CITATION: *Inquest into the death of Peter Limbunya* [2008] NTMC 057

TITLE OF COURT:	Coroner's Court
JURISDICTION:	Coronial
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HEARING DATE(s):	13, 14, 15 & 16 November 2007, 15 & 16 April 2008
FINDING OF:	Ms Sue Oliver SM

CATCHWORDS:

Reportable death, preventable death at remote airstrip**,** patient travel.

REPRESENTATION:

Counsel:

Assisting:	Ben O'Loughlin
Department of Health & Community Services:	Mr Kelvin Currie
Katherine West Health Board:	Mr Tony Young
Family of Deceased:	Mr Pat McIntyre

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

No. DO137/2006

In the matter of an Inquest into the death of

PETER LIMBUNYA
IN AUGUST 2006
AT KALKARINGI AIRSTRIP

FINDINGS

(1 September 2008)

Ms Sue Oliver SM:

Introduction

1. The inquest into the death of Peter Limbunya was conducted at both Kalkaringi and at Katherine on 13 to 16 November 2007 and 15 to 16 April 2008. During the inquest the deceased was referred to as "The Old Man", which is a term intended to be respectful of him and of Aboriginal tradition. It is one commonly used in the Northern Territory to avoid offensive use of the name of a senior deceased person. As these findings are in writing, I will refer to him as Mr Limbunya although it is necessary to record his full name as part of the formal findings as to identity under the *Coroner's Act*. In any oral publication of the findings, use of his name should not be made out of respect for him, his family and traditions. At the end of the oral evidence and submissions, I gave leave to Counsel for the Family to file further written submissions and for any written response. A written submission from Counsel for the Family was received. No written responses have been made.

2. The death of Mr Limbunya was a reportable death pursuant to section 12(1) of the *Coroners Act,* in that it appeared to have been unexpected and

resulted if not from one, but from a series of what may broadly be considered as "accidents" within the terms of section 12(1).

3. Pursuant to section 34 of the *Coroners Act*, I am required to make the following findings:

> (1) A coroner investigating –
>
> (a) a death shall, if possible, find
>
> (i) the identity of the deceased person;
> (ii) the time and place of death;
> (iii) the cause of death;
> (iv) the particulars needed to register the death under the *Births, Deaths and Marriages Registration Act*; and
> (v) any relevant circumstances concerning the death.

4. In addition, section 34(2) provides that I may comment on a matter, including public health or safety connected with the death being investigated. Additionally, I may make a report and recommendations pursuant to section 35:

> (1) A coroner may report to the Attorney-General on a death or disaster investigated by the coroner.
>
> (2) A coroner may make recommendations to the Attorney-General on a matter, including public health or safety or the administration of justice connected with a death or disaster investigated by the coroner.
>
> (3) A coroner shall report to the Commissioner of Police and the Director of Public Prosecutions appointed under the *Director of Public Prosecutions Act* if the coroner believes that a crime may have been committed in connection with a death or disaster investigated by the coroner.

5. Members of the deceased's family and of the Kalkaringi and Daguragu communities attended much of the Inquest. I would like to commend the community members and in particular the deceased's son, Mr Geoffrey Peter and his stepdaughter Ms Cassandra Algy for the great dignity demonstrated both in the giving of evidence and in general attendance and for the respect

they have shown to the process. The deceased's niece, on behalf of the family, read to the Court a statement (subsequently tendered [F4]) which gave some history of the deceased's life, establishing the importance that he held as a senior man to his community and providing insight into his character and why he was much loved and now missed by his family. I thank the family for providing that background. At the time of his death, the deceased was one of only three surviving senior men who took part in the famous walk off from Wave Hill Station in 1966, in order to secure equal rights of pay for equal work for Aboriginal people and which culminated in the return of traditional land. He is described by his family as "a wise man, a knowledge man and a teacher. He was known for his cleverness, his great sense of humour and his cheeky reactions. The government authorities stole his sister from his family when she was 6 years old but he was there to tell her that her family has never forgotten her when she was found more than 50 years later". He was "an important law, ceremony and medicine man … known in communities from Yuendumu to Yarralin". He was an accomplished horseman in his working life and his walk carried the legacy of broken bones not properly corrected. He was multi-lingual, speaking three languages, Gurinji, Ngarinman and Ngaliwuru but not English.

6. I also received a statement from Mr Michael Paddy of Kalkaringi Community who is the President of the Daguragu Community Government Council. He said that following the death of his own uncle, the deceased was the oldest senior tribal member of the community. To explain the significance of senior community members in Aboriginal communities, Mr Paddy said:

> "Old people have all of our stories and all of our culture. Without them we are nothing. That's why we look after our old people.
>
> Mr Limbunya meant a lot to this community. He was a respected person. He was an important figure for men's business. He was one of the people with all of the stories and all of the culture. When he

passed on, he took with him our tribal ceremony song, and all that goes with it."

7. It is important that these matters are properly recorded so that his character and his significance to his family and community are understood, including their great sense of loss and grief that he should have spent his final time alone in the circumstances that will become apparent.

8. The death was investigated by Senior Constable Geoffrey Meng and I have before me a coronial brief in relation to the investigation compiled by Senior Constable Meng [CA11], including the autopsy report. I also have additional statements tendered, some of which form part of the brief, a certificate from Births Deaths and Marriages of the Aboriginal Population Records with respect to the birth of the deceased [CA17] and various reports to which I will refer.

9. I heard oral evidence from members, including family members, of the Kalkaringi and Daguragu Communities, those involved in the health care and the arrangement of and transport of Mr Limbunya to and from the Katherine Hospital and the authors of reports received.

Relevant Circumstances Concerning Death

10. The issue that arose for consideration in the Inquest was to ascertain how it came to be that an elderly man being returned from hospitalisation to his community came to an unexpected death in bush land away from his home community of Daguragu and the airport where he was last seen. This necessitated a consideration of the roles and actions of the health care providers and of his transport arrangements and decisions made by them. Consequently, I granted leave to Mr Kelvin Currie to appear as Counsel for the Department of Health, to Mr Tony Young to appear as Counsel for the Katherine West Health Board and to Mr Pat McIntyre to appear for the deceased's family. Counsel assisting was Mr Ben O'Loughlin.

11. There were, in my view, many contributing factors leading to the ultimate tragedy. It was a combination of factors that lead to Mr Limbunya's untimely death.

12. The evidence of the events leading up to the death of the deceased may be summarised as follows. I will turn, in due course, to each of the matters which I consider ultimately contributed to his death. The deceased became ill with pneumonia on 11 August 2006 and was taken to the Katherine West Health Clinic at Kalkaringi. He was assessed as requiring hospitalisation. There was considerable delay during the day and evening in his transfer to Katherine Hospital due to the aero medical flight being diverted to other communities to evacuate more critically ill patients. He was eventually evacuated from Kalkaringi by plane in the early hours of 12 August 2006. He was not accompanied by an escort for the journey and hospitalisation, although his stepdaughter, Cassandra Algy, was packed and ready to go. The assessing doctor on his evacuation, Dr David Brookman, had assumed an escort would go with him, but left this detail to the nurse, Brian McNamara. He was treated in Katherine Hospital and on Monday 21 August 2006 was discharged, his travel having been arranged in Katherine by the hospital travel clerk on Friday 18 August 2006. He was taken by the hospital courier with others to the airport, where he joined a charter flight travelling first to Yarralin where the other passengers were dropped off and then he continued on to Kalkaringi. There was no one present on arrival at the airstrip to meet him. He was escorted to the airstrip passenger shelter by the pilot who immediately took off again. It was not until Thursday 24 August 2006 that police were notified that he was missing.

