CITATION: *Inquest into the death of Edward James Laurie* [2017] NTLC 015

TITLE OF COURT:	Coroners Court
JURISDICTION:	Darwin
FILE NO(s):	D0158/2015
DELIVERED ON:	15 June 2017
DELIVERED AT:	Darwin
HEARING DATE(s):	23 & 24 May 2017
FINDING OF:	Judge Greg Cavanagh
CATCHWORDS:	**Long term petrol sniffing, failure to realise objects of the *Volatile Substance Abuse Prevention Act*, failure to provide a treatment program, failure to follow processes outlined in *Act***

REPRESENTATION:

Counsel Assisting:	Kelvin Currie
Counsel for Top End Health Service	Peggy Dwyer

Judgment category classification:	B
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IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0158/2015

In the matter of an Inquest into the death of

EDWARD JAMES LAURIE
ON 11 OCTOBER 2015
AT HOUSE 44 BULLA COMMUNITY,
NORTHERN TERRITORY

FINDINGS

Judge Greg Cavanagh

Introduction

1. Edward James Laurie, the deceased (for cultural reasons he will be referred to as Mr Laurie), was born 18 September 1991 in Katherine to his parents Dominique Long and Nicholas Laurie. He grew up in Bulla and undertook his Primary School Education at MacFarlane Primary School in Katherine. He then went to Kormilda College in Darwin where he completed year 10.

2. He died in his home on 11 October 2015 due to petrol sniffing, "inhaled solvent toxicity".

3. He told authorities he had been sniffing petrol since the age of 10 years.

4. At the age of 16 years he got into an argument with another petrol sniffer and petrol was thrown on him and set alight. He spent over a month in hospital with full thickness burns to his thighs and calf. He required extensive skin grafts.

5. From the age of 17 years he was identified as having mental health issues. From time to time he suffered from psychosis during which he had auditory hallucinations.

6. He was referred to in medical notes as anorexic and weighed about 55 kilograms. He was addicted to petrol, cannabis and alcohol.

7. There were however times when his addictions were far less of an influence over his life. When he was working he became healthy. He worked when it was available, mustering and branding cattle at Kildurk Station, driving road graders and working at the Palumpa Community meatworks. He also became healthy when he visited family at Groote Eylandt. His cousin was a positive influence telling him that he mustn't sniff petrol.

8. However, for a good deal of the time there was a predictable pattern. A downward spiral. After being sectioned to the Mental Health Unit or spending time in gaol he would come out healthy. However he would then begin to abuse substances and petrol. Eventually he would stop taking the medication for his mental health and would develop psychosis. During the downward spiral he would often become angry and violent. He would then be sectioned and taken to the Mental Health inpatient facility and the pattern would reset.

Volatile Substance Abuse Prevention Act

9. On 2 December 2004 during the second reading speech of two Bills relating to volatile substance abuse, the Minister for Health and Community Services stated in part:

> "The clear intent of these bills is that intervention is to take place where volatile substance abuse in occurring."

10. The Minister went on to detail the "unacceptably high levels of harm associated with the abuse of volatile substances - harm to the individual who abuses these substances, their families, and to their communities" and

the high costs to the broader community of those suffering cognitive impairment by reason of their abuse of volatile substances.[1]

11. On 9 February 2006 the *Volatile Substance Abuse Prevention Act* (the Act) commenced. Pursuant to that *Act* if a solvent sniffer was assessed as being at risk of severe harm that person could be mandatorily required to undergo a treatment program.

