CITATION: *Inquest into the death of Naomi Smith* [2018] NTLC 017

TITLE OF COURT:	Coroners Court
JURISDICTION:	Darwin
FILE NO(s):	D0116/2017
DELIVERED ON:	19 June 2018
DELIVERED AT:	Darwin
HEARING DATE(s):	16 August 2017, 13 December 2017, 9 &10 April 2018
FINDING OF:	Judge Greg Cavanagh
CATCHWORDS:	**Death in Custody, complex mental health presentation, inadequate resources available in Alice Springs**

REPRESENTATION:

Counsel Assisting:	Kelvin Currie
Counsel for Top End Health Service	Stephanie Williams
Counsel for Department of Corrections	Duncan McConnel

Judgment category classification:	A
Judgement ID number:	[2018] NTLC 017
Number of paragraphs:	100
Number of pages:	24

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

No. D0116/2017

In the matter of an Inquest into the death of
NAOMI SMITH (previously known as KIRSTY ANN HUNGERFORD)
ON 7 JULY 2017
AT ROYAL DARWIN HOSPITAL

FINDINGS

Judge Greg Cavanagh

Introduction

1. Naomi Smith (the deceased) was born on 20 October 1990 to Leanne and Leon Hungerford in Townsville, Queensland. She was named Kirsty Ann Hungerford. She officially changed her name to Naomi Smith on 1 August 2011.

2. At the age of 12 she was removed from her parents due to long term physical and sexual abuse by her father and brothers. She became a client of the mental health services at the age of 13 years. She moved to Brisbane for a time to enable intensive support. While there she joined a church congregation. She moved back to Townsville and into a unit where she was given 24 hour support, seven days a week.

3. At 14 years of age she met Emily Brooker (Emily) and her mother. She was said by Emily to be "very gifted at drawing, painting, sculpting and writing poetry. She loved, camping, fishing, photography, spending time with her dog Katie and doing woodwork".

4. However, she had difficulty maintaining stable school placements and was not able to work.

5. She was diagnosed with borderline personality disorder (BPD), post-traumatic stress disorder (PTSD) and depression. She had 65 admissions to Townsville Adult Mental Health Unit predominantly with suicidality and deliberate self-harm. Some of her suicidal attempts were of high lethality.

6. The symptoms of her mental health disorders were often exhibited during times of stress. On such occasions she reported having hallucinations, often of her father. When well, however, she was said to be a person whose company people enjoyed and who had great relationships with a wide group of very good friends.

7. She was on a significant number of drugs and those made her predisposed to weight gain. She was morbidly obese, weighing 150 kilograms. She also had sleep apnoea, asthma, cardiovascular problems, Type 2 Diabetes and hyperlipidaemia.

8. In early 2017, Emily obtained work in Alice Springs and Naomi moved to Alice Springs also. She wanted to make a fresh start. Given the complexity of Naomi's condition, that posed considerable challenges. In Townsville she had a large and understanding support network. Townsville is also a larger metropolis with many more services than are available in Alice Springs.

9. Later reviews identified that even health systems in better resourced areas, would likely have struggled to meet Naomi's care needs. In Alice Springs the services were unable to provide and sustain the level of support needed.[1]

10. She first utilised the mental health services in Alice Springs on 17 April 2017. There followed 26 presentations to Alice Springs Hospital. Sixteen times she was admitted to the Mental Health Unit and on 4 occasions to the Intensive Care Unit. She came to the attention of the Northern Territory

[1] Root Cause Analysis p 8; Report of Dr Elcock p2

Police on 7 May 2017. There followed a further 22 involvements with Police.

11. The Mental Health Unit utilised the same management plan as Townsville for dealing with and treating Naomi. In essence the plan sought to encourage Naomi to take some responsibility for her behaviour. Involuntary admissions were acknowledged as often counterproductive however a limited number of short term (48 hour) voluntary admissions were considered appropriate.

