking help. As noted by one witness, parental concern is an important indicator, "it is undisputed parents know their kids best and what is and isn't normal for them. Parents should feel empowered to see a doctor if they are concerned."[6]

19. There are various sepsis resources available for parents, for example: https://health.nt.gov.au/media/pdf/sepsis/sepsis-in-babies-and-children-brochure.pdf; or the Royal Children's Hospital Melbourne, https://www.rch.org.au/kidsinfo/fact_sheets/Sepsis/. Primary health services should ensure information about sepsis is readily available for parents and carers.

20. Given the extent of medical treatment Kumanjayi Johnson received during his life, all of which was facilitated by his carers, I was satisfied that VK was informed, engaged and diligent with his medical care. Tragically, Kumanjayi did not display worrying symptoms until shortly before his death and he was promptly taken to hospital. Those circumstances are a stark reminder of the importance of continued public education about sepsis and the speed with which sepsis can lead to fatalities.

General Practitioner appointment on 3 June 2024

21. At first blush, it might seem that the telehealth appointment on 3 June 2024 was an opportunity to identify earlier that Kumanjayi Johnson had an infection and needed treatment. However, having reviewed the evidence I am satisfied that Kumanjayi was not critically unwell on 3 June. At that stage Kumanjayi's symptoms were not sufficient to raise a specific concern in respect of sepsis, or otherwise indicate a need

[6] Dr Whitehouse – 3.5

for urgent assessment, and I find that the GP provided appropriate guidance and advice to VK.

22. I come to that conclusion based on the following:

    a. at the telehealth appointment the doctor thoroughly questioned VK in order to assess key symptoms;

    b. Kumanjayi Johnson did not present with dehydration (he had normal wet nappies), he had an intermittent fever but not higher than 38.7, he was clingy when feverish but not irritable or lethargic, and was not having difficulty breathing;

    c. sepsis can progress rapidly, within 12 to 24 hours; [7] and

    d. Kumanjayi's complex health background may have contributed to a rapid decline prior to his death.

23. I thank the GP, and the clinic where they worked, for the assistance provided to the coronial investigation.

Telehealth appointments

24. While there is no reason to consider that an in-person appointment with a GP would have led to a different outcome for Kumanjayi Johnson, his death has led me to reflect on the use of telehealth services.

25. The treating GP gave evidence that:

    a. the criteria she considers when assessing sepsis is usually based on direct observations, and these can be more difficult to assess over a telehealth appointment;

[7] Exhibit 1 - 3.5 [52] Dr Whitehouse

b. in her view junior, doctors receive limited training and experience on how to undertake telehealth appointments and there would be benefits in simulation training for junior doctors;

c. informed by her experience with Kumanjayi Johnson, her current practice is to avoid telehealth appointments with young children where possible. If a telehealth appointment is necessary she now routinely schedules a face to face review appointment within 24 to 48 hours, which can be cancelled if the carer feels it is no longer needed.

26. The clinic where Kumanjayi was seen had a policy covering telehealth appointments, which excluded patients under 16 years of age unless approved by a doctor at the practice. The policy does not provide guidance on clinical considerations for determining whether a telehealth appointment is suitable, or how to address any disadvantages that arise from telehealth rather than in-person consults. The practice also directed me to and advised that they comply with the guidelines from Services Australia for telephone and telehealth appointments, however, those guidelines do not address when telehealth is appropriate from a clinical perspective.

27. Training or guidelines that assist practitioners to navigate the clinical implications of telehealth would be useful, particularly for new or more junior practitioners. Clinics should consider whether their current supervision and guidelines are adequate. I commend to others the approach implemented by this GP in her current practice, namely, scheduling a follow up appointment within 24-48 hours. Whether such a practice is valuable as a standard practice or would only suit a particular cohort of patients is beyond the scope of this inquest.

"Tack on" appointments

28. Another issue raised by the appointment that took place on 3 June, was that it was a 'tack on' appointment. Kumanjayi Johnson did not have a booked appointment but was seen following a request by VK during her appointment. As a result, the GP did not have access to Kumanjayi's file prior to the consult nor an opportunity to review

his history, as she might normally do in advance of an appointment. There was also time pressure, as appointments are booked for a standard time period for one patient.

29. In hindsight, the GP considers that she should not have accepted what was in effect a second appointment for Kumanjayi. Instead, she could have assisted VK to make another separate booking for him. I expect it is more difficult for new practitioners to say no to a patient's request, and I agree with the GP when she said, "I believe it would be beneficial and would improve registrars' holistic education to encourage and empower doctors to say no where necessary and to not feel pressured into situations where they are not comfortable."[8]

30. I do not suggest that additional patient requests should, as a matter of policy, be refused. In this case it was beneficial for VK, and Kumanjayi Johnson, to obtain the advice that was given. However, each doctor will need to consider their own specific circumstances, capacity and the urgency of the request and should feel confident to provide patients with an alternative if they are unable to assist.

31. I encourage the clinic where Kumanjayi Johnson was seen, and GP clinics generally, to review their guidelines on telehealth and 'tack on' appointments, to ensure doctors are provided with appropriate guidance and support. In respect of telehealth, guidance might include:

    a. clinical considerations for when a telehealth appointment is or is not appropriate;

    b. how to manage the clinical disadvantages of a non-face to face appointment; and

    c. whether follow up appointments should be booked as standard practice generally or for a particular cohort of telehealth patients.

[8] Exhibit 1 - 3.5 [65]

32. A copy of these findings will be sent to the Royal Australian College of General Practitioners and the Australian College of Rural and Remote Medicine for their consideration.

Hospital treatment on 6 June 2024

33. NT Health undertook an in-depth case review of Kumanjayi Johnson's treatment at PRH on 6 June 2024. The review identified a lack of contemporaneous documentation and a potential delay in his treatment.

