

CITATION: *Inquest into the death of Kumanjayi Brogus Ungwanaka* [2026]

NTCC 12

TITLE OF COURT: Coroners Court

JURISDICTION: Alice Springs

FILE NO(s): A0061/2023

DELIVERED ON: 21 September 2026

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FINDING OF: Elisabeth Armitage

CATCHWORDS: Preventable death in the High Dependency Inpatient Unit at Alice Springs Hospital; Schizophrenia; combined drug toxicity; failure of mental health nurses to conduct appropriate physical monitoring; failure of mental health nurses to identify a deteriorating patient; failures to comply with NT Health policy, procedures and guidelines; failure to comply with the Rapid Tranquilisation Mental Health Procedure; failure to complete a medicine reconciliation; failure to implement Root Cause Analysis

**recommendations; capacity and
consent; involuntary patient; outdated
legislation; Advance Personal Plans.**

Mental Health and Related Services Act 1998

Advance Personal Planning Act 2013

REPRESENTATION:

Counsel Assisting: Sandra Wendlandt

Counsel for Family: Jessica Clarke

Counsel for NT Health: Tom Hutton

Counsel for Dr Sally Simpson: Ian Read

Counsel for Dr Arthur Graf: Trevor Moses

Judgment category classification:	A
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IN THE CORONERS COURT
AT ALICE SPRINGS IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. A0061/2023

In the matter of an Inquest into the death of
KUMANJAYI BROGUS UNGWANAKA

ON: 22 NOVEMBER 2023

AT: ALICE SPRINGS HOSPITAL

FINDINGS

Judge Elisabeth Armitage

Introduction

Overview

1. Kumanjayi was a deeply loved mother, daughter, sister, partner and cousin. Like many in our community she suffered from a mental illness. She was diagnosed with schizophrenia. In the days before her passing she was suffering from a deterioration of her schizophrenia. She knew she was ill and she wanted to go to ‘Ward 1’ to be cared for and to get better. She passed away just after midnight on 22 November 2023 in the Alice Springs Hospital (ASH) Mental Health Inpatient High Dependency Unit (HDU), which is also known as ‘Ward 1’. She had been there for only a few hours before she passed away. She was only 34 years old.
2. The Regional Executive Director of the Central Australia Regional Health Service and institutional respondent for NT Health, Ms Rebecca Schultz, frankly conceded

that her death was “entirely preventable.”¹ NT Health takes full responsibility for the failings in her care.²

3. At the time of her passing, she was an involuntary patient, and an inquest was mandatory. Even though it was difficult and distressing for them to listen to the evidence about Kumanjayi’s passing, many of her family members attended the inquest, including:

- Magdeline Ungwanaka – Kumanjayi’s mum
- Sherlene Brogus – Kumanjayi’s sister
- Sherane Brogus – Kumanjayi’s sister
- Elva Jingo – Kumanjayi’s daughter
- Vera Long – Kumanjayi’s daughter
- Theo Long – Kumanjayi’s son
- Terence Long – Kumanjayi’s partner
- Arfa Ungwanaka – Kumanjayi’s little mum (aunt)
- Saleen Ebatarinja – Arfa’s daughter
- Christyanne Ebatarinja – Arfa’s daughter
- Camilla Minor – Kumanjayi’s niece and Magdeline’s granddaughter
- Sarita Jack – Kumanjayi’s niece
- Jamie Winston – Sarita’s child
- Natchesta Ungwanaka – Sarita’s mum and Magdeline’s niece
- Celissa Charles – Magdeline’s niece
- Everart Wheeler – Sherlene’s partner
- Patrick Poulson – Kumanjayi’s little dad
- Faiye Minor – Magdeline’s cousin
- Josie Fly – Kumanjayi’s aunty

¹ T 664 (R Schultz)

² Folio 23, Affidavit R Schultz, [7]

4. It was clear from the attendance of her extended family and their participation in the inquest that they wanted to know what happened to Kumanjayi. Some members of her family had rightly, and in good faith, encouraged her to go to hospital in the belief and expectation that she would be looked after, would get better, and would come home to them. Kumanjayi's family are not responsible for what happened to Kumanjayi and should not feel any guilt or shame. They were entitled to expect that she would be well looked after; and I acknowledge that it must now be very hard for Kumanjayi's family to trust the Northern Territory health system.
5. In the coroner's jurisdiction the standard of proof applicable for findings is the balance of probabilities, "in conformity with the sliding scale of satisfaction explained in *Briginshaw v Briginshaw*."³ In *Briginshaw*, the High Court explained:⁴