12. On Sunday, 25 June 2017 her symptoms escalated. Emily contacted police to report that Naomi was cutting her wrists. Naomi told the responding police that the voice of her father was telling her to kill herself and that she had been consuming cleaning products on a daily basis in an attempt to do so. She was admitted on an involuntary basis to the Mental Health Unit.

13. She was difficult to contain and continually attempted to self-harm. She swallowed a nicotine inhaler, a replacement inhaler, a rubber glove and soggy toilet paper. On occasion she had to be restrained. She banged her head, attempted to open old wounds and continued to attempt to consume objects. She was supervised in the High Dependency Unit (HDU).

14. She remained in the HDU until Tuesday, 27 June 2017. It became apparent that the Mental Health Unit in Alice Springs Hospital did not have the facilities or resources to deal with the continuing behaviours. Their staff were exhausted and at least one was injured.

15. At 9.50am the specialists determined to try to implement the management plan and offered Naomi a voluntary admission. She refused to stay voluntarily. She said that she would set herself alight if released. The doctors contacted police to alert them to her impending discharge and her threats to self-harm. She was released at 10.00am.

16. Upon discharge Naomi walked out the front of the hospital and across the road to the petrol station. She picked up one of the petrol bowser nozzles

and emptied the residual petrol onto the front of her jumper. She then lit the petrol. Police were quickly on the scene, put out the flames and returned her to the hospital. She ate a latex glove in the back of the ambulance. She was readmitted at 10.50am.

17. While being examined Naomi continued to try and consume harmful items and swallowed a name tag. Upon examination Mental Health determined that her emotional state was her usual state. She was not depressed and had no psychosis. She was offered but refused a voluntary admission. It was determined to discharge her once more. Naomi told the psychiatrist that if released she would go back across the road and burn herself.

18. The Hospital notified the police of the impending release and police waited on the other side of the road. She was discharged at 12.30pm. Naomi exited the hospital and after smoking a number of cigarettes, crossed the road and once more tried to pour petrol on herself while holding a lit cigarette.

19. Police intervened, handcuffed her and returned her to the Hospital at 1.40pm. Police spoke to the Mental Health team in an attempt to develop a management strategy. It was suggested that she might be dealt with criminally. She was kept in hospital that night.

20. She was released the following day (Wednesday, 28 June 2017) at 1.30pm. Police were advised of her impending release and her continued threats to burn herself at the petrol station across the road. She crossed the road to the petrol station to burn herself and was stopped by three police officers. She was arrested and taken to the Police Watch House.

21. While in the cells she ingested toilet paper, reopened wounds on her arm, wrote on the wall with her own blood and intentionally fell forward striking her face on the toilet bowl. St John Ambulance was called to take her to the hospital. She was found to be fit for custody. A voluntary admission to the mental health unit was offered but she refused.

22. She was returned to the Watch House at 4.20pm. On her return she threatened to throw herself head first onto the toilet and then began hitting her head against the wall. The custody sergeant obtained approval to put Naomi in the emergency restraint chair (ERC).

23. She complied with instructions to get into the chair. While restrained she stated that if she was released she would continue to try and kill herself. She was checked at regular intervals by the custody nurse and her limbs mobilised at regular intervals.

24. At 7.50pm she was removed from the restraint chair and taken to the hospital for a psychiatric assessment. Emily was at the cells at that time and accompanied Naomi to the hospital. Emily expressed her frustration and disappointment at the refusal of Mental Health to admit Naomi on an involuntary basis. They once more offered a voluntary admission. Naomi however refused.

25. She was returned to the Watch House at 9.00pm. She was charged with Recklessly Endangering Serious Harm and Threat to Burn. She was refused police bail. She was kept in custody pending her appearance in Alice Springs Local Court the following morning. At 11.00pm that night she was once more taken to the hospital for psychiatric assessment and remained in the Emergency Department overnight.

26. On Thursday 29 June 2017 at 9.00am the Local Court Judge refused bail and adjourned the charges to 13 July 2013. She was returned to the watch house. She continued to try and harm herself by ingesting a toilet roll and hitting her head against the wall. She was put into the restraint chair for another 30 minutes before being transferred to the custody of the Department of Corrections at 11.20am.