12. The *Act* was amended in 2009 to streamline the processes and provide more options available to be ordered by the Court. In the second reading speech on 20 October 2009 the Minister for Health stated:

> "When the *Volatile Substance Abuse Prevention Act* was introduced in 2006 … one of the most debated and contentious parts of the legislation was the arrangements for people to be referred for an assessment for court-mandated treatment. At the time, this was an untested approach to volatile substance abuse with some outspoken critics who objected to the implied erosion of personal freedoms. The act was, therefore, drafted with a number of safeguards in the form of multiple approvals from the responsible minister, with treatment orders being limited to eight weeks, and with treatment being defined as one of a handful of nominated residential treatment facilities.
>
> Three years on, it is apparent the concerns which drove this strong public debate are no longer of such primary concern. So much so, I note some of the strongest opponents to this legislation and, indeed, members of the opposition, are now calling for compulsory treatment arrangements for people with chronic alcohol problems based on the *Volatile Substance Abuse Prevention Act.*
>
> The amendments propose to expedite and streamline this part of the act by assigning the powers and functions currently assigned to me, in Part 3 of the *Volatile Substance Abuse Prevention Act 2006,* to the Chief Health Officer of the Northern Territory. This is the responsibility which I believe aligns well with the health protection responsibilities of the role."

[1] Second Reading Speech -Volatile Substance Abuse Prevention Bill 2004 (Serial 270) and the Misuse of Drugs Amendment Bill 2004 (Serial 271).

13. The objects of the *Act* are stated at section 3:

> "(1) The objects of this *Act* are to support child, family and social welfare and improve the health of people in the Territory by providing a legislative framework for:
>
> (a) the prevention of volatile substance abuse; and
>
> (b) the protection of persons, particularly children, from harm resulting from volatile substance abuse."

14. The *Act* provided at section 33 for the making of an Application for Assessment to an Assessor if a person was reasonably believed to be at risk of severe harm.

15. From 2008 until his death in 2015 there were 16 Applications for Assessment lodged by doctors, nurses and Police in relation to Mr Laurie. Seven of those were lodged in the last three weeks of his life.

Applications for Assessment of Mr Laurie

Application 1

16. On 28 April 2008 an Application for Assessment was made by staff at Royal Darwin Hospital after Master Laurie was admitted with full thickness burns after the assault while sniffing.

17. That application was finalised on 8 September 2008 *with no recommendation for an order* because there was no information after his discharge from hospital that he had returned to sniffing petrol.

Application 2

18. On 2 March 2011 an Application for Assessment was made by staff at Katherine Mental Health Services. It was noted that his increased use of solvents over the last two weeks was jeopardising his mental wellbeing. He

had threatened to set fire to himself and had been sectioned under the *Mental Health and Related Services Act*.

19. That application was finalised on 29 April 2011 *with no recommendation for an order* due to Mr Laurie being imprisoned.

Applications 3 & 4

20. On 27 January 2012 & 31 January 2012 Applications for Assessment were made by the Katherine Mental Health Service and Police at the Timber Creek Police Station due to increased sniffing that was triggering Mr Laurie's underlying mental health condition.

21. Those applications were finalised sixteen months later *with no recommendation for an order* when Mr Laurie's sniffing ceased for a period. Prior to that period the following incidents are recorded in the notes of the Assessor:

    a. "On 8 February 2012, Timber Creek Health Clinic reported that he was sniffing petrol every night and had stopped taking his medication for his mental health. The Clinic asked that Mr Laurie be mandated for treatment but were told that was something that "takes time".

    b. On 14 March 2012, the Alcohol and Other Drugs Coordinator in Katherine reported that Mr Laurie was sniffing several times a day. He said that local clinicians were strongly of the view that he required mandated treatment.

    c. On 20 June 2012 he was reported to be sniffing and obtaining the petrol from vehicles in the Bulla Community.

    d. On 16 October 2012 he was sniffing and introducing others to sniffing. He was said to be giving girls petrol to sniff and then requesting sex.

e. On 29 October 2012 he was arrested siphoning petrol from a service station. He said he wanted to get help for his addiction and if he didn't get it he would hang himself.

f. On 31 October 2012 he siphoned fuel obtained from a motor vehicle and sniffed it. He said he no longer wanted help.

g. On that same day the Assessor had a telephone conversation with a staff member from the Katherine Mental Health service. The Assessor was told that provision of more medication would make no difference if Mr Laurie continued sniffing petrol.