34. After that review, statements from Dr Lowe and Dr Pandithage were obtained. With the benefit of those statements, I am satisfied that there was no delay in Kumanjayi Johnson's treatment and that he received appropriate, comprehensive and timely care. In coming to that finding I relied on the following matters.

    a. Although the initial assessment indicated Kumanjayi Johnson was a triage category 3, the triage nurse was concerned about him and reclassified him as triage category 2. Category 2 indicates an imminently life-threatening condition, and the patient is to be seen within 10 minutes.

    b. The triage nurse personally sought out Dr Lowe, one of the registrars on duty, and made sure he was aware of Kumanjayi and the need to see him promptly.

    c. Medical records indicate Dr Lowe was aware of Kumanjayi by 5:14 am, 8 minutes after his arrival to the hospital and Dr Lowe gave evidence that he saw Kumanjayi immediately.

    d. After taking a history and completing a short initial review, Dr Lowe's medical opinion was that Kumanjayi Johnson was seriously unwell and likely septic.

    e. Dr Lowe immediately commenced the Advanced Paediatric Life Support protocol.

f. While the initial treating medical staff were both registrars, they arranged for the on-call Emergency Specialist to attend and in addition advice was obtained from two Paediatric Consultants and the on call Anaesthetic Consultant.

g. Dr Pandithage, the Emergency Specialist on call who attended during the latter half of Kumanjayi Johnson's treatment, undertook a review of the treatment provided to Kumanjayi. Dr Pandithage is an experienced practitioner. She has worked as an emergency consultant for more than 20 years. I accept her evidence that all appropriate care and treatment was provided in a timely way.

35. The evidence establishes that Kumanjayi Johnson was seen promptly and the hospital staff were cognisant of the seriousness of his condition and alert to the possibility of sepsis. While it was not necessary to hear oral evidence from any of the staff who treated Kumanjayi Johnson, I acknowledge that it would have been a distressing experience given his young age and the speed of his decline. VK expressed her gratitude for the work of medical staff, and I trust that has been passed on to them.

36. In respect of the statement in the review that there was limited contemporaneous documentation of assessment and treatment, I make no criticism of individual staff given the nature of the emergency treatment that staff were administering.

37. The NT Health Case Review identifies that Kumanjayi Johnson's case should be presented to ward staff as a teaching opportunity and I support that response.

Department of Children and Families

38. The Department of Children and Families (**the Department**) completed a practice review of the child protection services provided to Kumanjayi Johnson during his life.[9] The review identified several issues with record keeping as well as potential failures to meet Departmental standards. Issues highlighted by the review were:

[9] Exhibit 1 - 5.1

a. Poor record keeping. By way of example, Mr Peter Fletcher, who was the Department's institutional witness, identified a 6 month gap from February to August 2023 in which there were no meaningful entries on Kumanjayi Johnson's file;

b. A formal care team meeting did not take place as required by the *Child in Care Practice Guidelines*;

c. Child protection practitioners should have had contact with Kumanjayi Johnson at least once every 6 weeks, but the records do not show that occurring;

d. Care Plans were not updated as frequently as required and sometimes lacked appropriate detail;

e. Records showing efforts to contact Kumanjayi Johnson's mother and facilitate family contact were limited; and

f. It is not clear that Departmental guidelines on working with victim-survivors and perpetrators of domestic violence were followed.

39. Mr Fletcher identified a junior workforce in combination with high vacancy rates and resultingly high caseloads for individual workers as major contributing factors in the failings identified. It is trite to say that when there are not enough staff service standards cannot always be maintained. While that is the reality of an overworked and junior workforce, it should not be accepted as the norm and is it not good enough for the Northern Territory's most vulnerable children. I acknowledge Mr Fletcher's evidence that recently introduced frameworks around coaching and the like may improve staff retention and capabilities.

40. Giving due acknowledgment to staffing challenges, these findings do not comment on the decisions or actions of individuals, instead I have focussed on the systemic issues that could be improved. Specifically, the need to adequately resource and implement existing policies and goals to ensure delivery for every child in care.

Contact with family

41. After he was discharged from hospital following his birth, regular contact was established between Kumanjayi and some of his siblings and cousins who were also in care. However, there was very limited contact between Kumanjayi Johnson and his parents and other adult family members.

42. The records indicate that in the 2 years and 7 months following Kumanjayi Johnson's discharge from hospital after his birth, he only spent time with his mother on 3 occasions; on 15 and 16 February 2022 and once in late May/early June 2022. The last visit was potentially organised by Kumanjayi's carer VK, not the Department.[10] Other family members also attended some of these visits and there was just one separate visit, with Kumanjayi's paternal grandmother, on 2 February 2024. The Department scheduled a further 2 visits that did not go ahead: one in March 2022 was cancelled because Kumanjayi was unwell; and his mother did not attend a planned visit in August 2022.

43. Facilitating time between Kumanjayi Johnson and his parents and other adult family members is an express legislative obligation. Section 8(4)(a) of the *Care and Protection of Children Act 2007* provides, "if a child is removed from the child's family… contact between the child and the family should be encouraged and supported." Pursuant to section 10, the best interests of the child, which is the paramount concern in any decision making, includes consideration of:

    (ca) *the need to strengthen, preserve and promote positive relationships between the child and the child's parents, family members, kinship group and other persons who are significant in the child's life*; and

    (ha) *if the child is an Aboriginal child – the child's right to enjoy the Aboriginal culture and tradition of the child's family and community*

[10] There are no progress notes recording the visit, Mr Fletcher's affidavit records it as taking place on or around 1 June 2022 at [108] but in the table at [203] refers to the visit taking place on 25 May 2022. The statement of views and wishes, Exhibit 1 - 5.2 at p 312, suggests the visit was potentially organised by Kumanjayi's carer VK, this is consistent with the phrasing in the care plan, "my family attended my birthday celebrations".

including the need to maintain ongoing contact with the child's family and connection to country and language.