27. She was taken to the Alice Springs Correctional Centre (prison). While being processed Naomi picked up a pen from the reception desk and tried to

stab herself in the neck. She then repeatedly hit her head on the cell walls and floor. She was placed in a restraint chair. She remained in it for two hours.

28. She was then taken to Alice Spring Hospital for further assessment. Naomi continually told those present that she wanted to die. She arrived at the Alice Springs Hospital at 3.25pm. Again the Mental Health Team found that she was not suffering a mental health disturbance and indicated that she was fit for custody.

29. She was returned to the prison at 4.00pm and placed in the padded cell for observation overnight. At 4.30am (Friday 30 June 2017) she was observed to start hitting her head against an air vent in the padded cell until it bled. She then pulled chunks of her hair out and wrapped them around her neck in an attempt to choke herself. She wrote on the walls in her own blood, “I hate dad”. At 5.20am she was placed in the restraint chair. She was released at 7.20am.

30. At 7.35am she choked on a corner she had torn off her “at risk” blanket. At 10.40am she was placed back in the restraint chair. She was released at 12.40pm. While walking down the hallway she lunged sideways to pick up a pen with which she tried to stab herself in the neck. She was returned to the restraint chair.

31. At 2.20pm she was taken back to Alice Springs Hospital for further assessment. It was determined that her mental state was not disturbed. The Superintendent of the Prison, Bill Yan, spoke to the Consultant Psychiatrist at the Forensic Mental Health Unit in Darwin. It was agreed that Naomi would remain at Alice Springs Hospital over the weekend and then transferred to Darwin for specialist care. It was agreed that the prison was not a safe place for her, particularly as there was no medical team on site after 8.00pm. She could not be transferred earlier because Darwin did not have a place for her at that time.

32. On Saturday, 1 July 2017, it was determined that Naomi was not suffering a psychotic episode and should be returned to the prison in accordance with the management plan. She was discharged at 11.00am. Superintendent Yan directed the Correctional Services Officers to remain at the hospital with Naomi. He then made further phone calls and at midday it was determined that Naomi would be readmitted to the hospital on an involuntary basis until her transfer to Darwin. Emily spent significant amounts of time with Naomi from that point until her transfer to Darwin. While Emily was with her, Naomi was generally relaxed. When she was not with her, Naomi continued to attempt to kill herself.

33. At 5.00pm on Sunday, 2 July 2017 Naomi was transferred to ICU. Naomi had brittle airway disease. When she had been ventilated previously it had been noted her lungs were a little stiff. The specialists decided it would be better if they could stage her sedation in preparation for the flight to Darwin.

34. They developed the plan that she would be intubated in the late afternoon and they would settle her on the ventilator overnight. They would then transfer her to the transfer ventilator with enough time for her to get used to that. They could then ensure that she was completely stable and safe to take the flight.

35. At 5.00pm she was sedated and intubated. The intubation went smoothly although there was a period of desaturation (79%) and possible aspiration. Twelve hours later she developed a fever and was given antibiotics for suspected aspiration pneumonia. She was given enoxaparin for Deep Vein Thrombosis (DVT) prevention and calf compressors were applied.

36. Due to the ICU at Royal Darwin Hospital not having a bed available on Monday morning, the transfer was delayed a few hours until 1.55pm Monday 3 July 2017. She was admitted to the ICU at the Royal Darwin

Hospital at 7.10pm. She was administered 5000 units of heparin on admission and every eight hours thereafter as DVT prophylaxis.

37. The plan was that she would be stabilised and extubated. She would then be admitted to the Forensic Mental Health Unit.

38. The concerns on her arrival related mainly to her fever. It was thought that it was probably due to aspiration pneumonia but there was also some concern that it might have been due to possible neuroleptic malignant syndrome or the ingestion of foreign bodies (i.e. the inhalers, latex gloves, medical dressings and hair), perhaps leading to perforation.