13. A search and investigations were immediately organised by police. The Police case note entries form part of the brief and indicate that the report was received at 11.30am and a line search involving community members commenced at 11.55am. The area searched was from the airstrip shelter walking between the airstrip and airstrip access road through to the main

road [that links Daguragu and Kalkaringi]. At 1415 a helicopter obtained from the meatworks was airborne. On that day the helicopter was in the air searching from 1415 to 1600 and 1615 to 1715 and searched the airstrip surrounds. The OIC used a quad bike to search the surrounds of the airport. Across the next days, inquiries and searches were made around Daguragu, Kalkaringi and surrounding communities, in Katherine and at Limbunya station in case he had been taken by someone to one of these places. Six members of the Territory Response Section of Police arrived to assist the search at around 1.30am on Friday 25 August. Line searches continued, including in grass and bush along the Daguragu access road, as did searches using motor bikes and the helicopter in grid searches. The general view obtained by Police that can be ascertained from the statements tendered is that Mr Limbunya should be near the airport because he could not walk very well. Community and family members were consulted as whether there were other areas that could be searched but none could be identified. Line searching continued through Saturday and on Sunday bike and helicopter searches extended out a radius of 15km from where he was last seen. He could not be found. At 0800am on 28 August 2008 Police advised Mr Geoffrey Peter, Mr Limbunya's son, that the search would be called off. His body was located by three local community members that same day. Records indicating that at 1725pm Mr Peterson Ross attended the Police Station to advise that the body had been found. The location of the body is shown on a map of the area attached to the report showing it to be in the opposite direction to the road that leads either to Daguragu or Kalkaringi. The site was also viewed by the Court.

14. Dr Paul Botterill, a locum forensic pathologist at the Royal Darwin Hospital performed an autopsy on Mr Limbunya's body and provided an Autopsy Report that formed part of the Brief. Dr Botterill found that the cause of death was pneumonia with hypertension a contributing condition. Dr Botterill also gave oral evidence in which he said that it was probably more

realistic to suggest that a combination of the underlying pneumonia plus the stress, the physiological stress associated with dehydration, are likely to have resulted in Mr Limbunya's death. Dr Botterill estimated that death would have occurred within 36 to 48 hours after being left at the airstrip. Dr Botterill's examination also revealed that Mr Limbunya had a polyp within his right main bronchus. Dr Borrerill explained that if this was causing a block of that particular are of the lung, obstructing the windpipe would explain why he was discharged with the pneumonia appearing to have cleared up, when it wasn't as resolved as it appeared. Dr Botterill did not think that anyone would have been aware of the polyp within the lung.

15. A report of Dr Paul Luckin was also tendered. Dr Luckin has considerable experience in search and rescue. He was contacted by Sergeant Sean Gill by telephone on Friday 25 August 2006 for advice as to further conduct of the search for Mr Limbunya. Dr Luckin gave the opinion that Mr Limbunya was probably a wise and experienced man, although old and frail, and would probably have found the trough or creek (which he had been told existed in the search area). Dr Luckin felt that if Mr Limbunya was not near water, he would almost certainly not be alive - if he were still alive, he would be within a kilometre of water. The purpose of the advice was to narrow the search area to that which increased the chance of finding Mr Limbunya still alive. On 5 September 2006 Dr Luckin was advised that Mr Limbunya had been found deceased about 800m from the area searched. He was not near water.

16. At the request of Counsel assisting, Dr Luckin provided his opinion as to the likely time of death. Taking into account the environmental factors and Mr Limbunya's physical condition, Dr Luckin's view was that he would expect him to survive for about 36 hours, but probably not much longer than 48 hours. These are "best guesses". Expanding on this, Dr Luckin said that "if he had no water after being dropped at the airstrip at 1800 (sic) on Monday 21Aug06, I would expect him to have survived through Monday night and

probably Tuesday 22Aug06, possibly Tuesday night, but I would doubt that he survived through the day on Wednesday 23Aug06."

17. Although Dr Luckin's advice as to the time of drop off at the airstrip is incorrect (the flight manifest and the pilot's evidence being that Mr Limbunya was last seen by him at 3.55pm when the flight departed the air strip), this would seem to make minimal difference to Dr Luckin's estimates.

18. Mr Robbie Peters, one of the local men (and Mr Limbunya's nephew) who located Mr Limbunya's body also gave evidence as to his opinion as to when Mr Limbunya had died. Mr Peters is a very experienced traditional medicine man. He was away for the week during which the search for Mr Limbunya was conducted and on arriving back on the Sunday, found out that the old man was missing. He said he had a feeling he knew where the body was located. Mr Peterson Ross in his statement confirmed that Mr Peters told him that he was feeling strongly that Mr Limbunya was on the other side of the airport. The next day, Mr Peters, Mr Ross and a Mr Daniel Palmer went to the area where Mr Peters and Mr Palmer walked into an area of long grass about 400-500 metres in from the road where they located Mr Limbunya's body. Mr Peters was asked, by Counsel representing the family, whether he thought Mr Limbunya had passed away less than three days [before he was found] to which proposition Mr Peter's agreed. I think it particularly unfortunate that the question that required Mr Peter's assessment as to time of death was asked in a leading form. The risk of "gratuitous concurrence" (agreement out of politeness) that arises with Aboriginal witnesses with strong traditional backgrounds is well appreciated in the Northern Territory. When Counsel assisting asked Mr Peters "How many days do you think he could have stayed alive for?" Mr Peters responded "maybe a day at the most, a day and a half or so, that's roughly". More weight must be given to that answer in my view because the response can more confidently be seen to be Mr Peters' direct opinion without

suggestion being put to him. His view is consistent with that of Dr Luckin and Dr Botterill.

19. Counsel for the Family in written submissions suggests that I should conclude that during the Police search, that Mr Limbunya was still alive and mobile and not in the location in which his body was found. This is put on the basis that helicopter searches passed over that location and foot and bike searches passed nearby so that had he been in that location, he would have been seen. There is no evidence that supports that view rather to the contrary, those who found the body did not immediately see it from the road. They had to walk through the long grass to find the body. The body was under a tree would explain why it was not observed from the helicopter that flew over the area. The submission was also put on the basis that Mr Peters' evidence was that Mr Limbunya had walked more than 5 but no more than 10 kilometres before he passed away. Again this evidence was given as a response to a question leading that evidence. I have already commented on the reliability and weight of evidence lead in that way. The view is contrary to the view obtained by Police from a number of community and family members set out in various statements that Mr Limbunya would not have been capable of walking very far. It is inconsistent with the evidence of the pilot as to his last observation of Mr Limbunya's ability and pace of walking.

20. If Mr Limbunya was mobile and walking around the area during the search, which covered an extensive area around the airstrip, then it seems to me it would have been more likely that he would have been seen rather than the contrary. There is no support on the evidence for the proposition advanced by Counsel for the Family and I find that Mr Limbunya passed away no later than Wednesday evening 23 August 2006, which may be noted was prior to the search commencing.