h. On 1 November 2012 he was reported to be extremely agitated and threatening to rape children if he couldn't get petrol or other substances. He was 'sectioned' under the *Mental Health and Related Services Act.*

i. He was discharged and put on a bus to Darwin two days later with a view to him going voluntarily to a rehabilitation facility in Nhulunbuy. He did not stay at the pre-arranged accommodation in Darwin and could not be located for the flight the following day.

j. On 13 November 2012 he was taken by ambulance to Royal Darwin Hospital due to solvent misuse but left before being seen.

k. On 15 November 2012 he was taken to Royal Darwin Hospital by Police due to solvent misuse but again left before being seen.

l. On 16 November 2012 he was located by Police sniffing petrol in Palmerston and was taken by Ambulance to Royal Darwin Hospital. He said he wanted to stop sniffing.

m. On 20 November 2012 he voluntarily went to a rehabilitation facility in Nhulunbuy.

n. On 26 November 2012 he was expelled from the facility for breaking into a shed to get fuel, sniffing it and verbally abusing a staff member.

o. On 1 December 2012 he was taken to Royal Darwin Hospital by Police after being located sniffing petrol.

p. On 23 December 2012 he was taken to Royal Darwin Hospital by Police after being found sniffing petrol.

q. On 1 and 4 January 2013 he was found intoxicated and injured from fighting and was taken to Royal Darwin Hospital by Police.

r. On 8 January 2013 the Assessor wrote the following to her Manager:

> "[Mr Laurie] had been living in Darwin since November 2012 and continues to exhibit high risk behaviour. He is regularly taken into protective custody at Darwin Watch House and is also frequently conveyed to Royal Darwin Hospital by Police or ambulance after being located intoxicated from petrol sniffing. [Mr Laurie] is currently non-compliant with his medications. In the past [Mr Laurie] has been stable when properly medicated".

s. On 4 February 2013 he went to Groote Eylandt and fell under the influence of his cousin who told him not to sniff petrol. There were no more reports of sniffing petrol from that point until the Applications for Assessment were finalised on 15 May 2013."

Application 5

22. On 10 July 2014 an Application for Assessment was made by Community Mental Health. The Application indicated that the family was concerned

about Mr Laurie's return to petrol sniffing. The application was not accepted and *no order made*.

Application 6

23. On 15 October 2014 an Application for Assessment was made by a doctor at Cowdy ward at the Royal Darwin Hospital. The application recounted that Mr Laurie had presented to the Bulla Health Clinic on 27 August 2014 and 20 September 2014 suffering from drug induced psychosis. He was evacuated on 20 September 2014 to Royal Darwin Hospital suffering auditory hallucinations.

24. He was discharged from the Mental Health Unit on 22 October 2014 and went straight back to sniffing petrol. The Bulla Health Clinic and the Police were of the view that treatment needed to be mandated.

25. The application was finalised on 22 December 2014 after he was said to have travelled to Kununurra on 27 November 2014 *with no recommendation for an order* (although he had returned to Bulla on 3 December 2014).

Applications 7 & 8

26. On 2 February 2015 an Application for Assessment was made by staff at Timber Creek Health Clinic. It stated that Mr Laurie had been stealing jerry cans and sniffing fumes. Community members had told the clinic that he had started sniffing the moment he got off the bus after being discharged from the inpatient Mental Health unit in Darwin.

27. Four days later on 6 February 2015 an Application for Assessment was received from the Officer in Charge of Timber Creek Police Station. It stated that Mr Laurie had been sniffing daily and that with the increase in his substance abuse and his mental health issues he posed a significant risk to himself and others. It said "the locals" were frightened. He had been

breaking into houses for fuel and on one occasion was "flogged" while trying to steal fuel. He had refused his medication and was sniffing in front of 10 children in the community.

28. Those two applications were not finalised before his death on 11 October 2015, eight months later. There was *no recommendation for an order made*.