39. During her stay in the ICU at Darwin she was kept sedated. The extubation was anticipated to be "complex" due to her exhibited behaviours. However she also continued to need support for both her oxygen levels and blood pressure.

40. On 4 July 2017 during the 11.30am Ward Round the following note was made:

> "Stay intubated today – clearly not appropriate for extubation & transfer to mental health unit given respiratory support."

41. A similar note was made the following day. At 1.55pm the prison called ICU to say that when she was to be extubated they would send three prison guards due to anticipated aggressive behaviour.

42. On 6 July 2017 there was mention of a plan to slowly lighten the sedation on the day shift when more staff were available. On that day the ICU specialist called Emily. The notes state:

> "Explained Naomi is too unwell to be extubated at present due to her infection/ neuroleptic malignant syndrome. She is having a CT of her chest and abdomen this afternoon to see if we can identify a source of the fevers. Explained the pneumonia is improving but having ongoing fevers."

43. Naomi was taken for the CT scan at 3.30pm. She returned to the ICU an hour later. During that evening she became progressively unwell. Her temperature was 40 degrees and she had a heart rate of 130 beats per minute.

44. By 11.00pm the formal report for the CT scans had not been received. One of the doctors contacted the on-call radiologist.

45. At 11.40pm, after she was turned in bed, Naomi's condition deteriorated further. She became hypotensive and her blood pressure fell. A bedside transthoracic echocardiogram indicated a likely massive pulmonary embolus. Naomi was given thrombolysis and cardio pulmonary resuscitation for 45 minutes. However, she could not be resuscitated and she was declared deceased at 12.56am, 7 July 2017. She was just 26 years if age.

46. At 2.15am the results from the CT Scan (taken at 3.45pm the previous afternoon) were received. The report confirmed that the deceased had bilateral obstructive pulmonary emboli in the right and left pulmonary arteries, lobar and segmental branches.

Autopsy

47. An autopsy was performed by forensic pathologist, Dr John Rutherford. He reported that:

> "The venae cavae and pulmonary arteries were intrinsically normal but there was a coiled saddle embolus occluding the terminal part of the main pulmonary trunk extending into the main left and right pulmonary arteries. When disentangled the thrombus measured 32 centimetres in length and up to 1.2 centimetres in width."

48. His comments were:

- "The interval between formation of the deep vein thrombosis and dislodged (sic) and to cause pulmonary embolism is uncertain.
- It is quite possible that the deep vein thrombosis had formed in the lower limbs days to weeks before demise and had only been dislodged shortly before the fatal sequence of events.

- It is likely that the severe obesity was a very significant contributing factor to the formation of deep vein thrombosis.

- Immobilisation, necessary for transfer to a secure facility for psychiatric condition, in the form of induced coma may have been a further contributing factor to the development of deep vein thrombosis.

- The so-called "unexplained" pyrexia may have been a consequence of pneumonitis, the clinically surmised but pathologically unprovable neuroleptic malignant syndrome (or other similar syndrome related to the administration of medication) or simply related to pulmonary embolism (mild pyrexia may be associated with pulmonary embolism in a significant minority of cases and more profound pyrexia in a smaller proportion of cases)."

49. Dr Rutherford concluded that the cause of death was pulmonary embolism as a consequence of dislodged deep vein thrombosis. He also noted that the middle and lower lobe consolidation seen on the chest X-ray may have been the result of previous smaller pulmonary emboli. He found no convincing evidence of pulmonary infection histologically.

Directions Hearing

50. On 17 August 2017, I opened the inquest and conducted a directions hearing. Detective Tony Henrys, as the senior investigating detective, gave evidence. A number of issues were raised. Most relevant for present purposes:

- whether it was the contractor or Royal Darwin Hospital that was responsible for the delay in the results of the CT Scan; and

- There was no forum that was able to jointly plan the management of the deceased between the Department of Health, Corrections and the Police.

51. I made orders for provision of the brief from Police and the Root Cause Analysis from the Department of Health by 31 October 2017. A further

directions hearing followed on 13 December 2017 at which the hearing dates were set for the week commencing on 9 April 2018.