Formal Findings

21. Pursuant to section 34 of the *Act*, I find, as a result of evidence adduced at the Public Inquest, as follows:

(a) The identity of the deceased person was Peter Limbunya. No record of the day or month of his birth appears to exist, however the Aboriginal Population Records held by the Registrar of Births Deaths and Marriages record him as having been born in 1928 at Limbunya in the Northern Territory.

(b) The place of death was at a place in bush around 400 metres from the end of the Kalkaringi Airstrip opposite to the airstrip entrance and the road that leads to the main road connecting Kalkaringi and Daguragu. Death is likely to have occurred no later than Wednesday evening 23 August 2006 but no earlier than 4pm on Tuesday 22 August 2006.

(c) The cause of death was pneumonia together with a combination of exposure to heat and lack of water.

(d) Particulars required to register the death:

1. The deceased was male.

2. The deceased's full name was Peter Ngoreela Bungiari Bungayari.

3. The deceased was an Aboriginal Australian.

4. The cause of death was reported to the Coroner.

5. The cause of death was confirmed by post-mortem examination carried out by Dr Paul Botterill.

6. The usual address of the deceased was at Daguragu in the Northern Territory.

The Location Of The Airstrip and Facilities

22. It is helpful to understand the geographic relationship of the airstrip to the communities of Kalkaringi and Daguragu and the physical facilities at the airstrip. I was able to informally observe these on arrival and departure to Kalkaringi for the first day of the hearing. The Court also took a formal view of the area in which the deceased's body was found.

23. Unlike many remote communities where the airstrip is located close to the township, this airstrip is some distance from Kalkaringi, situated between it and Daguragu, which was the deceased's home. The airstrip is not on the main road, but at the end of a bitumen road that runs 1.1km from the main road that does link the two townships. It is not a through road, so the only traffic likely to travel the road is persons going to and from the airstrip. Mr Limbunya had not flown in and out of the community on many occasions during his life.

24. The facilities at the airstrip are very basic. There is a passenger shelter consisting of an open iron shed, which although it provides direct sun shelter, was extremely hot inside. There was a water tank to the back of the shed providing water to the toilet and wash basin area. However no access to a tap was available because this was inside the locked toilet area. There was no tap on the outside of the water tank. This was also the situation at the time when Mr Limbunya was left there. Consequently, although water was on hand, there was no access to it even though Mr Terrence Jackson, who was airport manager at the time, gave evidence that the problem of providing access to the toilet area and therefore water, had been fixed by relocating the fire fighting equipment, the fire equipment being given as the reason for having that area locked at the time Mr Limbunya was left there.

25. It remains a matter of concern that there is no access to water for those waiting at a remote airstrip. Fixing an automatic tap to the tank, one that is pressed and then cuts off on release, should answer any concerns about taps being left on and the tank emptying.

26. Although there was evidence that earlier in his journey back to Kalkaringi Mr Limbunya had a water bottle with him, no bottle was found with his body or during the search. On being left at the airstrip, he was therefore without water and unable to obtain any. He would have been very hot in the shelter (the Australian Climate Statistics [CA15] shows the average mean maximum temperature for August to be between 30 to 35 degrees (ºC). Dehydration in those circumstances would not be unexpected. Indeed the autopsy report, although it gives pneumonia as the cause of death, notes that the possibility of dehydration and exposure as at least contributing factors are difficult to exclude.

When did Mr Limbunya leave the Airstrip?

27. It is not known how long Mr Limbunya remained at the shelter. He was left there, according to the statement and evidence of the pilot after the plane arrived at 15.49pm. Mr Terrence Jackson, the then airport manager, went to the airstrip to do his daily check of security some time between 5.30pm and 6.00pm. The check involved driving around the airstrip and checking the fence perimeter, all the way around, to make sure no animals were stuck inside. He did not check the shelter on this occasion. He did not see Mr Limbunya. Mr Jackson checked the shelter the next morning and found a pillowcase with clothes in it that belonged to Mr Limbunya. However this raised no concern with Mr Jackson, as he assumed that someone may have been camping out there.

28. It seems more likely than not that Mr Limbunya was still in the shelter at the time Mr Jackson conducted his check. It is possible that he had fallen asleep. He was an elderly man still recovering from illness who had just

travelled a considerable distance by plane. The shelter would have been very hot at that time of the day. Given the description by the pilot of how slowly Mr Limbunya was walking on leaving the aircraft, it seems unlikely that if he had set off walking away from the shelter, in the direction that his body was found that Mr Jackson would have failed to have seen him somewhere along the perimeter as he did his security check. At that time it would have still been light and the areas immediately adjacent to the perimeter fencing are clear. It seems more likely than not that Mr Limbunya would have waited some time at least, expecting someone to come for him. I am inclined to a conclusion that most likely he was still in the shelter at the time and then later, perhaps at night, dehydrated and confused as to his whereabouts, he set off in the direction where he was ultimately found. The evidence of Dr Botterill, the pathologist who performed the autopsy, was that a reduced airway could affect a person's ability to reason and the person may behave in a way that would be uncharacteristic of them. This would be particularly so in an elderly person. An explanation was offered by Mr Peterson Ross that a bush fire behind Kalkaringi was burning that night and that Mr Limbunya may have confused the light with that of Daguragu.

29. In my view, the lack of access to water at the airstrip and consequent dehydration cannot be discounted as a contributing factor to Mr Limbunya walking off in the direction that he must have taken, that is, away from the access road.

The System For Communicating Return Patient Travel

30. In contention is the question of whether a facsimile (fax) message advising of Mr Limbunya's return travel arrangements was sent by Patient Travel and received at the Kalkaringi Clinic. Ms Anne Sheales, the Patient Travel Clerk at Katherine Hospital, gave a statement that formed part of the brief and oral evidence, that on Friday 18 August 2006, she faxed the passenger manifest with Mr Limbunya's details to the Clinic. In her statement, Ms

Sheales said that she faxed 3 Clinics with that document, Lajamanu, Kalkaringi and Yarralin at around 10.21am. She did that around the same time she faxed a document with the same information to Aboriginal Air Charter, the company to undertake the travel charter. The copy of the fax received by Aboriginal Air, shows it was received at 10.22am.

31. Fax records, including Telstra records were tendered. According to those records, a fax was received from the number that coincides with the Katherine Hospital switch number to the Clinic numbers at Lajamanu at 10:20:27am, Kalkaringi at 10:21:16am and at Yarralin at 10.22.06am on 18 August 2006. The Kalkaringi records show a fax of 37 seconds duration. The activity report for the Kalkaringi Health fax number shows a fax having been received and completed over 36 seconds starting at 10:18am on that day. The disparity of the Telstra 'sent' time and the Kalkaringi 'received' time is consistent across all records, suggesting that the fax machine at Kalkaringi is set three minutes earlier than the Telstra time.

32. However no member of staff of the Clinic who gave evidence could recollect sighting the fax, either on that day or on the Monday (the day of Mr Limbunya's travel). Dedei Armah, a registered nurse at the Clinic, gave evidence that she was expecting a fax herself about holiday arrangements and was checking the fax machine between 10.00am and 12 noon Friday morning and that no faxes arrived. The Telstra records indicate, however, that other faxes were also sent that day. No record of the fax has ever been found.