29. On 13 February 2015, while in search of fuel, Mr Laurie held a knife to a community member's neck saying that he would kill him. Five days later, after assaulting another person with a rock, he was sectioned under the *Mental Health and Related Services Act* and evacuated to Darwin.

30. On 5 March 2015, while still in the Joan Ridley Unit at Royal Darwin Hospital he was assessed by the Volatile Substance Abuse Assessor. He was sedated at the time, but still angry and threatened to shoot the nurses at Bulla. He said he did not want to go to rehabilitation.

31. The assessor was of the opinion that the he was not suitable for rehabilitation. On 11 March 2015 the rehabilitation provider at the Drug and Alcohol Service Association (DASA), at Alice Springs indicated that due to his history of violence they would not accept him into rehabilitation.

32. On 12 March 2015 the Assessor prepared an Assessment Report. Paragraphs 19, 20 and 21 state:

> **"19 Criteria for treatment order (s35(2))**
>
> Not applicable at this time.
>
> There is no suitable treatment facility in the Northern Territory to accommodate Mr Laurie at this time. Drug and Alcohol Services Alice Springs (DASA) is the only residential rehabilitation centre in the NT that accepts adult VSA clients. DASA has not accepted Mr Laurie due to the high risk he poses to staff and clients at the facility. DASA is not a secure facility and they do not have nursing or mental health trained staff at the centre.
>
> **20 Treatment Options**

> To be discussed at Multi agency meeting on Tuesday 17 March 2015 10am.
>
> Currently involuntary client in Joan Ridley Unit.
>
> Due for Tribunal review 1 April 2015.
>
> **21 Treatment plan and recommendation**
>
> Formalised assessment of Mr Laurie's cognitive status when mentally well to determine if he has suffered an acquired brain injury and may be eligible for support from Disability services or Guardianship."

33. The Assessment report was not provided to the Chief Health Officer.

34. On 17 March 2015, another service provider offered to provide a placement for Mr Laurie. There was discussion about the fact that Mr Laurie would not attend voluntarily. The Assessor did not realise orders under the *Act* could be utilised where the service was not a dedicated rehabilitation facility. Due to that misunderstanding the potential placement was not investigated as an option.[2]

35. On 22 May 2015 Mr Laurie was discharged from the Mental Health facility back to Bulla Community. He was said to sniff petrol regularly after his return.

36. The Police Sergeant wrote to the Assessor on 3 June 2015 stating:

> "Given the fact that he just returned to the community, the amount of medication he is on, the number of young persons in the house and his current behaviour I would suggest that whilst there is no treatment centre for him, Bulla is not suitable either. I have included DCF in the email".

Application 9

37. On 13 July 2015 an Application for Assessment was made once more by Police at Timber Creek Police Station. Mr Laurie suffered a seizure while

[2] Transcript p 73

sniffing. He was said to have been unconscious for 15 minutes. When he returned to consciousness he resumed sniffing petrol.

38. On 29 July 2015 he had another seizure. Those attending could smell the petrol from the gateway to the property.

39. On 31 July 2015 the Assessor told the Department of Children and Families that there was nothing the Volatile Substance Abuse Team could do.

40. On 7 September 2015 the Assessor noted that consideration would be given to closing the case as Mr Laurie was 'unsuitable' for rehabilitation. *No recommendation was made for an order.*

Application 10

41. On 21 September 2015 Police found Mr Laurie in his room lying face down in a container of petrol. He was unconscious. The officers carried him out of the room and lifted him into the back of the Police van. At that point he took a gasp of air and "came back to life". They took him to the Health Clinic where he was assessed and released.

42. However, Mr Laurie was asking for help with his addiction and Sergeant Scott Aiken was so concerned for Mr Laurie's welfare that he drove him from Bulla to Katherine District Hospital (approximately three hours) for treatment.

43. At the hospital Mr Laurie said he wanted help with his addiction. However, he absconded from hospital, missed the bus back to Bulla and began sniffing petrol around Katherine.