Investigation Brief of Evidence

52. The coronial investigation brief prepared by the Major Crime Squad was excellent. I commend Detective Elle Bennett and Detective Tony Henrys on the quality of the brief and the care and attention that obviously went into the investigation.

Responsibility for late report on CT scan

53. At the second directions hearing it was still not clear whether the late provision of the CT scan report was to do with the procedures of RDH or their contractor, Regional Imaging. The Top End Health Service advised during the course of that hearing that the procedures at fault lay with the contractor. A copy of the brief of evidence was subsequently sent to Regional Imaging. However, on receipt of further statements and documents it was obvious that the Top End Health Service were mistaken about where the issues lay.

Issues

54. Those that undertook the root cause analysis stated that the care provided to Naomi was guided by contemporary best practice guidelines for the treatment of people with Borderline Personality Disorder. That appears to be the case.

55. However part of the complexity of the presentation of Naomi was that her issues were not solely related to Borderline Personality Disorder. She had also been diagnosed with Post Traumatic Stress Disorder from the horrific experiences she endured in her childhood as well as depression. She was also said to have an attachment disorder.[2]

[2] Root Cause Analysis page 7

56. That complexity led to Emily questioning whether the diagnosis was correct:

> "I personally don't believe the Alice Springs Hospital spent enough time to be able to gauge a true diagnosis for Naomi. Naomi had way more good times in life than bad and her relapses were never erratic. They were slow and would gradually increase to a point where even the Townsville team would admit her as an involuntary patient despite the plan they had. Whenever Naomi became erratic or escalated suddenly it would almost always relate to a trigger or an event that reminded her of a past trauma.
>
> Having supported Naomi since she was 14 years of age I would say her symptoms aligned more with PTSD or a complex PTSD as opposed to borderline personality disorder. From the research I've done … although their symptoms are very similar they should be treated differently. I may not be an expert in mental health but I was an expert on Naomi." [3]

57. Certainly the access of Naomi to the Forensic Mental Health Team was limited. That inevitably had an effect on diagnosis and treatment. The Root Cause Analysis stated:

> "There is a level of tension between the CAHS Mental Health team and the FMHT, based in Darwin around the provision of Forensic Mental Health cover throughout the Territory. This is longstanding and appeared to be with respect to resourcing, funding and governance. There was no evidence of a discussion with the forensic team about NS prior to her becoming a client of Correctional Services. This is linked to the demand on their services which means they struggle to meet the need of those clients already known to Corrections and have limited if any capacity to take on additional work." [4]

58. The complexity of her condition was a challenge to the limited resources available in Alice Springs. In practical terms by 27 July 2017 the Alice Springs Hospital did not have the facilities and resources to involuntarily admit Naomi without sedation (and sedation posed significant risks). The Root Cause Analysis stated:

---

[3] Transcript pp 82,83

[4]

> "… in this instance of a client with severe Borderline Personality Disorder and extreme emotional dysregulation and challenges, the level of containment, care and support required fell beyond the skill, experience and expertise of many generic mental health staff."[5]

59. Two of the recommendations of the Root Cause Analysis were to increase the availability and role of the Forensic Mental health Services:

> "A review of the **availability and role of forensic mental health services in the Northern Territory** should be undertaken, as soon as possible, to ensure that the service in Alice Springs has an equitable level of service that meets the complex needs of that population …Such a review may want to consider whether a unified Forensic Mental Health Service would provide a better service in terms of service delivery, quality and safety."
>
> "Given the lack of clarity around **the governance of clients from Alice Springs being treated by the Forensic Mental Health Service**, this should be clearly established together with a specified service model. " [6]

60. Without the expertise of the Forensic Mental Health Team, the Alice Springs Hospital struggled. They attempted to deal with the issues by pushing Naomi onto other services. Firstly Police and then Corrections. Neither Police nor Corrections could deal with the escalating behaviour and distress of Naomi and their only option was to continually return Naomi to the Mental Health Team for assessment in the hope that she would receive appropriate support and treatment. The repeated rejection of Naomi by each service, particularly the mental health service, is likely to have exacerbated Naomi's distress and deteriorating mental state.