"The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issue is proved to the reasonable satisfaction of the tribunal. In such matters 'reasonable satisfaction' should not be produced by inexact proofs, indefinite testimony, or indirect inferences."
6. There were several significant factual matters in dispute during the lengthy evidence heard during the inquest which ran over eight days. That there were differing accounts of critical factual events shortly before Kumanjayi's death was gravely concerning to me, Kumanjayi's family, and no doubt to NT Health. It was not necessary to resolve all the differences. Where it has been necessary to make findings which require me to accept or reject a witness's version of events, I have applied the balance of probabilities as explained in *Briginshaw* and have considered *all* of the evidence received in the inquest. However, the events and assessments are addressed chronologically in these findings.
7. The inquest received a number of expert reports from: Professor David Joyce, a toxicology expert; Dr Kate Roberts, a forensic psychiatrist; and from Professor Luke

³ (1938) 60 CLR 336, cited in *Hurley v Clements & Ors* [2009] QCA 167

⁴ *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363

Lawton, emergency physician who was engaged by the North Australian Aboriginal Justice Agency. The inquest also had the benefit of a medicine review from pharmacist Dr Alice Gilbert which formed part of the NT Health Root Cause Analysis (RCA). I was grateful for the assistance of these experts.

Her cause of death

8. On 22 November 2023 Kumanjayi was found unresponsive in the HDU and a Code Blue was called at 12.17am. When all attempts at resuscitation failed she was declared deceased at 1.15am. In the days and in the hours immediately preceding her death, Kumanjayi had received antipsychotics and sedatives in response to a relapse of her schizophrenia. Following an autopsy and post-mortem toxicology, the forensic pathologist considered her cause of death was due to combined drug toxicity of this medication, specifically, Olanzapine and Ketamine.
9. As part of its RCA,⁵ NT Health initiated a medicine review. The medicine review calculated that on 21 November 2023, Kumanjayi had received ~198% of the recommended maximum dose of antipsychotics. Kumanjayi passed away just after midnight following this day of highest risk. The medicine review identified that on 21 November 2023, Kumanjayi was exposed to three antipsychotics (Aripiprazole, Droperidol, Olanzapine). She was also given three different types of benzodiazepines (Diazepam, Midazolam, Temazepam). The medication review found no clear reason why multiple benzodiazepines were chosen, noting that two might be appropriate to enable varying routes of administration. The review considered that the decision to prescribe and administer Midazolam 10mg IM and Droperidol 10mg IM placed Kumanjayi at significant risk. This combination was at the highest end of dosing, usually reserved for acute severe behavioural disturbance and done at the point of transfer. Whilst Midazolam is safe, respiratory depression is a possibility, especially in higher doses. Patients should always be monitored closely for potential adverse effects after administering an intramuscular sedative drug. The RCA panel concluded that the root cause of Kumanjayi's tragic death was the

⁵ Folio 18 RCA

cumulative volume of antipsychotics and sedatives administered, including via the Rapid Tranquilisation Mental Health Procedure (RTP), and the failure to provide physical monitoring, as required by the RTP.

10. Having reviewed all the records, Professor Luke Lawton considered that there was no recorded justification for the administration of medications under the RTP.⁶ He explained that the Droperidol and Midazolam resulted in heavy sedation. In this heavily sedated state Kumanjayi's airways partially obstructed and she could no longer breathe effectively.⁷ Her oxygen levels declined and her carbon dioxide levels rose. She became hypoxic which caused a cardiac arrest.
11. Prof Lawton considered that nursing observations of a rise and fall of the chest were insufficient to assess the breathing quality of a sedated patient⁸ and Kumanjayi's deterioration would have been identified with pulse oximetry and appropriate physical monitoring. Based on his considerable experience,⁹ Prof Lawton considered that Kumanjayi's venous blood gas, which had a pH of 6.66 during the Code Blue response, was indicative of a prolonged period of hypoxia. He considered there must have been at least 20-30 minutes of circulatory failure to produce that reading.¹⁰ Prof Lawton told me that Kumanjayi's deterioration should have been identified and appropriate interventions would have prevented her death.
12. The toxicology expert, Professor David Joyce, considered that the use of antipsychotic and sedative drugs "*put her at risk of two potentially lethal outcomes. They were malignant cardiac arrhythmia and respiratory insufficiency.*"¹¹ Cardiac arrhythmia caused by the drugs administered was considered but ultimately rejected on the evidence available. Concerning respiratory insufficiency, he considered her