44. That Application was not finalised before his death and *no recommendation for an order was made.*

45. On 24 September 2015 the Police found him sniffing petrol in Katherine behind the Shell service station. They took him to hospital. He told the

doctor that he had been depressed for several years and wanted to go to Cowdy ward (the Mental Health ward at Royal Darwin Hospital) so he could get three meals a day. His anorexic appearance was noted and he said he was hungry.

Applications 11 & 12

46. On 25 September 2015 Police found Mr Laurie sleeping in a Katherine Street with two small containers of petrol beside him. When woken he told the Police he had been sniffing. He was taken to the hospital for an assessment.

47. On that same day Applications for Assessment were made by both the Police and a doctor at Katherine District Hospital. Those Applications were not finalised before his death and *no recommendation for an order was made*.

48. On 29 September 2015 Police found Mr Laurie sniffing petrol and took him to Katherine District Hospital. The same thing happened the following day, 30 September 2015. Police found him sniffing behind the Red Cross building in Katherine. Mr Laurie told the nurse that he wanted to stop sniffing.

Application 13 & 14

49. On 30 September 2015 two separate Applications for Assessment were made by Police. One application related to a specific incident where Police had found Mr Laurie sniffing petrol from a McDonald's cup filled with petrol and took him to the Katherine District Hospital for assessment.

50. The other stated that Police had found Mr Laurie sniffing three times in the last three days and each time on release he had gone straight back to sniffing. The Sergeant making the Application said that Mr Laurie wanted help to quit. The Sergeant was of the opinion that his sniffing was getting worse.

51. On 1 October 2015 the Assessor once more asked that DASA consider taking Mr Laurie into their rehabilitation program. They declined.

52. Those Applications were not finalised before his death and *no recommendation for an order was made*.

Application 15

53. On 2 October 2015 a Police Officer made an Application for Assessment after finding Mr Laurie on 24 September 2015 behind the Shell Service station sniffing 40 cents of petrol that he had stolen from the petrol bowser. Police stayed with him while waiting for an ambulance but it didn't arrive and so took him to Katherine District Hospital.

54. That Application was not finalised before his death and *no recommendation for an order was made*.

Application 16

55. On 7 October 2015 another Application was made by Sergeant Scott Aiken of Timber Creek Police Station. He stated:

> "I have received a report just now from … the local pastor at Bulla Community who was concerned as of today [Mr Laurie] has gone straight back into his old ways and has been heard asking around for petrol to sniff. [Mr Laurie] has only been in Bulla community for a few days and if he is not given assistance and support he will end up succumbing to his addiction."

56. On 9 October 2015 the Assessor flew to Bulla. Mr Laurie was not there but the Assessor spoke to the Community and told them there was no rehabilitation centre in the Northern Territory that would take Mr Laurie. He provided a 10 point plan to assist in keeping safe and keeping fuel from Mr Laurie.

57. At 10.30am on 11 October 2015 Mr Laurie was found unresponsive in his room. He had a bottle of petrol nearby. His father and a neighbour began

cardio pulmonary resuscitation (CPR). However Mr Laurie was already deceased and unable to be revived.

Issues

58. He was known to be at risk of severe harm as defined by the *Volatile Substance Abuse Prevention Act* for much of the period from 2008 until his death and yet the powers provided under that *Act* for the making of treatment orders were never used.

59. His family asked that treatment be ordered by the Court. The family said that he needed more time than was provided by the inpatient Mental Health Service (when he became psychotic). They said he was asking for help but was too weak to undergo treatment voluntarily.

60. The local Health Clinics asked that Court ordered treatment be instituted, as did the Drug and Alcohol Counsellor, the Police, the Mental Health Service and the psychiatrist. However, despite Mr Laurie being at risk of severe harm no order was sought under the *Act*.