61. That exposed the inability of the various government services in Alice Springs to coordinate their services or form a joint plan. That was the subject of the first recommendation of the Root Cause Analysis:

---

[5] Page 9
[6] Page 14

> "Consideration should be given to establishing a multi-agency referral program in the Northern Territory, so that when clients with complexity … requiring support by a wide range of agencies including health care, ambulance, police and corrections are present, a clear multi-agency response is devised proactively."[7]

62. Such a multi-agency group could have commenced coordinating a response in April 2017. As it was there was no coordination or cooperation until the Superintendent at the prison, Bill Yan insisted that Forensic Mental Health Services assist in resolving what by that point had become a crisis for Naomi and all of the services in Alice Springs engaged in her care.

Deep Vein Thrombosis (DVT)

63. It is not possible to know at what point the deep vein thrombosis developed. It is possible that it developed during this period of crisis in Alice Springs when the Mental Health Unit, the Police and Correctional Services were by various means immobilising Naomi. Counsel for the Department of Corrections provided a list of the major periods of restraint:

a. her admission to ASH on 25 – 26 June 2017;

b. her apprehension and transport by SJA to ASH on 27 June 2017;

c. her arrest and detention by police on 28 June 2017 including 2 episodes of restraint in an ERC for 90 minutes and 2 hours respectively;

d. her subsequent overnight admission to the ED of ASH, where she was mildly sedated and rested in bed;

e. her continued detention by police on 29 June 2017 prior to attendance at Court and afterwards, prior to being conveyed to ASCC, including a further period of 30 minutes in an ERC;

f. her restraint in an ERC for 2 hours on 29 June 2017 shortly after arrival at ASCC before being transported to ASH in a police van;

g. her restraint in an ERC at the ASCC on the morning of 30 June 2017 for a period of 2 hours and her further restraint in an ERC for 65 minutes, 2 hours and 48 minutes and 60 minutes respectively;

[7] Page 14

h. her restraint with hand and foot restraints in place in ASH ED in the afternoon and subsequent intermittent physical restraint during the evening of 30 June 2017, also with periods of mild sedation.

64. From that point it is less likely she would have developed DVT due to the prophylaxis administered.

65. No criticism can be made of Police, Corrections or the Mental Health Unit over that period for failure to administer prophylaxis because the problems they were encountering were self-harming behaviours, including Naomi hitting her head on walls and the floor and reopening wounds to cause herself to bleed. It does however illustrate the desperate need for those with the expertise and facilities to engage and deal with the crisis at a much earlier time.

66. Naomi did have risk factors for DVT due to her morbid obesity and smoking. Superintendent Bill Yan gave evidence during the course of the inquest. He was asked questions about the guidelines for using the restraint chair and whether he thought the risk factors should be taken into account. That very afternoon he instructed his lawyers to provide submissions in which he committed to the following:

> "(a) Amendment to the Standard Operating Procedures for Alice Springs and Darwin Correctional Centres in relation to use of ERCs discussing the risk factors of DVT including the increase in risk where a person presents with co-morbidities such as obesity, history of heavy smoking and other identifiable risks. This will include, subject to expert advice on best practice, procedures for identifying possible symptoms of DVT; and
>
> (b) Amendment to training materials for Corrections Officers being trained in the use of ERCs to include training about the material health risk factors including DVT, and how to check for DVT."

67. I commend the Department of Correctional Services for their willingness to learn and their proactive approach. It is not the first time Superintendent Yan has demonstrated an ability to learn and improve the practices and procedures of the Alice Springs Correctional Facility.

68. I would commend that approach also to Police should they continue to utilise the restraint chair in their watch houses.

Transport to Darwin and ICU in Darwin

69. Doctor Mark Elcock provided an expert review to the Top End Health Service in relation to the medical care and treatment. He was of the opinion that the arrangements for transport and the care of Naomi while in ICU at the Royal Darwin Hospital were appropriate.