44. Further, legislatively mandated care plans must include decisions about contact between the child in care and other persons (section 70(2)(c)(ii)) which must include contact with family members.

45. The Department accepts that it has obligations to take active steps to maintain family contact and provide for cultural needs. Mr Fletcher gave evidence about the Department's policies and procedures, including the Practice Guidance, that seek to implement these legislative obligations. The Practice Guidance sets out that the purpose of family contact is to maintain meaningful and significant relationships between the child and their family[11] and places responsibility on the child protection practitioner for, "advocating, planning for and coordinating the child to develop, have and maintain strong, positive connection to their family."[12]

46. As Mr Fletcher explained these obligations continue for children under a long term order, "family connection, particularly for an Aboriginal child, is - is really an important part of the - their life and… should be an important part of their care plan."[13] The onus is on the Department to ensure this occurs and where necessary that may mean finding 'creative' ways to ensure contact is maintained.[14] It is to be expected that some parents who are facing challenges in their own life and who are unable to care for their children will be difficult to reliably contact by phone. Accordingly, evidence of a few phone calls and left messages is not, in my view, sufficient to meet the Department's obligations.

47. Despite the legislative requirements and the internal guidelines, the Department failed to adequately advocate, plan for and coordinate Kumanjayi Johnson's connection with his family.

[11] See Exhibit 1 - 5.5 Fletcher [45]
[12] Exhibit 1 - 5.5 Fletcher [198]
[13] Transcript of the inquest held on 24 March 2026 at page 13.
[14] Transcript page 25

48. In so far as family connection was concerned, the Care Plans for Kumanjayi Johnson were inadequate.

a. The first Care Plan, dated 7 July 2021, contained no arrangements for family contact and instead set out only that, "Contact arrangements need to be developed with family members" and that the Department would meet with Kumanjayi's parents and extended family to develop an access plan.[15]

b. 3 months later, an unsigned draft Care Plan which was likely prepared shortly before Kumanjayi's release from hospital in October 2021, continued to state, "Contact arrangements need to be developed with family members."[16]

c. The Care Plan commencing on 23 February 2022, 7 months after the first protection order was made, contains the first recorded plan for family contact. The plan proposed 2 x 1 hour supervised visits on consecutive days every 6 weeks. This was insufficient. Such limited time could not result in the creation or maintenance of meaningful and significant family relationships for Kumanjayi. As the Department acknowledged, the rationale for requiring visits to be supervised was not articulated and the plan for moving to unsupervised contact was absent. The gap of 6 weeks between visits was said to be justified because Kumanjayi's mother was in Tennant Creek. However, as at February 2022, it is not clear that Kumanjayi's mother was based in Tennant Creek, as she was in Darwin and attended access visits on 15 and 16 February 2022. I doubt the Department definitively knew Kumanjayi's mother's location, but as far as their written records go, they are consistent with her being in Darwin from February 2022 until early August 2022 when

[15] 5.2 p 182

[16] The date is estimated based on the content of the plan which states that Kumanjayi was still in hospital, but includes information about surgery that took place on 13 October 2021 and references to transition to Kentish care placement having been planned and progressed, see Exhibit 1- 5.2 p 290 onwards.

she contacted the Department to notify them that she was moving back to Tenant Creek.[17]

d. The next Care Plan, signed in October 2022, documented that Kumanjayi, "has been seeing mum and dad every six weeks but since July, mum and dad have moved back to Tennant". This was inaccurate. At no time did 6 weekly visits occur. The care plan went on to state that Kumanjayi's parents, "have promised to visit [Kumanjayi] when they are in Darwin."[18] However, the plan contained no contact details for Kumanjayi's mother or father, with the practical result being practitioners (who changed regularly) had limited means to arrange visits. This care plan put the onus on Kumanjayi's biological parents to make access arrangements whereas under the legislation the statutory parent (the CEO) was obliged to encourage and support contact with family and to act in the best interest of Kumanjayi's wellbeing.

e. The Department produced no care plans to the inquest from 2023. Care Team meeting minutes from 27 October 2023 listed no people in the contact arrangements section nor any entries in the family members' section despite concerns about Kumanjayi Johnson's lack of contact with his parents being identified at the meeting. The minutes record the 'next steps' which were for a) the case manager to try to contact Kumanjayi's mother and facilitate a meeting with family and the ACW, and b) to schedule monthly meetings to review contact with parents. The progress notes provided end in February 2023. There is no evidence in those notes that either of those steps were undertaken. Mr Fletcher's summary of the Department's interactions with Kumanjayi Johnson record no efforts in 2023 to contact Kumanjayi's mother, father or other family members, nor any actions taken following the care team meeting on 27 October.

[17] Transcript page 57
[18] Exhibit 1 - 5.2 p 336

f. The care plan from April 2024 had no input from family as the case manager had been unable to contact Kumanjayi's parents and instead conducted a desktop review in respect of other family members. There is no evidence as to how workers attempted to contact Kumanjayi's parents. Simply calling Kumanjayi's mother's last known mobile number would have been entirely inadequate and not in line with the Department's obligations. The plan recognised the concerns about lack of family contact and stated that Kumanjayi had not seen his mother since June 2021, but it contained no suggestions as to how the goal of facilitating contact might be achieved. Earlier suggestions that the case manager was organising for Kumanjayi to visit his sister in Tenant Creek[19] and the hope that family could support Kumanjayi to travel to community for visits[20] appear to have disappeared from consideration. The care plan was incomplete and in effect provided no information as to how the Aboriginal and Torres Strait Islander Child Placement Principles were being considered and implemented; no information about how connection with family would be recommenced; nor how culture, language, identity and connection to home community would be facilitated. Multiple sections of the plan are completed only with the phrases 'desktop review', 'in progress' or 'to be review[ed].' Despite these clear and apparent inadequacies, the plan was endorsed and approved by the team leader and the manager. Given that management endorsed such an inadequate and incomplete care plan I am satisfied that those kinds of inadequacies were systemic.