61. Why the *Act* was not used to intervene or treat Mr Laurie became the central issue for the inquest.

The Scheme

62. The *Act* set up a scheme that includes the appointment of "Assessors". After receipt of an Application for Assessment, if the Assessor is satisfied the information indicates the person is at risk of severe harm, the Assessor must make an assessment of the person, prepare an assessment report, provide it to the Chief Health Officer and then notify the person that sent the Application as to whether the person was assessed as at risk of severe harm.[3]

[3] Section 34(1)(b)-(d)

63. Guidance as to the information to be included in the assessment report was set out in the *Volatile Substance Abuse Clinical Guideline*. The Guideline required the assessment to be completed within two weeks "if practicable".[4]

64. As soon "as practicable" after receiving the assessment report the Chief Health Officer was required to make a decision "about whether or not to apply for a treatment order".[5]

65. If the decision of the Chief Health Officer was to apply for a treatment order then the Chief Health Officer was required to apply to the Court for that order "as soon as practicable".[6]

66. The Guideline provided that where a treatment order was sought, contact with the person at risk would be maintained until the treatment order was completed and for an additional two months after completion of the treatment program to monitor whether the treatment was successful or not.

67. Where, on assessment, risk was not identified, monitoring could occur for a further two months.[7]

68. That scheme however, was not followed by the Assessors when dealing with Mr Laurie.

69. That appears to have been due to a number of factors, the most influential of which was the lack of treatment options the Assessors had available.

Treatment Programs

70. In the first iteration of the *Act*, "treatment program" was defined:

[4] The Guideline p 12.
[5] Section 35(1)
[6] Section 36(1)
[7] The Guideline p 9

"treatment program" means a program for the treatment of a person at risk of severe harm, including a program for withdrawal, stabilisation, rehabilitation or aftercare.[8]

71. The *Act* also required that the treatment order specify the place where the person was to participate in the program.[9] The effect was that the Assessors came to view 'treatment programs' was synonymous with "treatment facilities".

72. When the *Act* was amended, section 31A was inserted to provide increased options "to meet the diverse needs of those being referred".[10] Added to "treatment" was the term "intervention". The section in part reads:

"31A Treatment program

(1) A ***treatment program*** is a program of treatment or intervention appropriate for a person at risk of severe harm.

(2) A treatment program may provide a person at risk of severe harm with any of the following:

(a) treatment for withdrawal, stabilisation, rehabilitation or aftercare;

(b) therapeutic, health, diversionary or educational intervention;

(c) any other type of treatment or intervention intended to alleviate the severe harm;

(d) a combination of any treatment or intervention mentioned in paragraphs (a) to (c)."

73. The treatment or intervention could be at a residential facility or any other place or no specific place.[11]

[8] Section 31
[9] Section 40(2)
[10] Second Reading Speech 20 October 2009
[11] Section 31A(3)

74. However, the change in the *Act* was not reflected in a change in practice. The only treatment programs utilised remained rehabilitation programs conducted in residential facilities. There appeared to be no consideration given to 'interventions'.

75. Similarly, the amendment to the *Act* brought significant changes to section 34. The older version required a complex process where the Application for Assessment went to the Minister who decided whether the person should be assessed. If the Minister was satisfied the person required assessment then sub-section 3 stated that the Assessor must "as soon as practicable, provide the Minister with a written assessment".

76. If the person was assessed as being at risk of severe harm, "the assessor must include in the assessment a recommendation for an appropriate treatment program and specify the place or places where such a program is administered".[12]

77. The amendments removed the requirement for the Minister to approve the assessment of a person. The amended section 34 left it to the judgement of the Assessor as to whether the information received in the Application indicated the person to be at risk of severe harm.

78. The amended section did not however leave it to the Assessor to determine whether an application should be made for a Court order to receive treatment or intervention. That was made the responsibility of the Chief Health Officer.[13]

79. The amended section 34 states that if the Assessor was satisfied on the information provided that the person was at risk of severe harm the

[12] Section 34(4) Volatile Substance Abuse Prevention Act 2005
[13] Section 35

Assessor **must** make an assessment of the person, **must** prepare a report and **must** give it to the Chief Health Officer (my emphasis).[14]

80. If the assessment found the person to be at risk of severe harm the assessment report **must** recommend an appropriate treatment program (my emphasis).[15]

The Issues

81. It is clear that the plain meaning of section 34 was not understood by the Assessors. Assessment reports were not usually provided to the Chief Health Officer. I was told they were only prepared and given to the Chief Health Officer when the Assessor was recommending a treatment program be mandated by Court Order. In the case of Mr Laurie such a recommendation was never made.