33. The weight of the evidence supports the view that the fax was sent to Kalkaringi on 18 August 2006, advising of Mr Limbunya's travel on the Monday. Ms Sheales and the other staff at Patient Travel had a very set routine as to how they arranged and then advised of travel. There is no reason why she would depart from these long established procedures on this occasion. Her evidence of sending the fax is supported by the records for

those phone lines. No fault with the fax machine at Kalkaringi has been identified.

34. It was a busy weekend at the community; Freedom Day in celebration of the famous walk off from Wave Hill Station. There was much activity and the Clinic was not constantly staffed over the weekend, including on the Friday.

35. The Clinic had a system for dealing with faxes that advised of return Patient Travel which may, at the least, be described as haphazard. Faxes were taken off the machine by whoever sighted them and pinned on a notice board. Someone during the day would attend the airstrip to pick up the incoming patient. There did not seem to be any real operational system in this regard. There was no specific allocation of that duty to any particular staff member and no system to ensure that patients had been picked up.

36. The system for return Patient Travel was defective from the Hospital end as well. The fax itself was part of a defective system because it gave no estimated time of arrival (ETA). As Mr Peter Campos, Assistant Secretary, Acute Care, Department of Health and Community Services observed in his evidence, the system of sending faxes to advise of travel relied on an assumption that one having been sent to a Clinic, that it would be received and acted upon. Mr Campso said that the assumption had been robust in the past, but it was proved incorrect.

37. There was no system check to ensure that such communications had been received by Clinics. Although Mr Campos' observation was that the assumption had been robust in the past, there is no way of telling whether in fact this was true. There may well have been incidents where there was a failure of communication for some reason. In communities where the airstrip was close to town, a failure of communication of this nature would not necessarily have caused a problem, with either the patient walking home or someone coming out to the strip to see what the plane was that had landed. That the system had worked without fatal incident led to an

assumption and complacency that the system worked well and efficiently but in truth, it was almost inevitable that what occurred with Mr Limbunya would happen at some point in time. Evidence as to further instances of failure of the Patient Travel system show that this was not an isolated incident. The pilot gave evidence of calling Clinics when no-one had met a plane and the person had luggage or small children.

38. Even after the death of Mr Limbunya, the system in the days after went initially unchanged. Mr James Walker told of travelling back from treatment in Darwin via Katherine. On 1 September 2006 he was almost dropped off at Lajamanu rather than at Kalkaringi and then on arrival at Kalkaringi, there was no one to collect him. He borrowed the pilot's phone to call around numbers until he found someone to come and get him. In his case, the pilot refused to take off until he saw someone arrive for him. When he went subsequently to the Clinic to ask why no-one was there to pick him up, he was told by Rob Roy that the Clinic had not received anything to say he was coming. The Katherine Hospital Patient Travel Diary for 2006 [DHCS3] shows the travel arrangements for 1 September 2006 for Mr Walker as travelling to Lajamanu not Kalkaringi. The charter was not scheduled to travel to Kalkaringi at all, only to Lajamanu and back. This would explain why the Kalkaringi Clinic had no advice of Mr Walker's travel. In his case, the error appears to have arisen in Patient Travel, either from Darwin or Katherine.

39. The tendered brief also contained a statement of Ms Glenda Wardle who arrived at the airstrip with three others on Friday, Freedom Day. No-one was there to collect them. They walked the distance to the main road where they were picked up by the shop manager. As she walked home from the Council Office where the passengers were dropped, she spoke to Rob Roy to ask him why there was no one there to pick her up. She said she couldn't hear what he said back. The phone records referred to previously show faxes having been sent or received at the Kalkaringi Clinic on 17 and 18

August 2006 (i.e. the day before and of Ms Wardle's travel) from the Katherine Hospital fax number. Ms Wardle's travel destination via Janami Air is correctly stated in the 2006 hospital travel diary. The error in this case is likely to have arisen from the Clinic's system for patient pick-up and the limited staffing or the Freedom Day holiday.

40. The report of Anne-Marie Stranger, who at the request of the Deputy Coroner, provided an assessment of the organisational breakdown in the travel arrangements for Mr Limbunya and the lack of provision of an escort for his hospitalisation was tendered [CA16] and Ms Stranger gave evidence. Ms Stranger is Director and Senior Vice President of the Tasmanian Branch of the Australian College of Health Service Executives. She is employed as a Health Services Executive with the Tasmanian Department of Health and Community Services. Her report indicates that amongst other experience, she spent 18 years working for Queensland Health, the majority of which were based in rural and remote areas including working in Aboriginal and Torres Strait Islander communities. Ms Stranger reviewed and commented on:

- the policies and procedures for the transfer of patients
- the Chalmers report, in particular the list of problems and recommendations
- the decision not to provide an escort
- any other systemic problems not already addressed by the Chalmers Report or police investigation, and
- appropriate recommendations in order to prevent the situation arising in the future.

Ms Stranger at p6 of her Report comments:

> "The record keeping, particularly in relation to recording incoming and outgoing faxes, clearly has limited the ability to track the fax sent by the patient travel clerk at Katherine regarding the patient's repatriation details. The information provided by the manufacturers of the Kalkaringi Health Centre fax machine to the police appears to describe normal operations of fax machines in my experience.
>
> The reliance on pinning a note on the notice board in the hope that someone will pick it up and take action is poor practice. A day book would be more appropriate so that the incoming staff can see what tasks need to be done that day, such as making arrangements for someone to collect a patient from the airport. The transient staffing arrangements compound any poor practices as the staff member may be unfamiliar with common practice at the Clinic.
>
> It is noted that that the Kalkaringi Health Clinic operation times mean that effectively after 16.30, any patient travel information that is faxed after this time is not seen until the next working day. Communication from Katherine Hospital about patient travel is often impeded by the lack of a contact person after Clinic hours. There is no mention in the guidelines or procedure manual about this situation".

41. With due respect to Ms Stranger, no expertise should have been required for the Katherine West Health Board or Clinic to appreciate that the operational system for patient pick up at Kalkaringi was flawed. I have concluded that on the occasion in question, the fax regarding Mr Limbunya's travel was sent and received on the fax machine, it was for some reason not noticed or nor acted upon by Clinic staff. Likewise, the system employed to advise of travel by Patient Travel at Katherine Hospital was based on the flawed assumption that if a fax was sent, it would not only be physically received, but come to the attention of a person who would ensure it was acted upon. There was no checking system to ensure that actual communication had been made and without the provision of an ETA, the system presumably relied on Clinic staff keeping a look out for an arriving aircraft.

42. I do not criticise personally the Travel Clerks at Katherine Hospital who used the system, or the nursing and other health staff at the Kalkaringi Clinic. Ms Sheales, in particular, gave a very strong impression of her

commitment to her work over a lengthy period and her efficiency in providing what are indeed complex arrangements for the transport of people both in and out of communities in the region on a daily basis, co-ordinating that travel to coincide with day appointments and the admission and discharge of patients from the hospital. The challenges of that work should not be underestimated; there are few places in Australia that would face the daily task of multiple patient transport over vast distances to meet health care needs. It would be unfair to suggest that Ms Sheales had personal responsibility for the system in place. That responsibility rested with more senior officers of the Department and the lack of proper oversight appears to have been accepted by the Department. Likewise, the responsibility for a proper system to ensure patient pick up at Kalkaringi was with those responsible for the organisation of the Clinic's operations, not with the hard working Clinic staff.