49. While I found that the proposal for 6 weekly supervised visits was itself inadequate, planning for and facilitating even that minimal level of contact was problematic from the outset. When visits did not go ahead as planned the records reveal a lack of activity by Department staff to proactively reschedule or follow up with Kumanjayi's mother.

[19] October 2022 care plan, Exhibit 1 - 5.2 p 335
[20] Care Team meeting minutes, 27 October 2023, Exhibit 1 - 5.2 p 452.

a. When Kumanjayi Johnson's mother attended the Department office for a planned visit on 31 March 2022 and Kumanjayi was unable to attend due to illness, staff did not take advantage of the opportunity to schedule a replacement visit. Assuming that this could be arranged at a later date was risky because Kumanjayi Johnson's mother did not have a phone number on which she could be consistently reached, and there was no guarantee that any attempted future efforts to re-schedule could be communicated.

b. Progress notes from 5 April 2022 record the case manager spoke to Kumanjayi's mother by phone and reassured her that Kumanjayi was now well but there is no record that a further visit was offered or scheduled at that time.[21] There is no evidence of a replacement contact visit being ever offered for the missed visit on 31 March.

c. Kumanjayi's family attended his birthday celebrations which took place in late May or early June 2022, and which appear to have been arranged by VK.

d. The next contact between the Department and Kumanjayi's mother was on 12 August 2022, when Kumanjayi's mother contacted the case manager. Her call was not answered and she left a message informing that she was returning to Tennant Creek but would be back in Darwin for the scheduled visit on 22 August. She requested a call-back. There are no progress notes to indicate the case manager or anyone returned her call or made contact prior to the next planned visit. When Kumanjayi's mother missed the visit there are no records of any attempts to contact her to see why she missed the visit or to offer assistance with transport from Tennant Creek, if that was a barrier.

e. Mr Fletcher was unaware of the Department making any offers to assist Kumanjayi's mother with transport from Tennant Creek to Darwin so her son could benefit from having a relationship with her. The care plan immediately after Kumanjayi's parents informed the Department they had returned to

[21] 5.2 p 105

Tennant Creek contained no reference or plans for transport assistance.[22] The Department is legislatively required to "support contact" and this type of support should have been offered.

f. Following the planned August visit, Mr Fletcher's affidavit identified no further attempts being made by the Department for Kumanjayi to have parental (or extended adult family) [23] contact.

50. Despite the statutory provisions mandating the Department's responsibility for supporting Kumanjayi's contact with his biological family and policies to that effect, these responsibilities were largely overlooked and ignored. I am concerned that because Kumanjayi was on a long-term order, Departmental staff no longer considered family contact a priority. Indeed, the stability of Kumanjayi's placement seems to have resulted in him not receiving the Department input that the Department, as his statutory parent, was obligated to provide.

51. Accepting that the vulnerabilities of Kumanjayi Johnson's mother made her difficult to contact and some attempts to contact her might not have been recorded, the evidence in the care plans and progress notes of efforts to support Kumanjayi Johnson to have contact with his family is woefully inadequate. What was planned, and the little contact that eventuated, was insufficient to allow Kumanjayi to create and maintain meaningful relationships with his family.

52. A lack of contact with family meant that Kumanjayi Johnson also missed out on the opportunity for meaningful connection and exposure to his Aboriginal culture, language and country. That connection was critical for his wellbeing, and the failure to provide that connection may well have manifested in his behaviour, if he had survived, particularly in his teenage years.

[22] Transcript page 32-33; Kumanjayi's mother's statement refers to the Department paying for her bus and a few nights accommodation in Darwin so she could come back to visit Kumanjayi, but there are no records of this expenditure in the material provided by the Department. I accept it took place given Kumanjayi's mother's evidence but this speaks to the gaps in record keeping.
[23] Transcript page 35

Managerial oversight

53. One means of ensuring that polices and goals are adhered to in practice is through appropriate management and reporting procedures. Mr Fletcher gave evidence of monthly reporting that records compliance with care plans, face to face contact between the child protection practitioner and the child, existence of care teams, staff coaching and appropriate caseloads. Mr Fletcher indicated that arising, at least in part, from his reflections on this case, he would like to introduce a further metric that reports on contact with family and access to country.[24]

54. For many children contact with family should be regular and frequent, but I accept that for some that may not be logistically realistic, and for some it may not be safe. Accepting that there will need to be some level of flexibility, this information should be captured and reported on because it is vitally important that when time with family is not happening as often as it should, these children are identified and there is managerial oversight and response. Otherwise, children like Kumanjayi Johnson will continue to miss out on the opportunity to develop meaningful connections with family and country. Children who miss out are at risk of feeling lost, vulnerable, isolated and abandoned. Experience demonstrates this loss of connection and belonging will often manifest in challenging behaviours and poor mental health as children get older. It increases the likelihood of them coming into contact with the criminal justice system. These outcomes are the opposite of wellbeing.