82. When the Assessor was not recommending a Court order, the Assessor sent a memo seeking that the Chief Health Officer agree to make no recommendation. The memo did not provide other options and did not have potential treatment (or intervention) programs. No assessment report was attached to the memo.

83. That removed from the Chief Health Officer the ability to properly exercise the discretion required to be exercised pursuant to section 35 of the *Act*. In practical terms the Assessor was determining the outcome of the exercise of that discretion.

84. It may have been reasoned that if no program was able to be offered then there was no point in going through the process because the Chief Health

[14] Section 34(1)(b) & (c)
[15] Section 34(3)

Officer was unable to apply to the Court for a treatment order in any event if there was no treatment program.[16]

85. However, such reasoning misses the point. It is not the Assessor's function to make that determination. The practice also had the effect of disguising the fact that the available options did not mirror the intent of the legislature when extending those options by the insertion of section 31A into the *Act*.

86. In effect, the lack of available options was not elevated high enough within the Top End Health Service (TEHS) and Department of Health that an appropriate treatment or intervention was identified and resourced. That seems to have been the case despite the Chief Health Officer seeing the memoranda sent to him stating that there were no facilities available.

87. Those failures to follow the clear intent of the *Act* were compounded because the Top End Health Service and the Department of Health did not in the procurement and funding of treatment programs seek that services be provided to the angry and potentially violent petrol sniffers. I was told that the management of the Volatile Substance Abuse service area had no involvement in the procurement of the services.

88. In my experience petrol sniffers are often difficult to deal with and can be violent. In fact the symptoms of withdrawal from volatile substances include aggression and violence. Such people need assistance, perhaps more than those that are compliant. If options are not available for the treatment of such persons the objects of the *Act* are thwarted.

Case Management

89. Rather than preparing an assessment report and providing it to the Chief Health Officer, the Assessors "case managed" Mr Laurie. I was told by the

[16] Section 35(2). Such reasoning was provided in a letter from Dr Charles Pain dated 15 February 2017.

Assessors' manager that, "as the *Act* has the intention of being least restrictive, the assessment may determine a court ordered program is not the best option and the [Assessor] makes other plans to support the person at risk, their family and community".

90. I was informed that the first intervention is to obtain support from families, friends and local Alcohol and Other Drugs staff. The person is then monitored to ensure they refrain from further solvent abuse. However if those measures fail voluntary rehabilitation is discussed. If that is refused and the person continues to abuse solvents then a treatment order might be in their best interests.

91. There is of course nothing to suggest that such progression is not appropriate to Alcohol and Other Drugs clinicians. However, Assessors under the *Act* have a different and defined role set out in the *Act*. That role is not consistent with the practice followed by the Assessors in case managing a person after receipt of an Application for Assessment. In doing so they ignored their statutory duties under section 34 to assess, prepare a report with treatment options and provide it to the Chief Health Officer.

92. As has been noted above the effect of the practice was that Assessors determined what treatment programs, if any, were utilised for those assessed at risk of severe harm rather than the Chief Health Officer.

93. The Assessors case managed or monitored Mr Laurie over periods totalling 51 months. Not once during those periods was an action taken by the Assessors, or anyone else, that required the powers provided by the *Act*. In other words, although the Assessors believed their activities were pursuant to the *Act*, there was nothing done that could not have been done had the *Act* not existed.

94. In circumstances where the *Act* and Guideline sought that Mr Laurie be assessed and treatment program options provided to the Chief Health Officer within a short period that was obviously inadequate.