⁶ T 437 (Prof Lawton)

⁷ T 435 (Prof Lawton)

⁸ T 442 (Prof Lawton)

⁹ T 450 (Prof Lawton)

¹⁰ T 441-442 (Prof Lawton; he said he had never seen a pH of this level in his career and the significance of it was palpable)

¹¹ Additional documents list, folio 16, p 13 [42]. A third was considered- malignant neurolept syndrome- but disregarded as inconsistent with her medical history

obesity a risk factor, and her snoring an indicator. Similarly to Prof Lawton, Prof Joyce explained that sedative intoxication can cause a person to stop breathing due to an evolving asphyxia.¹² Prof Joyce considered that Kumanjayi was a high risk of ventilatory failure in ED, and the absence of notes in the HDU suggested that her deterioration went unnoticed.¹³

13. Prof Joyce considered that *“the overall evidence... point[s] towards asphyxial death in the context of profound sedation.”* He said *“the weight of evidence points towards upper airways obstruction and asphyxia during sedation as contributors to her death. However, the contribution of drugs to the fatal outcome cannot be completely disentangled from the risks posed by the physical and psychiatric conditions themselves.”*¹⁴
14. It was clear from the evidence discussed in these findings that a string of cascading failures by NT Health staff contributed her death. These included failures in communication and documentation between medical staff, a failure to document and reconcile her medicine, over-sedation that was not warranted by her presentation, a failure to properly observe and monitor her when she was sedated, a failure to properly consider her co-morbidities and failures by multiple staff to follow hospital policies. These were the failings of individuals, working in a system which permitted mistakes to occur, and in a system which did not identify the mistakes or rectify them in time to save her life. Kumanjayi was given too many drugs and too little care and this fatal combination caused her death. With a proper level of care her death would have been prevented.
15. Having considered all of the evidence I was satisfied that the cause of death was the cumulative volume of antipsychotics and sedatives administered, including via the RTP, in combination with a failure to provide physical monitoring, as required by the

¹² Additional documents list, folio 16, p 9 [43-44]

¹³ Additional documents list, folio 16, p 9 [47]

¹⁴ Additional documents list, folio 16, p 9 [52-53]

RTP. Under heavy sedation Kumanjayi's airways obstructed. She could not breathe effectively (asphyxia). Her prolonged hypoxia (low oxygen levels) caused her death.

***Pukumani* - disturbing similarities**

16. In the *Inquest into the death of Pukumani* [2025] NTLC 3 I considered the passing of Pukumani who was medivacced from her community and admitted as an involuntary patient into Royal Darwin Hospital on 4 August 2021. On 8 August 2021 Pukumani passed away in the Joan Ridley Unit (**JRU**), a Darwin Mental Health Inpatient ward, from an acute respiratory failure in the context of chronic obstructive pulmonary disease and multiple anti-psychotic and sedative medication administration. The NT Health RCA¹⁵ conducted into the circumstances of her passing was completed on 28 January 2022, that is, 22 months before Kumanjayi passed away.
17. In Pukumani's RCA, NT Health identified failings in the care provided to her including:
 - a. A failure by mental health nursing staff to complete prescribed observations of Pukumani overnight in the JRU.
 - b. A failure by mental health nursing staff to conduct proper respiratory checks and record the same.
 - c. A failure to provide a system of supportive supervision to mental health nursing staff to ensure standards of practice were met.
 - d. The use of high dose and multiple antipsychotics in the mental health unit which was not supported by firm evidence and in circumstances where the risk and potential for adverse events is well known.