70. I heard from Dr Stephen Gourley, the Director the Emergency at the Alice Springs Hospital and Dr Sarah Jones, a consultant for the Intensive Care Unit at the Royal Darwin Hospital. They were both impressive witnesses and it was evident that they had put a lot of effort into the care and treatment of Naomi and in preparation for the inquest. I noted that Dr Sarah Jones made the effort to attend the entire inquest.

The Delayed CT scan report

71. The delay of the CT scan report became a difficult issue. Despite being told that the Top End Health Service believed it to be due to the processes and procedures of the contractor, my office received no evidence to support that allegation.

72. A number of enquiries were made of the Top End Health Service as to when that information would be available, but it was not forthcoming. On 4 April 2018, the General Manager of Regional Imaging, Mark Simpson, provided a statement. It described a very complex system. However it seemed that in this case the system had functioned as intended and in accordance with the contract between the Top End Health Service and the Top End Health Service.

73. At 5.11pm on Friday 6 April 2018 (after COB on the business day before the inquest) my Office was provided with a statement from Dr Alison Maclean, the Director of Medical Services at the Royal Darwin Hospital. That

statement did not indicate where the process failed and appeared to support the statement made by Mark Simpson.

74. It indicated that Regional Imaging "advised they had changed a document which sets out the process for contacting the reporting Radiologist after hours". It went on to say, "This will make the process more clear for requesting clinicians."

75. During the inquest Dr Maclean told me that the document had been prepared by Regional Imaging and had been first discussed at a meeting five days ago and would be rolled out on the Monday following the inquest. It changed the times when the onsite radiologists could be assumed to be available to report on a scan from 5.00pm to 4.30pm.

76. There was also an urgency flagging system for reports on scans that Regional Imaging had introduced in mid-2017 that was believed to be in response to the death of Naomi.

77. She said she had been the Director of Medical Services for 12 months and responsible for radiology since January 2018. She thought the issue with the CT scan report was more of an individual issue rather than a systems issue and a "one-off".

78. She said she hadn't been aware that Naomi died of a pulmonary embolism until much later and wasn't aware of the delay in the CT until relatively recently. She wasn't aware until the last three months that she could get access to autopsy reports and she wasn't aware of the information provided during the opening to this inquest about the cause of death and the delay in provision of the CT scan report.

79. Overall Dr Maclean's evidence as part of the institutional response was not particularly helpful. I was left with the impression that she had not prepared for the inquest in the manner expected (and usually provided), by the Royal Darwin Hospital.

80. A schedule of all of the recommendations from the Root Cause Analysis and the Dr Elcock's review was prepared and attached to the statement of Dr Charles Pain. He is the Executive Director of Clinical Governance and the Executive Director, Medical Services for the Top End Health Service. There were 18 recommendations in total. At the date of the inquest the only recommendations said to have been implemented were those relating to radiology. It was indicated the implementation was the changes made by Regional Imaging. The balance it was said would be implemented in April or July 2018.

81. From the evidence it was apparent that little progress had been made. It seemed that everyone had been waiting for the completion of firstly the Root Cause Analysis and then the expert review before making any improvements. The Root Cause Analysis was completed on 11 December 2017 and the expert review on 5 March 2018.

82. It was disappointing that there had been no progress particularly in relation to having a multi-agency forum to deal with complex cases. The formation of such a forum had been raised in both directions hearings. It is hoped that progress is made before another complex case leads to such distress and crisis.

Comment

83. In April 2017 Naomi Smith came to Alice Springs in the Northern Territory with her adopted sister and carer to have a fresh start. She had very complex needs and drew extensively on the services of the Alice Springs Hospital and the Alice Springs Police over the next few months.

84. It should have been clear that there was a need for intervention and assistance from the Forensic Mental Health Team based in Darwin. However, perhaps due to limitation of resources they were not available to the Mental Health Unit at Alice Springs Hospital.