95. I do not intend that as a criticism of the Assessors. One of the Assessors told me they are clinicians and case managing is what clinicians do. They impressed as particularly compassionate professionals and during their evidence appeared willing to accept that their practice had not been in keeping with the *Act*.

Leadership and Supervision

96. There was an obvious lack of leadership and supervision. It is regrettable that successive Chief Health Officers and those in management positions did not seek to ensure compliance with the *Act*, find solutions to the obvious difficulties and ensure the intent of the *Act* was realised. The current Chief Health Officer, Dr Hugh Heggie, agreed that leadership needed to come from his Office.[17]

97. Dr Heggie also agreed that if there was not a ready treatment option, the Department needed to find or create one.[18] He then affirmed the statement made in his declaration saying:

> "I would like to apologise for the tragic passing of Mr Laurie and pay my respects to his family".

98. He went on to tell me of the opportunities that should be taken to learn from this tragic event to improve and that a review needed to be conducted.

99. I was provided the following figures relating to the numbers of individuals with whom the Volatile Substance Abuse team engaged in the Top End of the Northern Territory:

[17] Transcript p 113
[18] Transcript p 114

Year	Individuals referred to TEHS	Treatment Orders made	Treatment Orders Completed	Voluntary Rehab Entry	Voluntary Rehab Completed	Cases Closed
2008	42	6	3	7	3	42
2009	199	11	7	8	3	199
2010	179	20	18	8	4	179
2011	169	14	8	20	5	169
2012	351	7	4	21	3	351
2013	271	11	4	22	3	271
2014	289	12	5	21	2	302
2015	381	10	4	38	15	397
2016	285	2	1	43	9	NK

100. There was however no information on whether those figures represented successful resolutions or whether the same persons were reflected in those figures year after year. There was also no information available on whether the treatment orders or voluntary rehabilitation were successful over the short or longer term.[19] That would be of particular interest given the low completion rate in both cases.

101. The first column does not relate to number of Applications for Assessment received. That was obviously much greater. I was told there were 505 Applications in 2016.

[19] Transcript pp 88-89

Review

102. The Top End Health Service did not undertake a review of the care and treatment provided to Mr Laurie in the months following his death. I was told that is regretted.

103. However, the Top End Health Service and the Department of Health provided draft terms of reference for undertaking a comprehensive review of all facets of the Volatile Substance Abuse processes, procedures, Guideline and *Act*. It is anticipated the review will be complete in about 7 months. I commend the Top End Health Service and the Department on their willingness to ensure that the service provided is appropriate to the needs of such persons, their families and the community.

104. In the meantime there is an immediate need to ensure that appropriate training and supervision is provided to the staff to ensure that there is compliance with the substance and intent of the *Act*.

105. Pursuant to section 34 of the *Coroner's Act*, I find as follows:

(i) The identity of the deceased was Edward Laurie born 18 September 1991, at Katherine in the Northern Territory.

(ii) The time of death was 11.00am on 11 October 2015. The place of death was House 44 Bulla Community in the Northern Territory.

(iii) The cause of death was inhaled solvent toxicity (from petrol sniffing).

(iv) The particulars required to register the death:

1. The deceased was Edward James Laurie.

2. The deceased was of Aboriginal descent.

3. The deceased was not employed at the time of his death.

4. The death was reported to the Coroner by staff at the Bulla Health Clinic.

5. The cause of death was confirmed by Forensic Pathologist, Dr John Rutherford.

6. The deceased's mother was Dominique Long and his father was Nicholas Laurie.

Recommendations

106. I **recommend** that the Top End Health Service and the Department of Health conduct as soon as possible the review proposed in the Chief Executive Memorandum provided to my Office and dated 19 May 2017.

107. I **recommend** the Top End Health Service provide such training and supervision as may be necessary to ensure their processes and procedures are in accordance with substance and intent of the *Volatile Substance Abuse Prevention Act.*

Dated this 15th day of June 2017.

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GREG CAVANAGH
TERRITORY CORONER