¹⁵ Ex 5 Serious Clinical Incident (ISR1) Root Cause Analysis Report RiskMan ID No: 116463

- e. No clear reason why multiple benzodiazepines were chosen, noting that two might be appropriate to enable varying routes of administration.
18. In response to those failings and with the stated intention of preventing a similar death, NT Health committed to:
- a. Improving visual observations of mental health patients including by requiring the taking and recording of respiration observations.
 - b. Round the clock on-site supervision from accountable management representatives in the Inpatient Unit to ensure standards of practice, such as clinical observations, are adhered to.
 - c. A review of the ‘Medication History and reconciliation TEHS Procedure’ (**Medication Reconciliation Procedure**) as an NT wide iteration and a review of the Rapid Tranquilisation Procedure.
 - d. The development of ‘Mental Health Deterioration Simulation Workshop’ training to assist staff to identify and respond to a deteriorating patient, with the targeted audience including Mental Health Nurses (**MHN**) and Patient Care Attendants (**PCA**).
 - e. The development of DETECT training specific to the mental health environment (with a focus on the circumstances of Pukumani’s presentation, deterioration and shortcomings in her care).
19. The Chief Psychiatrist and NT Health institutional respondent, Dr David Mitchell, said Pukumani’s death was preventable and NT Health takes full responsibility in the shortcomings of her care. He said that NT Health is committed to ensuring that systemic improvements are made in response to Pukumani’s death, and NT Health must learn from its shortcomings and ensure these circumstances are not repeated.
20. Given those undertakings and that stated commitment it was highly distressing to learn that the Clinical Director of Mental Health Services in Central Australia, Dr Marcus Tabart, knew nothing of Pukumani’s death, or the RCA that followed, or the

recommendations designed to prevent further similar deaths. He said he only learned of Pukumani's death when he heard a report about the inquest on the ABC News.¹⁶

21. Ms Rebecca Schultz explained that in 2022 there was no formal process for sharing RCA's or inquest findings among NT Health regions. Ms Schultz said that changed in 2025, when a committee was established to ensure this occurs.
22. While I accept the sincerity of the senior NT Health employees who gave evidence in this inquest, it is hard to accept promises about NT Health's commitment and capacity to implement change without some scepticism. The cold and hard truth for NT Health is that had the recommendations made in the Pukumani RCA been fully implemented in Central Australia, specifically, if appropriate respiratory checks had been conducted on Kumanjayi, her deterioration would have been detected and her death prevented.
23. In light of this history, I do not apologise if the recommendations made in these findings mirror or overlap with undertakings or changes already identified by NT Health. Where that is the case, the recommendations form part of the public record and are made with the goal of ensuring the necessary changes are implemented and embedded.

Recommendation No. 1

I recommend to the **Department of Health** that it establish a Senior Executive cross regional committee responsible for considering, tracking and implementing Root Cause Analysis and Coronial recommendations. All decisions (and reasons for those decisions) accepting, rejecting, amending, or implementing recommendations should be adequately documented. Six monthly progress reports tracking the progress of recommendations should be provided to the CEO.

¹⁶ T 608, 635 (M Tabart)

Background of Kumanjayi Brogus Ungwanaka

24. Kumanjayi was from Ntaria (Hermannsburg) community located approximately 130 km west of Alice Springs. She was a mum to three children, and an integral part of a close and extended family and community who loved her. English was not her first language. Her mob were Western Arrernte and she spoke Arrernte and Luritja. She moved between her homeland, Sandhill outstation, Ntaria and Papunya. She loved children and had worked in childcare in Papunya.
25. Kumanjayi suffered from several health conditions including rheumatic heart disease, chronic obstructive pulmonary disease, gastroesophageal reflux disease and iron deficiency. In 2014, when she was 25 years old, she was diagnosed with schizophrenia. She had numerous Inpatient mental health admissions including in 2019 and 2023. Her complex health profile made her very vulnerable.
26. As Kumanjayi was closely connected to family and culture she was mobile between her communities and across her country. Mobility is the norm for many cultural Aboriginal persons and, while it adds to the challenge of providing health services, it should be viewed and supported as a cultural strength. When Kumanjayi was in Papunya, she missed the remote mental health staff visits to Ntaria. The aboriginal health worker (AHW) who worked at the Ntaria clinic confirmed that Kumanjayi was often in Papunya, but the AHW said she did her best to look for Kumanjayi to assist her to receive medication.¹⁷ For Kumanjayi (and others like her), the community primary health services need robust systems for sharing information so that she could receive the continuity of care required to address her many health issues.
27. Kumanjayi knew that her medication reduced the symptoms of her schizophrenia. However, she sometimes struggled to take her medication¹⁸ and reported to medical

¹⁷ T123 (AHW)

¹⁸ Folio 6 (medical records – primary health). The NT Health institutional respondent indicated that there was sorry business in June 2023 which in part explained why Kumanjayi missed her depot injections. Additional documents, Folio 23, [99]. The AHW at the Ntaria clinic, said sorry business would not have stopped clinic coming out

staff that it did not make her feel good. The reluctance of patients to take medication with unpleasant side effects is common and is well understood by those caring for mental health patients. Labels like ‘non-compliant with medication’ do not acknowledge the complexity of the issue and are stigmatising. Kumanjayi is not to be blamed for sometimes choosing not to take her medication.