55. Reporting metrics are only effective if a) they accurately reflect the reality of what is taking place for a child, and b) management oversight actually improves compliance with legislative obligations and departmental goals. I am concerned that the care plan from 31 October 2022 did not present an accurate account of Kumanjayi's contact with his parents but was nevertheless approved by the team leader/manager and the care plan approved on 2 April 2024 was inadequate because multiple goals had no plans in place as to how they would be progressed. Despite this, it was endorsed by the team leader, and the Aboriginal Community Worker, and approved by the

[24] Transcript 37-8

manager. This is not acceptable. This inadequate plan would no doubt have been counted in the statistics, [25] and so given the impression it was of an acceptable standard.

56. Even though he was under a long term protection order, family connection should have remained a "critically important" part of Kumanjayi's life.[26] To better ensure that proper priority is given to maintaining family and cultural connections, I will recommend that the Department introduce a metric, to be included in monthly reporting, that a) measures family contact, and b) in the case of Aboriginal children, time on country.

Relationship building and supporting families of children in care in the interest of the wellbeing of the child

57. One of the Department's statutory roles is to provide support to the families of children in care: s 8A(a).

58. The Department should have supported Kumanjayi's parents to spend time with him, to be part of his care team and to take part in collective decision making, including in respect of Kumanjayi spending time on country.[27] Mr Fletcher agreed that the Department ought to have supported Kumanjayi's mother with "her ongoing difficulties with alcohol, her transitory lifestyle and difficulties" with a view to assisting her to maintain contact with Kumanjayi.[28] While I accept that the progress notes do not necessarily represent all work undertaken by the Department, in the absence of any other evidence of efforts by staff, I can only draw conclusions based on what has been recorded. The evidence before me indicates that limited support was provided to Kumanjayi's mother during Kumanjayi's life. This was perhaps the inevitable consequence of the Department failing to build rapport and establish a working relationship with Kumanjayi's mother.

[25] Transcript page 60
[26] Fletcher at Transcript page 13.
[27] Transcript page 14
[28] Exhibit 1 – 5.5 [230]

59. The records reveal that the Department lost contact with Kumanjayi's mother very quickly and never established a reliable means of communicating with her. They also reveal very limited evidence of any efforts to build rapport. Consistent with this lack of contact, there are very few indications of the Department providing support to Kumanjayi's mother or other family members.

    a. While the Department made referrals for Kumanjayi's parents to attend an alcohol rehabilitation facility, a domestic violence shelter and the banned drinker's register, [29] there was little follow up or further efforts when these referrals were not successful.

    b. The Signs of Safety Assessment and Planning Form of 1 July 2021 documented the need to re-explore the parents' willingness to attend a residential rehabilitation facility, but there is no record of any conversations or consideration of this option after this date.

    c. It appears that no referrals were made by the Department at all for Kumanjayi's mother following Kumanjayi's birth.[30]

60. Potential supports that could have been provided to the parents with the aim of supporting them to maintain close family connections with Kumanjayi included:

    a. Assistance with housing,[31] noting Kumanjayi's mother told Departmental staff that she would try to secure housing in Darwin so she could see Kumanjayi;[32]

    b. Further alcohol or domestic violence service referrals when earlier referrals were closed;

[29] There is some difficulty determining from the evidence and the records whether referrals were made by the Department, NAAJA or Royal Darwin Hospital, but it is not critical whether the referral is made by the Department or another service, provided the Department is ensuring adequate steps are collectively being taken to provide support.
[30] I note the evidence that the inclusion of Kumanjayi's mother on the Banned Drinker Register was due to expire in September 2021, suggesting she was placed on that register prior to Kumanjayi's birth. See 5.2 p 138, paragraph 31(k).
[31] Transcript page 54.10
[32] 5.1 – Practice Review, p 17 [66].

c. A referral to a support service external to the Department;[33] and/or

d. A referral to an organisation based in Tennant Creek.[34]

Aboriginal Community Workers

61. Mr Fletcher told me that it can be difficult for Departmental staff to build rapport and trust with parents, given their role in child removal, and that it is often the Aboriginal Community Worker team that establishes relationships with parents from an Aboriginal background.[35] I accept that a skilled Aboriginal Community Worker (**ACW**) brings a cultural expertise and capacity to engage parents that differs from the expertise of qualified Child Protection Practitioners. I agree with Mr Fletcher that there is also a need to elevate the role of ACWs.[36]

62. Mr Fletcher referred to two ACWs who "feature quite prominently in Kumanjayi's life and case records and are still a point of contact for" Kumanjayi's mother.[37] Despite this evidence, a search of the records shows less than 12 entries in the Department's progress notes that record ACW involvement. And these 12 include ACW interactions with other staff, and not family. Overall, there were far too few interactions between ACWs and the parents to allow a meaningful relationship to be built, and the level of involvement of ACWs was simply inadequate for the length of time Kumanjayi was in care.

63. While all children have a Child Protection Practitioner assigned to them, and that person has responsibility for meeting various statutory requirements, in contrast ACWs are not usually recorded in the system as being an 'involved provider' and unlike Child Protection Practitioners they are not allocated to families on an ongoing basis.[38] ACWs are generally only allocated specific tasks,[39] such as attempting to

[33] Although I acknowledge NAAJA, an external service, was at some point in time providing support, Department records don't establish for how long this took place and the nature of the support provided.
[34] Transcript page 23
[35] Transcript page 18
[36] Transcript page 19
[37] Transcript page 18
[38] Fletcher at Transcript page 19
[39] Transcript page 20

contact parents or advising the Child Protection Practitioner on proposed access with family. Given the acknowledged skills of the ACWs to engage with families and build rapport, I am concerned that the current task based allocation results in piecemeal interactions with ACWs at the cost of building the longer term relationships which are necessary to support deeper family engagement.

64. Regrettably I heard that there are not enough ACWs for each child or family to be assigned one. There are not enough of them to even allocate to children recently brought into care.[40] The start of a protection order, when a child is removed, is a challenging time for families but it is also a critical time to start the work of building rapport (or a working relationship) with parents.