43. A number of measures have been now put in place for return Patient Travel. These provide a proper check and balance to ensure that a tragedy of this nature does not occur again. When Patient Travel sends a fax advising of return Patient Travel, that document must be signed by the recipient for confirmation that it has been received and noted and then return faxed to the Patient Travel Office. If the confirmation has not been received, then the patient does not travel. At the Clinic a white board is used to record travel arrangements and there has been an adoption of incidents reporting: orientation of staff with respect to the Patient Travel Scheme at the Hospital occurs. Charter pilots are under instruction and charter contracts being amended, that if on arrival at a remote airstrip, no-one is there for the patient, that they must not leave the patient but return them by plane to their departure point. The Katherine region is also trialling an SMS and email system for travel arrangements and confirmation. These measures remedy the defective systems previously in place and should ensure no repetition of a tragedy of this nature occurs again.

The Patient Travel Scheme & Escort Provision

44. The Patient Travel Scheme (PTS) provides assistance to patients with travel and accommodation when they require access to medical treatment not available in their own area. There are three aspects to the system, the Patient Assistance Travel Scheme (PATS), Inter Hospital Transfer (IHT) and Medical Evacuation (MEDIVAC). There are PTS guidelines for each scheme [CA12]. Each scheme allows for an "escort" to accompany the patient in specified circumstances in the guidelines. The provision of an escort is required to be authorised by the delegated officer. Mr Limbunya's travel out of Kalkaringi was a medical evacuation (MEDIVAC) and under the PTS guidelines, the delegation for approval of an escort to accompany him was with the District Medical Officer.

45. Earlier in the day, when assessed by Dr Brookman at the Clinic, Dr Brookman requested his evacuation to either Darwin or Katherine and negotiated this with the DMO then on duty. In his statement, Dr Brookman described him as being "a generally frail old man suffering from a lower respiratory tract infection and dehydration". His "command of English was poor and he required a translator to obtain a medical history. His stepdaughter Cassandra Algy acted as a translator at Kalkaringi". With regard to an escort, Dr Brookman stated "I did not complete the escort section, as the ability to transport escorts was usually determined by the aircraft capacity and load, the availability of a member of the family to accompany him and the availability of a translator in Katherine (in this case for Daguragu). Leaving the form blank allowed it to be filled in closer to the time of departure". In Dr Brookman's evidence at the Inquest, it was apparent that there seemed to be some confusion in his understanding of the authorisation process for an escort. Initially he said that he had, in effect, authorised the escort, leaving the detail only, that is, the identity of the escort, to the nurse. He said he thought it was a bit unusual that authorisation had been sought from someone else (in reference to the DMO),

although earlier in his evidence, he agreed that the system was to obtain verbal approval from a DMO in either Katherine or Darwin. He agreed that on the criteria for an escort, Mr Limbunya qualified on the basis of his age (78 years) and poor English alone. Dr Brookman had only recently arrived in Kalkaringi as a locum, having been there two weeks following a one week orientation.

46. The attending nurse at the Kalkaringi Clinic, Brian McNamara gave evidence that he had considered that Mr Limbunya should have an escort to travel with him for his hospitalisation. Mr Limbunya's stepdaughter, Cassandra Algy, was available and willing to accompany him. She had her bag packed ready to go.

47. Although the decision to evacuate Mr Limbunya had been made earlier in the day, his transfer did not take place until the early hours of the next morning. This was due to the diversion of the flight for higher priority patient evacuations from other communities. According to Brian McNamara, when the flight nurse called to give the estimated time of arrival, he told her that there would be an escort and she said that he needed approval. In his last conversation with the DMO on call, Dr Juliette Buchanan, he provided her with an update and requested the escort approval. He said he gave the reasons that the patient was frail elderly and because the family was expecting an escort and one was available. He said that questions were then asked about the escort and whether she had helped during the night, to which he had responded that she was a young female who hadn't helped but had been present. He said that Dr Buchanan then said that she didn't feel that an escort was required. He then said he is an old man and she said it was not necessary. He said "OK".

48. Dr Buchanan was a DMO on duty that evening. She had taken over Mr Limbunya's transfer and care from another DMO at 7.00pm. Dr Buchanan was situated in Perth. She has worked in the Northern Territory and has

experience in remote transfers having worked as the doctor on medical evacuation flights and also had previous experience in Western Australia in a similar role to that of a DMO, providing medical advice over the phone, including emergency treatment advice and evacuation. Dr Buchanan said that she had no detailed memory of the incident. She said that she did not think that she had ever seen the Patient Travel Scheme guidelines, although she said she was familiar with the criteria for the approval of an escort and agreed she knew of the example given at 4.1 of the guidelines, that is a "frail aged or chronically ill person needing assistance to cope in a large metropolitan centre or with a complex transport system". She agreed that in retrospect, Mr Limbunya should have travelled with an escort, but that she didn't have enough information and couldn't see him to make that decision. In summary, her evidence was that there was reliance on the Clinic staff to convey the information needed to make the decision as to the need for an escort.

49. Mr McNamara's evidence was to the effect that Dr Buchanan refused the escort. Dr Buchanan did not believe that she had ever refused an escort where one was recommended from the local Clinic, yet she accepted that in accordance with what appeared on the form for Patient Travel attached to her statement, that on this occasion she must have done so. She proffered three explanations for the refusal:

- That the family had requested an escort but the Clinic nurse didn't believe there was an appropriate escort available
- That the family requested an escort but the Clinic nurse didn't believe that an escort was needed
- That this was the one and only time that she had ever disagreed with the impression of the Clinic nurse on site as to whether an escort was required

She agreed that if it were the latter situation, she would expect that she would recall it because it would be extremely unusual and thought that if there had been disagreement expressed with her decision, she would have changed it.

50. The accounts of Mr McNamara and Dr Buchanan may not be as at odds as initially appears. If what Mr McNamara told Dr Buchanan was that Mr Limbunya was frail elderly and the family expected an escort, then Dr Buchanan may have not understood this as a being a recommendation for an escort. Mr McNamara's evidence in relation to the conversation as to identity of the escort was that he had said she was a young woman and had been present but had not helped. This was not an accurate assessment because, as Dr Brookman said, Ms Algy had acted as a translator and Ms Algy's evidence was that she had to translate for her stepfather because he could not speak English. Clearly she had "helped" and would do so on the flight and on admission to hospital because without a translator, no effective communication could occur. Dr Buchanan was not told this either on her evidence or on that of Mr McNamara. Ms Algy's evidence was that Mr McNamara was disrespectful of her because of the way he was talking to her. The conclusion I have reached is that the conversation between Dr Buchanan and Mr McNamara was not understood by Dr Buchanan as constituting a request for an escort. Mr McNamara's own account is of the provision of very limited information and of very little resistance to the decision not to approve an escort. This would account for Dr Buchanan's belief that she had never refused an escort where one was recommended by the nurse on site.