Kumanjayi’s health deteriorates

28. Kumanjayi had not received her Aripiprazole depot injection since July 2023.

However, there was no evidence that she had been unwell until the days just before her death. Shortly after midnight on Saturday 18 November 2023, Kumanjayi contacted the Ntaria clinic because she had “*started to get this feeling,*” “*started to feel psychotic*” and she requested her depot injection (400mg of Aripiprazole). Her family confirmed that she was behaving strangely, was telling stories from a long time ago, and talking to herself. Clinic staff collected her and gave the depot injection. The records reveal that she had good insight, was cooperative and calm, and the staff told her to come back to the clinic in the morning.

29. At about 10.46am on 18 November 2023, Kumanjayi returned to the clinic requesting her prescribed Thyroxine medication. The clinic notes record that she was physically well but disinhibited; she was vocalising and touching the nurse (which ceased when requested). She was “*acting with self-insight*” and she asked, “*Can I go to Ward 1?*”¹⁹

30. On Sunday evening 19 November 2023 at around 9pm, Kumanjayi returned to the clinic with family. Her family said she was talking funny and to herself and crying uncontrollably.²⁰ Clinic staff considered that although highly strung, she was cooperative and could answer questions appropriately. The clinic nurse called the

to remind people to get their depots. Her notes were not always accurate as to when she went out to see clients, including Kumanjayi: T122-123 (AHW)

¹⁹ Folio 6 (medical- primary health) , pp 53 – 58; Ward 1 is a name given to the mental health Inpatient Unit at ASH.

²⁰ Folio 6 (medical- primary health) p 53

Medical Retrieval and Consultation Centre (MRaCC)²¹ doctor and, following his suggestion, Kumanjayi was given 10mg of Olanzapine and sent home. She was encouraged to come back the following day for review by a General Practitioner (GP), or sooner if her condition worsened.²²

31. On Monday 20 November 2023, Kumanjayi returned to the clinic with her mother and sister and was seen by Dr S at about 10am. This was the first time Dr S had met Kumanjayi. Dr S was employed by Central Australian Aboriginal Congress and arrived as a locum on 30 October 2023. Though new to Ntaria and the Northern Territory, Dr S had worked in Aboriginal health services and in remote communities in Western Australia since 2010. She was an experienced GP who had worked extensively with Aboriginal clients.
32. Her family said Kumanjayi had been manic for two days. They were worried she might get worse and wanted her to go to hospital. Kumanjayi told Dr S that she had slept well. She showed Dr S a photograph of her baby and offered the doctor a dummy and a baby bottle.²³ Dr S described her as a “*well, pleasant, happy, cooperative lady [...] unable to sit still, touching items on [Dr S’s] desk and face.*” Dr S recalled Kumanjayi telling her, “*there was lightning and rain and she said it had come through her hair and Jesus was talking to her and that’s what upset her or that’s what triggered her about the episode.*”²⁴
33. Dr S understood that Kumanjayi had missed four depot injections and considered she needed medication to help manage her symptoms. Dr S gave her Diazepam and Olanzapine, both 10mg, at the clinic. She was prescribed further doses of Olanzapine and Diazepam to take home for the night and for the following morning.²⁵ Although Dr S knew that her family wanted Kumanjayi to go to the

²¹ Medical retrieval and consultation service doctor. See also Folio 23 (institutional response of NT Health) p 9

²² Folio 6 (medical- primary health) p 54, 51

²³ Notes of Dr S Folio 7, p 2621 Coronial brief 1 of 2, Folio 31 (supplementary statement of Dr Sally S) p 4-5, Folio 6 (medical – primary health) p 48

²⁴ T23 (Dr S)

²⁵ Folio 6 (medical – primary health) p 48

hospital,²⁶ Dr S considered that it would be better for Kumanjayi to remain and recover in the community, if that could be achieved,²⁷ as Kumanjayi was cooperative and not a danger to herself or anyone else.²⁸ I agree that was an appropriate approach.