65. Given the limited resources in the ACW team, and because I did not hear directly from any staff within that team, I do not intend to make specific detailed recommendations about how work processes should change, but there is clearly scope for improvement. Mr Fletcher has undertaken to work with the Aboriginal practice advisor for the Greater Darwin region, who sits within the leadership team, and to consult with the ACW Team on updating the current work model to better utilise the skills of these important workers. [41] In addition, more needs to be done to build, recruit and retain the ACW workforce including by ensuring their pay scale reflects the cultural and other expertise that they provide.

External services

66. The Department funds external services to provide family support.[42]

67. I heard that funding for family support services is more commonly provided in reunification cases, or preventatively, to try and avoid a child being taken into care.[43] However, it would have been beneficial for a referral to be made in relation to Kumanjayi and his family to a Tennant Creek based family support service when his

[40] Transcript page 20
[41] Transcript page 20-21
[42] Transcript page 21
[43] Transcript page 62

mother was living there. It was a missed opportunity not to see whether a Tennant Creek based service could have been more effective than departmental staff in engaging Kumanjayi's mother and supporting her to maintain contact with Kumanjayi.[44]

Composition of care teams

68. In the circumstances where a parent is unable to care for their child, I expect it would be common for them to find participation in care team meetings extremely challenging, for a range of reasons. However, in a well-functioning and effective care team, parents should be supported to participate directly in decision making and planning concerning their child.

69. Mr Fletcher identified the failure to create the 'right' care team for Kumanjayi Johnson as a 'foundational step' that then contributed to the other concerns raised in the Department's review and this inquest.[45] From April 2024, Kumanjayi's care team was comprised solely of Department workers.[46] When there was little contact with Kumanjayi's family, these workers struggled to identify ways to keep Kumanjayi connected to family, culture, language and country.

70. Given Mr Fletcher's evidence about the importance of care teams, there is merit in having a formal structure that allocates responsibility for family support to an individual on the care team. As Mr Fletcher explained, when Kumanjayi first went into care and departmental workers were dealing with many competing obligations and work tasks, it would have been useful and appropriate at that early stage to have "someone whose sole focus was [on Kumanjayi's mother] and her safety and building rapport with her".[47]

71. If establishing a relationship is challenging or unsuccessful over time, the role should nevertheless continue so as to highlight the issue and to continue to identify

[44] Transcript page 23
[45] Transcript page 35
[46] Exhibit 1 - 5.2 pp 490 - 498
[47] Transcript page 26

alternative ways in which support can be offered and engagement achieved including by identifying extended family beyond the parents who could play a role in ensuring culture and connection to country is being properly prioritised in the child's life. For example, Aunties, Uncles and Grandparents have important roles and responsibilities for Aboriginal children. Efforts to build rapport and support parents or other key family members to engage in care planning should be documented and reported on.

72. Even in those cases where parents are engaging well, it is important that they remain supported and family connection remains a priority, especially in long term orders where reunification is no longer under active consideration.

73. I am not suggesting that this role requires an additional member of the care team, it could be allocated to an existing member. What is important is that there is clarity and focus on the role to ensure that sufficient priority is given to this statutory obligation.

74. The right person to support a parent or extended family member to participate in decision making and planning will likely vary between families and may change over time. Sometimes an external service will be best placed to provide support, for others an ACW may be the most effective person, and where meaningful relationships can be established with family members, it may be the Child Protection Practitioner. However, there needs to be a level of formality and accountability in the allocation of the family support person role to ensure parental involvement is not overlooked, de-prioritised or ignored – as occurred with Kumanjayi Johnson.

75. Mr Fletcher has indicated that existing practice resources could be revised to more specifically outline the role and accountability of a support person for the parents, or other applicable family members.[48]

76. I will make a recommendation aimed at ensuring practical steps are taken to prioritise the importance of families being supported to remain engaged in their child's life and

[48] Transcript page 43

care, and to ensure that active efforts are prioritised to ensure children remain connected to family, culture, language and country.

Partnering with victims of violence

77. Kumanjayi's mother was a victim of domestic violence. She needed support to achieve safety in her life, and a compassionate approach that recognised that many of the challenges the Department faced when trying to engage her, such as her transient lifestyle and alcohol use, stemmed from her history of trauma. Acknowledging the connection between the violence perpetrated against her and her current difficulties was crucial to being able to properly support Kumanjayi's mother to grow her relationship with Kumanjayi.

78. In about March 2020 the Department commenced operating under the Safe and Together Framework (the **Framework**) which is intended to ensure a perpetrator accountability model is implemented. Staff are expected to recognise the impact of domestic violence on survivors, 'partner' with survivors to provide support, and to hold perpetrators to account. The Department offers 4 day courses on the Framework and about 100 practitioners complete this training each year. In addition, there are online modules available for staff to undertake in their own time.

79. The affidavit filed on 7 July 2021 that accompanied the Department's application for a temporary protection order did not comply with this Framework. There was no evidence of the Department recognising and working with Kumanjayi's mother as a victim-survivor, and it included judgmental and stigmatising language that inappropriately blamed her for the harm caused to Kumanjayi by the perpetrators conduct.

80. Under the Framework, truly partnering with Kumanjayi's mother meant there had to better ways of staying in contact, over and above phone and text messages. As was recognised during the inquest, there needed to be more innovative and flexible ways for the Department to reach out to Kumanjayi's mother, for example, through her family, through community services, by identifying who else she stayed with or connected with when in Darwin, and/or via referred outreach services.