85. The mental state of Naomi deteriorated and toward the end of June became a crisis for Naomi, the Police and Alice Springs Hospital. Without appropriate specialist support the crisis deepened. None of the agencies could deal with Naomi and each pushed her to the other, often multiple times a day. For Naomi, who felt rejection very keenly, that likely compounded her issues.

86. There was no forum in which the agencies could jointly organise a management plan. There was no mutual understanding as to the way forward.

87. Mental Health could not deal with her and sought that Police utilise the criminal justice system. However, that did not assist because police and corrections could not manage Naomi. She remained in need of appropriate Forensic Mental Health Team expertise and facilities.

88. Because that was not made available to Naomi the various agencies resorted to restraint techniques that given the physical health issues suffered by Naomi may have contributed to the formation of deep vein thrombosis in her legs.

89. Eventually, the crisis reached such a point that Superintendent Bill Yan of the Alice Springs Correctional Centre contacted the Forensic Mental Health Team in Darwin and it was arranged to transport Naomi to Darwin.

90. She was sedated intubated and transported to Darwin. However, she developed a fever that may have been related to the deep vein thrombosis and her requirement for oxygen impeded her being extubated.

91. On 6 July 2018 a CT scan indicated some small pulmonary emboli. If that had been reported upon in a timely fashion Naomi would likely have been provided care and treatment aimed at reducing the blood clots. However it is unlikely that any such treatment would have changed the fateful outcome because the clots seen on the CT scan were minor compared to those that caused her death. That night when she was turned in her bed a massive deep

vein thrombosis of approximately 32 centimetres in length was dislodged from and travelled to and occluded the two main pulmonary arteries. She went into cardiac arrest and died despite the best efforts of the specialists.

92. At a relatively early point in time the major issues were understood and aired in open court. To date there is no evidence that the Top End Health Service has put any real effort into improving the responsiveness of the Forensic Mental Health Team or (along with the Central Australian Health Service) sought to develop a multi-agency group to jointly manage complex cases.

93. I was however encouraged to see that the Chief Executive of the Department of Health, Catherine Stoddart, made time to attend part of the inquest. It is hoped that she can bring some influence to bear on the Top End Health Service and the development of a multiagency forum.

94. Section 26(1)(a) of the *Coroner's Act* requires that I must investigate and report on the care, supervision and treatment of the deceased while she was in custody. The care, supervision and treatment of Naomi was of an adequate standard from the point that she was transferred from Alice Springs to Darwin.

95. Prior to that time no criticism can be made of those doing their best in Alice Springs. Indeed, the Police were particularly caring and supportive of Naomi. We heard at the inquest from Sergeant Jared Porch and saw footage from his body worn camera. It showed the care of Naomi to be of a very high standard and I commend Sergeant Porch on his compassionate and caring approach.

96. However, Naomi's care and treatment should have included input from the Forensic Mental Health Team at an earlier time. That did not happen. The suggestion is, that failure is a longstanding resource issue. If that is the case it should be fixed as soon as possible.

Formal Findings

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

(i) The identity of the deceased was Naomi Smith, born on 20 October 1990, in Townsville, Queensland, Australia.

(ii) The time of death was 12.56am, 7 July 2017. The place of death was Royal Darwin Hospital in the Northern Territory.

(iii) The cause of death was pulmonary embolism as a consequence of dislodged deep vein thrombosis.

(iv) The particulars required to register the death:

1. The deceased was Naomi Smith.

2. The deceased was believed to be of Aboriginal descent.

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

4. The death was reported to the coroner by the Department of Corrections.

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

6. The deceased's mother was Leanne Hungerford and her father was Leon Hungerford.

Recommendations

98. That the Top End Health Service do all things necessary to ensure that the Forensic Mental Health Team provides appropriate service to Central Australia so as to enable early intervention for complex cases.

99. That a multi-agency forum be established that includes a wide range of agencies (including Health, Ambulance, Police and Corrections) so as to enable a proactive and clear multi-agency response to complex cases.

Dated this 19th day of June 2018.

_____

GREG CAVANAGH
TERRITORY CORONER