51. In her report, Ms Stranger raises criticism of both Mr McNamara and Dr Buchanan. It is her view that "the RN should have queried the decision and strongly advocated for the patient, given the fact that the patient met the criteria under the guidelines and the current health status of the patient. She also believed that the DMO should have actively explored the patient's

circumstances and condition in more detail. Ms Stranger also points out that the Health Clinic staff at Kalkaringi could have followed up the matter the next day by seeking approval from the treating doctor in Katherine and arranging for Ms Algy to go on the next flight.

52. I agree with Ms Stranger's assessment that both the RN and the DMO should have given closer consideration to an assessment of the need for an escort in accordance with the criteria in the guidelines. If all relevant issues had been put forward or asked, then the need for an escort would have been apparent. However, the criticism of Mr McNamara does need to be measured against the circumstances at the time. Mr McNamara had been on duty starting around 8.45am on 11 August 2006. By the time Mr Limbunya was flown out at around 1.30am on 12 August 2006, Mr McNamara had been working 18 hours with only a 30 minute meal break around lunch time. He had been trying for many hours to get Mr Limbunya evacuated. His primary concern when told the plane was on its way was to get his patient prepared for the transfer and out to the airstrip. This in itself is not a task to be underestimated in terms of difficulty. He became focused on that task rather than on putting forward a full case for approval of an escort. He accepted Dr Buchanan's decision and got on with the transfer in circumstances where he must have been quite exhausted and anxious to complete the transfer for his patient's benefit.

53. It would also have been appropriate for there to have been a review at the Clinic during the day shift of Mr Limbunya's transfer, to check that all had gone according to plan. Dr Brookman after all had thought that an escort was warranted and it would have been possible to have the decision reviewed and for Ms Algy to travel into Katherine.

54. The lack of clarity and recording of how and why an escort was refused is in itself a matter of great concern. It was a decision critical to the outcome of this matter because had Mr Limbunya been escorted, none of the other

factors would, in my view, have led to his death because, at the very least, his stepdaughter would have been able to walk to the main road to seek assistance. It is unlikely that Mr Limbunya would have wandered off in those circumstances because he would have understood that she was going for help for them. In all likelihood, she may have shortly come across Mr Jackson on his way to the airstrip and he would have driven them back to town.

55. In my view, the evidence indicates that both Dr Buchanan and Mr McNamara focused their view on the need for an escort with respect primarily, and perhaps only, for his journey into and for during hospitalisation, rather than on the entirety of Mr Limbunya's treatment and travel needs. There is little evidence that there was full consideration of the need for his care over the entire journey, particularly for his discharge and return travel.

56. It was conceded by all relevant witnesses, that Mr Limbunya properly qualified under the PTS guidelines for an escort due to his age, frailty, deafness and language/communication difficulties. He could and should have been granted an escort for his stay in hospital, or at least for the return journey, though separate consideration of an escort for this leg does not seem to have been considered by anyone. Ms Algy might easily have travelled into Katherine on the day or days following his transfer from Kalkaringi to Katherine. Ms Algy presented as a capable young woman, deeply distressed that she had been unable to fulfil her role of caring for her stepfather during his illness and treatment and assist his safe return to Kalkaringi/Daguragu.

57. The PTS guidelines in themselves, and as concluded by the Chalmers report and Ms Stranger's report, are quite clear but confusion as to the understanding and operation of the PTS guidelines by the persons responsible for their use was apparent.

58. I find that Mr Limbunya should have been accompanied by an escort for his safe transport and hospitalisation. That need should have been met on transfer out of his community but could also have been identified and met either during hospitalisation or on discharge. Mr Limbunya undoubtedly met the criteria for an escort due to his age, frailty and language difficulties. It would have been appropriate for the Clinic at Kalkaringi to follow up to the escort situation the following day and it would be, in my view, good practice for the Clinic to have in place a system for escort review when patient transfers have occurred out of hours to ensure that if an escort was warranted and for some reason did not eventuate, that further steps then be taken to advocate for an escort for hospitalisation and/or repatriation.

59. The question of whether an escort is required when dealing with remote patients should be given greater primacy than was apparent in this matter. Language difficulties, cultural considerations (especially for senior men and women), limited experience with multiple transport arrangements, are all matters which may require the escorting of a patient to ensure not just safe travel, but effective health treatment. Staff training at both Clinics and for designated authorised officers should ensure that the reasons for escort assistance are fully understood. Requiring the decision maker on an escort to record the reasons for a refusal of an escort (where one is available) should assist to focus the designated decision makers on the criteria and to provide understanding to the patient and family as to why an escort was considered not necessary. It would allow for review of the situation at later stages in the patients journey, for example, on repatriation.

The Follow up of Mr Limbunya's Return

60. Mr Geoffrey Peter, Mr Limbunya's son, gave evidence that on the Tuesday after the celebration weekend (ie 22 August 2006) he went to the Clinic to find out when his father was returning from hospital. He asked Wayne Farquharson to ask Roslyn Farquharson, the Clinic receptionist, to find out

when his father was coming back. He did not speak directly to Ms Farquharson because she is his mother-in-law and direct communication between them is culturally unacceptable. Wayne passed on the message to Ms Farquharson. Her evidence was that she called and spoke to a woman and was told that Mr Limbunya was coming on the plane but was not given a time. The message was passed onto Mr Peter that Ms Farquharson would call him when she knew.

61. The evidence of Ms Farquharson is inconsistent with that of Ms Sheales and Mr Brodie from the Patient Travel Office. Mr Brodie recollected taking a call inquiring after Mr Limbunya at around the same time that is suggested by the evidence above. He said he would get Ms Sheales to call back. She agreed that when she returned to the office she was asked to call the Kalkaringi Clinic, which she did and that she spoke to a woman. She said she told her that Mr Limbunya had gone on the plane the day before.

62. I am inclined to accept Ms Sheales' account. It would not be logical for her to have told Ms Farqharson that Mr Limbunya was coming on the plane when she had checked her records and knew that he had already gone. I do not suggest that Ms Farqharson has not told the truth as she remembers it, but rather I think it is more likely that she did not properly understand what had been said and the wrong message was passed onto Mr Peter.

63. The following day, Wednesday 23 August 2007, Mr Peter said he spoke to Rob Roy, a community health worker, and asked again for there to be an inquiry as to when his father was returning. Mr Roy however said that it was the Thursday when Mr Peter spoke to him for the first time. Mr Roy also said that it was the Thursday, (24 August) that was the first time he rang and spoke to Ms Sheales. He said that following the call, he went straight to the police. Ms Sheales on the other hand was adamant that she had received a call from Mr Roy on Wednesday around lunch time and that she told him to call the Yarralin Clinic in case he got off there. Mr Roy's

evidence was inconsistent with his previous statement that formed part of the brief. In the statement he said that following the call with Ms Sheales, he asked Geoffrey (Mr Peter) to check around the community if he was there and get back to him. He then went to the airport with Roslyn Farquarson to pick up the troop carrier that Mr McNamara had left there and found Mr Limbunya's bag. He then drove back and went to the police.

64. In his evidence, Mr Peter said that the next morning (Thursday) he again asked that the hospital be called and Mr Roy agreed he made a call first to the ward and then to Ms Sheales. Ms Sheales informed him in strong terms that Mr Limbunya went on the Monday and that he should call the police. She called both Yarralin and the pilot and on being told by the pilot that Mr Limbunya got off at Kalkaringi, she called Mr Roy and told him that Mr Limbunya got off at Kalkaringi.