81. The failure to engage with Kumanjayi's mother as a victim-survivor was identified as a failing by the Department in its practice review. I was provided with a de-identified copy of a more recent care and protection affidavit which complies with the Framework, as evidence that the training is working and the culture is changing.[49] Mr Fletcher gave evidence that the model is much better understood now than when it was first introduced and it has become more embedded in practice.[50]

Mortuary

82. Following Kumanjayi Johnson's passing, Department staff informed his mother and arranged for her and other family members to attend a viewing in the identification room in the mortuary at Royal Darwin Hospital. The unsuitability of these facilities was distressing for his mother. Kumanjayi's mother wanted to touch him one last time as part of saying goodbye but was told that she was unable to do so and could only view him through the glass window.[51]

83. I am aware from my role as Coroner that similar issues have arisen for other families, and I considered it was appropriate to take a little time to investigate this issue. Further evidence was obtained from Ms Alison Grant, the grief counsellor in the Office of the Coroner. Ms Grant's statutory declaration along with some interstate and international guidelines for mortuaries and previous NT Government statements about budgeting for a new mortuary facility were collated and provided to the parties (**the mortuary evidence**).

84. The parties were given 7 days to indicate any objections to the mortuary evidence. No objection to the admission of that evidence, or a request for further time, was received in that time period and the mortuary evidence was received and exhibited as exhibits 4 through 8.

85. After that had occurred, correspondence was received from NT Health indicating an objection: firstly, it submitted it would be unable to test the evidence without

[49] Exhibit 3
[50] Transcript page 49
[51] Exhibit 2

reopening the oral evidence; and secondly, it submitted the mortuary evidence was outside the scope of the inquest.

86. Having considered this objection, I did not change my decision to admit the mortuary evidence. If there were any concerns about Ms Grant's evidence or the other mortuary evidence, that evidence could easily be contradicted or explained through NT Health providing their own evidence on the current facilities. NT Health and all interested parties were given opportunities to provide any further evidence or substantive submissions on two occasions. By providing those opportunities I was satisfied that natural justice was served and no prejudice was occasioned. In its letter of objection NT Health included information about the facilities and the relevant history of the design. This information was useful, I have taken it into account, and that letter became Exhibit 9.

87. In respect of NT Health's submission that the mortuary viewing arrangements were outside the scope of the inquest, while I accept that these arrangements are not relevant to the cause of death, I am satisfied they are sufficiently connected with the death being investigated to fall within the scope of the inquest. I am further satisfied that the mortuary and viewing arrangements concern matters of public health or safety about which I am permitted to comment.

Evidence in relation to the viewing facilities

88. Ms Grant's statutory declaration became Exhibit 4. Ms Grant's role, as the Coroner's Grief Counsellor, includes coordinating and attending the Darwin mortuary with families to provide support during viewings of deceased persons.

89. Ms Grant explained that the existing identification room is inadequate for viewings. She noted that:

    a. It is too small to accommodate larger family groups, and this is particularly the case in respect of indigenous families when the deceased is from a remote

community or is an elder.[52] While up to 10 people can squeeze into the small room, she said this is certainly not ideal. When larger groups attend a viewing the family cannot enter together but has to be split into smaller groups.

b. The viewing is through a glass window. Family members normally cannot touch their loved one.

c. There is no waiting area and no seating outside the room. Family have to wait outside (in the elements) or in the hallway. Ms Grant often stands with children in the hallway while waiting for parents to complete a viewing. The hallway is a shared space. Staff working not just in forensic pathology but the broader pathology department, such as microbiology, histology and serology, use this hallway as it is the main thoroughfare to access the laboratories, office space and staff facilities.

d. There is no dedicated public or disability access. The entrance used by family attending a viewing is next to the carpark closest to the emergency department and main hospital entrance. It is a public and busy thoroughfare. Public access is via a set of stairs, with the lifts located in the 'staff only' area. The stairs are partially open to the elements.

e. It is difficult to fit anything other than a regular sized wheelchair through the door of the viewing room.

f. The facilities do not easily accommodate families practicing their personal, religious or cultural rituals in relation to grieving and there is a lack of privacy. Wailing and hitting oneself is a cultural practice for some Aboriginal people and this can be heard by staff in the pathology building. The pathology staff are regularly exposed to audible and visible grief while trying to carry on their work.

[52] I understand from NT Health's response that the facility that is used is the identification room which was not designed as a viewing room per se, but I use this phrase given that is the manner in which the facility is being used in these cases.

g. The area is clinical and dated. [53] The bottom of the stairs is a makeshift storage space containing multiple trolleys and other items that are visible and spill out into the hallway.

90. NT Health accepts that the space is inappropriate for family viewings. NT Health explained that "the identification room was not designed to be [a] body viewing area or a bereavement facility for family members. No part of the mortuary was intended or built to accommodate public access."[54] However, to its credit, despite the inadequate infrastructure, NT Health and its staff recognise the importance of viewings and have done their best to accommodate them.

91. The NT Government previously set aside funds to build a new mortuary facility. In June 2023 a $1.23 million tender was awarded to design:[55]

a. "a new, modern fit-for-purpose facility" for autopsy and pathology services;

b. including "a culturally appropriate bereavement area to provide a space for loved ones going through the grieving process to identify and view bodies in a dignified and private manner";

c. "The bereavement area will include purpose-built mourning rooms and secure outdoor grieving gardens where cultural ceremonies can take place"; and

d. additional car parking for staff and the public outside the new mortuary.

92. As the Chief Minister at the time stated, it is "crucial we have culturally appropriate facilities for loved ones to gather at one of their most difficult times"[56] and the 2024 budget included $22.6 million for construction, "to upgrade the forensic mortuary, pathology and bereavement facility."[57] However, despite the allocation of funding and the expectation that construction would commence during the 2024 budget year

[53] See also the NT Government media release contained in exhibit 5 at p 1.
[54] Exhibit 9
[55] Exhibit 5 p 1
[56] Exhibit 5, p 1
[57] Exhibit 5, p 2

no works were undertaken. NT Health were later informed that the construction could not be completed within the allocated funding and the funding was reprioritised.