34. Dr S phoned Kumanjayi's mother that afternoon at 5.30pm. Kumanjayi was agitated and Dr S told her mother to administer the Olanzapine and Diazepam.²⁹ Kumanjayi's mother reiterated that Kumanjayi wanted to go to hospital. Dr S arranged for Kumanjayi to attend the clinic in the morning and her plan was for hospital if Kumanjayi had not improved.³⁰

21 November 2023 - Kumanjayi is made an involuntary patient

35. The following morning at around 8.30am Dr S phoned Kumanjayi's mother. Kumanjayi had been awake during the night, walking around, and had kept the whole household awake. Her mother said she could not manage and "*she needs to go to hospital.*"³¹ Her mother confirmed that Kumanjayi had taken Olanzapine 10mg and Diazepam 5mg at about 6am that morning. Dr S asked Kumanjayi's mother to bring her to the clinic.
36. Before Kumanjayi arrived, Dr S phoned the on-duty psychiatry registrar at ASH, Dr YH, for advice. From the description provided by Dr S, Dr YH considered that Kumanjayi could be administered further Olanzapine 10mg (up to 30mg per day) as well as further Diazepam (up to 30mg per day). He considered that Kumanjayi was acutely unwell and was displaying symptoms of psychosis, and he recommended that she be placed on a Form 9 under the *Mental Health and Related Services Act* 1998 (**MHRS Act**) and be brought to hospital.³²

²⁶ T 24 (Dr S)

²⁷ Folio 31 (supplementary statement of Dr Sally S) p 4 [30]

²⁸ Folio 31 (supplementary statement of Dr Sally S) p 4 [31]

²⁹ T 24 (Dr S), Folio 31 (supplementary statement of Dr S) p 5

³⁰ Folio 6 (medical- primary health) p 49 (written in retrospect on 22 Nov 2023)

³¹ Folio 6 (medical -primary health) p 47

³² T259-261 (Dr YH)

37. Kumanjayi and her mother attended the clinic at about 9.30am. Dr S noted that Kumanjayi was *“more settled today, neatly dressed, less restless, able to sit calmly however still touching everything”* and *“still quite agitated.”*³³ Her mother confirmed that the family were exhausted and Kumanjayi said that she wanted to *“go to hospital for one week.”*³⁴
38. Meanwhile, Dr YH rang Dr Mary Frost, a locum consultant psychiatrist at the Alice Springs Hospital. Dr Frost agreed with his proposed management plan but, as she was not familiar with local logistics, she told Dr YH to speak to another psychiatrist, Dr Van Schalkwyk. Dr Van Schalkwyk reminded Dr YH that the decision whether to place the patient on a Form 9 rests with the clinic staff, based on their in-person assessment, rather than him. Following these conversations, Dr YH called Dr S. While Dr YH still considered that a Form 9 was appropriate, he relayed to Dr S that the decision was hers to make. He suggested that she speak to the Clinic Manager about the transfer process.³⁵
39. Working in a team environment with the Clinic Manager, Dr S decided Kumanjayi should go to hospital.³⁶ Although it was Dr S’s preference that Kumanjayi be transported by private or clinic vehicle,³⁷ the Clinic Manager said that the clinic was too short staffed for a clinic vehicle to be used.³⁸ Dr S said she was reluctant to make Kumanjayi an involuntary patient *“because she was cooperative and wanted to go.”*³⁹ However, Dr S understood that the only available transport was via a MRaCC retrieval which required a Form 9.⁴⁰ Accordingly, at about 10am Dr S signed a Form 9 which had been filled out by the Clinic Manager.⁴¹

³³ Folio 6 (medical- primary health) p 44, T23, 25 (Dr S)

³⁴ Folio 6 (medical- primary health) p 44

³⁵ T261 (Dr YH)

³⁶ T25, 31 (Dr S)

³⁷ T34(Dr S) , T96 (Clinic Manager)

³⁸ T82-83, 90-91 (Clinic Manager). Sometimes the clinic vehicles meet MRaCC halfway: Dr Argy’s evidence T145-146; T 96 (Clinic Manager)

³⁹ T26 (Dr S)

⁴⁰ T26, 30, 31, 34-35 (Dr S)

⁴¹ Closing Submissions of Dr S at [4.14]; Folio 6 (medical- primary health) First Form 9; T 70-71, although this Form 9 indicates a satisfaction as to Mental Disturbance