65. Once again, communication between those involved was a problem. Ms Sheales believed she had made it clear to the callers from Kalkaringi that Mr Limbunya had returned on the Monday flight. This was either not understood or the significance not fully appreciated. Mr Roy's suggestion to Mr Peter that he ask around the community for the old man suggests that even when told on Thursday that Mr Limbunya had travelled back on the Monday, he did not appreciate that Mr Limbunya was missing until he found Mr Limbunya's pillowcase at the airport.

66. The communications between the Clinic staff and the Patient Travel staff show that no-one realised until the Thursday, the seriousness of what was happening or the danger that the exchange of information about his travel signified.

The Drop Off by the Pilot

67. Mr Angus Chartres, the pilot of the charter flight that returned Mr Limbunya to Kalkaringi gave evidence by telephone from Hong Kong where he is now located.

68. Mr Chartres had been flying remote services for a total of around 16 months, 12 of those out of Lajamanu at the time of this incident. He said that he had never been required to wait for a pick up to arrive at a remote airstrip and that he had done something between 33 to 100 drop-offs at Kalkaringi. There were many times when there was no-one there on arrival. To land at Kalkaringi there would be a fly over the community because it was in the flight path.

69. Mr Chartres said that he assisted Mr Limbunya to the shelter and then went back to get his bag for him. Mr Limbunya sat down in the shelter with his bottle of water and Mr Chartres went back to the plane and left. The flight manifest shows that the plane was on the ground for approximately six minutes from arrival until further take off.

70. Mr Chartres' evidence as to why he took no steps to ensure Mr Limbunya's safe pick up was centred on what he saw as his contractual obligations, that he was contracted only to run a charter flight, A to B and that he had been told by his employer not to "think outside the square", although he agreed that there had been occasions that he had called by mobile CDMA phone to Clinics where someone had requested that because of children or luggage.

71. He knew the distance from the airstrip to Kalkaringi. He had a phone and the telephone number of the Clinic. It was still early afternoon when staff would have been present. There could not have been any anxiety about the need to take off because of failing light. It may not have been part of his contractual obligations to ensure that passengers were picked up and it may have been that he had been directed by his employer to do nothing other than his flight duties. It may be that he assumed that as there had never

been a problem in the past, someone would eventually arrive to pick up Mr Limbunya. However his actions in simply depositing an elderly frail man returned from a hospitalisation at the most basic of facilities at the airstrip when he might just as easily made a quick call to the Clinic or to the Patient Travel Office in Katherine, lacked the most basic element of human compassion. Mr Limbunya was not a parcel to be deposited for someone to collect. Respect for his age and situation, would it may be hoped have caused most people to make that call to assist him. That telephone call to the Clinic would almost certainly have altered the outcome for Mr Limbunya. It was not an omission that caused his death, but it might well have prevented it.

72. However, having heard Mr Chartres in evidence, I did not form the view that his failure to call was made out of callousness or disregard for Mr Limbunya. There was a simple complacency and assumption that he would be picked up as others had been in the past. The same attitudes were apparent in the actions and inactions of many of those involved in this matter. There were a number of missed opportunities in relation to actions/inactions that might have altered the outcome for Mr Limbunya. I agree with what was put to me by Mt Currie, Counsel for DHCS, everyone in the process could have and would have done something more had they realised the risk that arose. However, the real issue was a defective system that was based on an assumption that it was safe and effective.

73. I note that the Department of Health and Community Services are seeking amendment to contractual terms for their charter arrangements to extend the duties of pilots to prevent any further incident of this nature and I agree that this is a most appropriate step.

Response from the Department of Health and Community Services (DHCS) and the Katherine West Health Board (KWHB)

74. Each of these organisations has acknowledged that the systems that they had in place around patient transfer from Kalkaringi, and in general with respect to remote communities, were deficient. Mr Sean Heffernan, CEO of the Katherine West Health Board, in his evidence before the Court offered a very moving apology to the members of Mr Limbunya's family in which he undertook that the Board was and would continue to improve upon the care they provide to members of communities served by the Board. Mr Campos acknowledged in his evidence that the belief that the system of Patient Travel operated by the DHCS was a safe one was based on false assumptions.

75. It was very clear that the tragedy of Mr Limbunya's death has had a profound affect on all those involved in his treatment and travel who gave evidence at the inquest.

76. This has not been a case where those involved have sat back to await the outcome and findings of an inquest before addressing the issues that gave rise to the tragedy. Immediate steps were taken to address the contributing issues I have identified. In September 2006, the DHCS began a process for responding to the risks in the PATS and by October an internal action plan had been developed on a local level, resulting in changes to the communications between PATS and remote Clinics. A review of staffing levels in the Katherine PATS office was conducted with an additional administration officer appointed, trial of an Aboriginal Liaison Officer to support the repatriation of patients to communities and improvement in the working space of PATS staff at Katherine Hospital. By November the terms of reference for a systems review of the incident by a panel comprised of members of DHCS and KWHB and chaired by Dr Elizabeth Chalmers were put in place. The panel completed it review in February 2007 with 24

recommendations addressed to both DHCS and KWHB ("the Chalmers report"). In March, DHCS developed a draft implementation plan for the recommendations of the Chalmers Report. DHCS instructed general managers of other hospitals to also implement as far as practicable to measures initiated by the Katherine Hospital regarding communication about patient repatriation. In August 2007, a consultant, Edward Tilton, was engaged by DHCS to facilitate a process between DHCS and the Aboriginal Medical Services Alliance NT (AMSANT) to gain as much agreement as possible for the implementation of the recommendations of the Chalmers Report across the whole of the NT and Mr Tilton convened a workshop involving a number of health services including KWHB in September 2007 with a report then being provided on 13 September 2007 ("the Tilton Report"). The report was released to participants in the workshop in November and there continues to be work with those participants to ensure the necessary changes to ensure safety on Patient Travel.

77. As I noted earlier the Deputy Coroner arranged for the Chalmers Report to be reviewed by an independent expert Ms Stranger. I do not suggest that Dr Chalmers did not exercise independence in her role as chair of the review panel, nor that the review team conducted the review in anything other than an open and complete appraisal of what occurred and of their systems but as Ms Stranger observed in her report, given that the panel was comprised of each of the parties directly involved in the transfer and care of Mr Limbunya it may have been desirable for an outside person to have been part of the review team, both from a public perspective and to offer a naïve perspective.

78. I was provided with a copy of all reports and have been given progressive updates of the implementation plan for the recommendations which charts not only the proposals and considerations against each recommendation but also documents the implications Territory wide and the progress and outcomes to date. It is apparent from the document that considerable work and progress has been made with respect to implementation. The Plan

addresses issues of Cultural Safety, Patient Travel, Collaboration and Education. Rather than canvas each of the recommendations and actions that have been taken or are proposed to be taken I have attached the Kalkaringi Implementation Plan that was tendered as Annexure A to these findings. They appear to me to be appropriate responses and actions to prevent any further tragedy of this nature, provided that are and continue to be fully implemented. They present as a genuine attempt by all involved to address and improve the health outcomes for Aboriginal patients. Much however will depend on staff training and understanding to ensure measures are adhered to, particularly where there is a high turnover of staff. It must also be recognised, as I believe the Plan does, as an ongoing process.