93. The 2026-27 budget and regional overview released by the NT Government states that $3 million over two years has been allocated, "for detailed planning of a new forensic morgue and bereavement centre, urgent works at Royal Darwin Hospital to expand capacity of the existing morgue, and refresh amenities including the viewing room and reception area." Of this $3 million, I heard that $1 million is allocated to further planning and $2 million is allocated to an upgrade at the mortuary, including "refreshing" the identification room and the reception area. Clearly this limited work will not resolve the issues identified above.

94. There is no dispute as to the importance of viewings in the grieving process. Viewings are time sensitive, they should be conducted as quickly as reasonably practicable.[58] "Body viewing is an essential part of the mourning process"[59] and "the therapeutic benefits for bereaved families… are well recognised."[60] Respect for the deceased and their loved ones requires "recognition and respect for cultural and religious customs and practices."[61] There is no dispute that the current facilities are inadequate and a dedicated viewing room and bereavement facility is needed.

95. While not every mortuary has a waiting or viewing area, where they exist there are plenty of guidelines that set out minimum requirements. This is not an exhaustive list, but I note the following matters:

[58] Exhibit 8 – State Coroner's Guidelines 2013, Chapter 4, p 12.
[59] Exhibit 7 – *Australasian Health Facility Guidelines*, Revision 7, July 2020, p 11.
[60] Exhibit 8 – State Coroner's Guidelines 2013, Chapter 2, p 7.
[61] Exhibit 7 – *Australasian Health Facility Guidelines*, Revision 7, July 2020, pp 6 and 11.

a. The waiting and viewing area must have separate public access which does not go through the autopsy suite[62] and should be acoustically separate from the autopsy unit.[63]

b. The waiting area should be separate to but directly connected to a viewing room.[64]

c. There should be direct access from the viewing room into the room where the body is placed, allowing the bereaved to touch the deceased. The bereaved should "generally be permitted to view, touch and hold the body, undertake memory making (such as hand and footprints, taking locks of hair), dress the body or perform religious, cultural or social rituals that do not interfere with the body and provided the ritual is not unduly disruptive to the mortuary environment."[65]

d. The interior should provide a 'serene environment' for the bereaved,[66] it should be fitted out in 'an appropriately dignified fashion'.[67]

e. Access for people with disabilities must be provided,[68] and an accessible toilet should be available either within or close-by.[69]

f. There should be no possibility of the public accidentally seeing a body. [70]

[62] Exhibit 6 – National Pathology Accreditation Advisory Council, *Requirements for the Facilities and Operations of Mortuaries*, p 6.
[63] Exhibit 6 – National Pathology Accreditation Advisory Council, *Requirements for the Facilities and Operations of Mortuaries*, p 6.
[64] Exhibit 7 – *Australasian Health Facility Guidelines*, Revision 7, July 2020, pp 12 and 13.
[65] Exhibit 8 – State Coroner's Guidelines 2013, Chapter 4, p 14.
[66] Exhibit 7 – *Australasian Health Facility Guidelines*, Revision 7, July 2020, p 15.
[67] Exhibit 6 – National Pathology Accreditation Advisory Council, *Requirements for the Facilities and Operations of Mortuaries*, Third edition, 2013, p 6.
[68] Exhibit 7 – *Australasian Health Facility Guidelines*, Revision 7, July 2020, p 14.
[69] Exhibit 7 – *Australasian Health Facility Guidelines*, Revision 7, July 2020, p 13.
[70] Exhibit 7 – *Australasian Health Facility Guidelines*, Revision 7, July 2020, p 13.

g. Access to an interview room should be provided for confidential discussions with police or staff. This may be provided via a co-located unit where appropriate.[71]

96. If the existing plans are not acceptable, then the NT Government should ensure a fit for purpose viewing and bereavement facility at the RDH mortuary is designed, funded and delivered.

Formal Findings

97. As per section 34 of the Coroners Act, I make the following findings:

(i) The identity of the deceased is Kumanjayi Johnson, born on 1 June 2021 at Royal Darwin Hospital;

(ii) The deceased was of Aboriginal origin;

(iii) The time of death was 7:13 am on 6 June 2024 at Palmerston Regional Hospital;

(iv) The cause of death was sepsis.

Recommendations

1. I recommend that the **Department of Children and Families** introduce a metric to be included in monthly reporting that measures family contact and, in the case of Aboriginal children, access to country.

2. I recommend that the **Department of Children and Families** review current processes and work flows and identify methods to ensure sufficient ongoing efforts are made to develop rapport, build relationships and provide support, to parents (or other relevant family members) of children taken into care so that connection with the child's family and culture can be prioritised, supported and maintained. To this end consideration should be given to:

[71] Exhibit 7 – *Australasian Health Facility Guidelines*, Revision 7, July 2020, p 12.

a. within each care team, allocating a member who has responsibility for (i) supporting a parent (or other family adult), including relationship building, and (ii) reporting and record keeping obligations concerning that support and engagement;

b. prioritising family rapport building when protection orders are first imposed with a continuing obligation to proactively maintain and build those relationships;

c. assigning ACWs to individual children (and their biological families) on an ongoing basis; and

d. expanding the circumstances in which referrals are made to external family support services to support biological families to maintain connection with their children in care, including in the case of long-term orders.

3. I recommend that the **NT Government** should ensure a fit for purpose viewing and bereavement facility at the RDH mortuary is designed, funded and delivered.