79. In addition to the recommendations concerning cultural safety and their implementation in the Kalkaringi Plan, the DHCS released an Aboriginal Cultural Security Policy in May 2007. Documents outlining that policy were tendered [F3]. As one of those documents states, Cultural Security is a strategy to improve services to Aboriginal people by making sure the way services are delivered takes important cultural matters that have a bearing on the health and Community outcomes into account. It recognises that cultural considerations are not uniform across each community in the Northern territory and there is a primary responsibility to work with individual communities and staff to find ways of building Aboriginal culture appropriately into services to promote the best outcomes.

RECOMMENDATIONS

80. I agree with the submission made by Mr Young for the KWHB that one of the issues identified by this tragedy is the importance of cultural safety, security and appropriateness in addressing the health needs of aboriginal people and I have mentioned above that the DHCS have released and commenced the operation of such a policy. He submitted that Aboriginal people in all systems have the potential to be ignored because they don't

speak English or do not speak and understand it fluently, they may be in a system that is foreign to them and illness, infirmity and age are features that make them even more vulnerable. "Gratuitous concurrence" – an agreement or lack of resistance to what is occurring arising out of cultural politeness also affects the service providers appreciation of what has actually been understood or agreed to. These are all features of Mr Limbunya's case. He did not speak or understand English fluently yet that does not seem to have been appreciated when he was in Katherine Hospital there being no evidence of the use of an interpreter in his care and no identification of how vulnerable he was in his repatriation. Ensuring that Aboriginal Cultural Awareness Program training is provided for all DHCS staff including reporting on the training delivered and numbers of attendees and that the NT Government work in conjunction with universities and training providers to develop and implement innovation in recruiting and retaining Aboriginal clinical staff across disciplines at Hospitals and regional health services and increasing the resources for interpreter services as recommended (Recommendations 4, 5 and 6) in the Tilton Report have my complete support. Mr Tilton confined his recommendations to the Katherine Hospital and region however these issues are clearly Territory wide and need to be addressed on that basis. The Implementation Plan (Attachment A) recognises and is attempting to address these issues and therefore requires no formal recommendation from me other than to say I endorse and encourage the further development and action of the plan.

81. The written submissions of the family also suggested a number of recommendations some of which cover similar ground as the ones above. In particular I agree with the suggestion that there should be greater use of interpreters at admission and during treatment where one is available for persons identified as requiring that assistance. I do not agree that this should be the case for all persons who have an aboriginal language as their first language as submitted. As with all speakers of a first language other

than English, the need for an interpreter will depend on the command of English as a second or other language, not on the fact of having another language as a first language. The implementation of the recommendations with regard to the Tilton report above should assist and alert staff to circumstances in which an interpreter is required

82. A number of the family submissions also dealt with matters not raised by the evidence in this inquiry. For example I am asked to recommend that resources for primary health care in Kalkaringi and Daguragu be increased, but there was nothing before me to suggest the inadequacy of current funding levels nor that increased resources would have resulted in a different outcome in this matter because on the evidence, Mr Limbunya required hospitalisation.

83. The inquiry did hear evidence regarding a request for notification of flights into Kalkaringi from organisations by the then Airport manager. The family submits that patient travel should be required to notify the Daguragu Council of all patient travel flights in bound to the Kalkaringi airstrip at least 24 hours prior to travel. Leaving aside the problem of client/patient confidentiality which this submission obviously raises, the suggestion is not a practical one because of the way in which the patient travel charters work, both taking people to and from day clinic appointments and repatriating them after hospitalisation. It is not clear to me how this would, in any event, provide assistance. The Clinic and the Hospital now have in place a safe and secure system for advice of patient travel by air and it is not clear on the submission what additional role or value the Daguragu Council would be expected to contribute.

84. I do agree with the submission that a system to provide better information to a patient's family as to their relative's travel plans is desirable, provided of course that a patient consents to sharing that information. This is a matter it seems to me for consideration as part of the cultural security policy and

would need to be developed on an individual basis depending on the clinic and community in question and the communication facilities available in those communities and to individual families. I recommend that the implementation of an advice scheme be considered as part of the continuing implementation of the Kalkaringi Plan.

85. Some of the family submissions however I believe are outside the area of recommendations covered by section 35(2) of the *Coroners Act* because they are not matters connected with the death that is the subject of this investigation. For example I have been asked to recommended the adoption and implementation as a matter of urgency (and with the highest priority being given to Recommendation 16) the 16 recommendations outlined in the Australian Senate Standing Committee on Community Affairs Report "Highway to health: better access for rural, regional and remote patients". The Report naturally concerns actions to be taken by Commonwealth, State and Territory authorities many of which are dependent on the agreement of all parties and are not actionable by one (i.e. the Northern Territory) alone, and not all recommendations are relevant to the issues that arose in this matter because the Committee was dealing with the broad range of travel needs across Australia. However I do express support for Recommendation 1 which deals with the need for the next Australian Health Care Agreement to recognise the fundamental importance of patient assisted travel schemes adding that the different needs of remote Aboriginal people and the increased complexity in a geographical jurisdiction such as the Northern Territory requires special consideration in that Agreement for the effective and safe function of those schemes.

86. The family also submitted that the decision-making authority for escorts be housed in a local or regional setting with people who have direct access to the patient, potentially with broader use of the Katherine West Health Board and the staff of the Kalkaringi clinic. While I agree that the persons with direct access to the patient are undoubtedly the ones with the better

understanding of the patient's needs there is I think a practical difficulty with this suggestion particularly in relation to MEDIVAC where situations might arise that mean that there is no room for an escort on the plane and a decision must be made for the escort to not travel. In practical terms it will be the DMO who will need to make that decision over the course of arranging the evacuation. However, it seems to me that the primary consideration as to making a decision as to qualification for an escort will be met by the Patient Risk Profiling Tool now in use because it assists all involved in the decision to make a full and proper assessment of the patient against the criteria. I would recommend, if not already in practice, that where a decision is made remotely by a DMO to refuse an escort that the reasons for the refusal be recorded and a copy provided to the clinic requesting the escort. The need for an escort for persons from remote communities should be emphasised in staff training as being a primary not secondary consideration as part of the patient's overall health needs and care.

87. It remains a matter of concern to me that there is no access to water for those waiting at the airstrip at Kalkaringi. It was not clear during the inquest whether the facilities at the airstrip were under Council control or Territory or Commonwealth control. Access to water in remote areas where the airstrip is not within short walking distance of a community seems a fundamental safety issue. I recommend an audit of remote community air strips to establish what facilities exist and whether they are sufficient to safe guard persons who might be left there for whatever reason for some period.

88. The death of Mr Limbunya was a preventable death and a tragedy for his family and community. The response of the organisations involved in his care and transfer to and from his community to this tragedy was immediate and has involved intensive and continuing consideration of all of the matters that contributed to it. The Kalkaringi Implementation Plan is a considered and considerable response aimed not only at preventing a tragedy such as

this from occurring again but is likely to result in greatly improved health outcomes for Aboriginal people from remote areas.

89. I hope that it will be some small measure of comfort to Mr Limbunya's family and community that his passing has led to a greater recognition of the factors that influence the health outcomes for remote aboriginal patients and that their needs and safety will in the future be better addressed as a result.

Dated this 1st day of September 2008

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Sue Oliver SM