40. At around 11am Dr S phoned MRaCC and spoke to the retrieval consultant, Dr Phillip Argy. A retrieval team was confirmed and Dr Argy requested that Midazolam and Droperidol be on standby at the clinic in case they were required to manage her agitation.⁴² At 11.06am Dr S completed an ‘Urgent Referral’ for the attention of Dr YH, which described Kumanjayi as being acutely unwell with psychosis. It noted that she was *“unable to be managed in the community as she is restless, not sleeping, eating excessively and talking to Jesus. She said that lightening and the rain on the weekend upset her.”*⁴³ Her medications administered from 19-21 November were listed. Kumanjayi was *“cooperative and wishes to go to hospital.”*⁴⁴
41. Despite receiving this referral, Dr YH did not formally advise the ASH Inpatient mental health unit (**Inpatient Unit**) nor the Emergency Department (**ED**) of Kumanjayi’s arrival. Dr YH understood it was the responsibility of MRaCC to inform the hospital of the transfer and arrival time.
42. Having been placed on a Form 9 (recommendation for compulsory psychiatric examination under the MHRS Act) Kumanjayi and her mother left the clinic to pack for hospital. Shortly after midday her mother phoned the clinic and requested that Kumanjayi be collected because her behaviour was deteriorating. When clinic staff arrived at her home, she was crying and partly in a state of undress in the shower.⁴⁵ Although she was agitated she remained cooperative and the Clinic Manager and AHW assisted Kumanjayi to return to the clinic.
43. On her return to the clinic, Dr S described her as *“pleasantly psychotic,”* cooperative and happy to go to hospital⁴⁶ and she was given 5mg Droperidol and 2mg

pursuant to s 42 of the MHRS Act I accept this was marked in error and the ground relied on for the Form 9 was in fact Mental Illness pursuant to s39 of the MHRS Act.

⁴² Folio 6 (medical- primary health) p 44

⁴³ Folio 6 (ASH admission 21.11.23) p 21

⁴⁴ Folio 7, coronial brief 1 of 2, p 2627

⁴⁵ T97 (Clinic Manager)

⁴⁶ T41 (Dr S)

Midazolam.⁴⁷ Following those medications, she was nursed one-to-one and closely monitored. At about 1.50pm she was given a further 1mg of Midazolam as she was agitated after a bathroom visit. At around this time respiratory concerns were identified (the *first* time) which included noisy breathing. Actions were taken to maintain Kumanjayi's oxygen levels including significant shaking to wake her, she was placed in the recovery position, and "*nasal prongs were applied as her oxygen saturation levels had dropped.*"⁴⁸

44. At around 12.25pm the Clinic Manager phoned Dr Argy who advised the MRaCC retrieval team were departing Alice Springs as a Priority 1.
45. The Retrieval team arrived at 2.35pm and Kumanjayi was asleep and snoring slightly. She was receiving oxygen and had good oxygen levels. When roused Kumanjayi began shouting, she attempted to get up and was touching staff. The retrieval doctor considered her to be unpredictable and lacking insight, risks which warranted sedation during the ambulance transport to ASH.
46. The retrieval doctor also found her to be a high risk of airway obstruction, due to obesity, a large neck, her snoring and because she had received benzodiazepines.⁴⁹ Her ECG results revealed an elevated QTc. As to any further sedation, the retrieval doctor phoned Dr Argy who advised that no further Droperidol or Olanzapine or Benzodiazepines should be given because of the ECG results and "*her high risk of airway obstruction.*"⁵⁰ This was the *second* time a risk to Kumanjayi's respiratory capacity was identified. Ketamine was chosen as the sedative for transport as it decreased the risk of an airway obstruction.
47. Prior to her departure, Dr S signed a second Form 9 at about 3pm.
48. No family members accompanied Kumanjayi in the ambulance.

⁴⁷ T29, closely monitored T64

⁴⁸ Coronial brief 1, folio 7

⁴⁹ MRaCC records a discussion about a form 9 at 11.24am, Folio 6 (medical – primary health) p 24

⁵⁰ Folio 12, additional documents, p 6-8

49. During the drive to ASH Kumanjayi was given Ketamine to sedate her.⁵¹ She woke during the journey and screamed out “*am I dead*” and similar.⁵² As she was extremely agitated she received further Ketamine. All medications administered were documented in the retrieval records.⁵³
50. There were no issues identified concerning her care during the retrieval process. Prof Lawton considered her medication during the transfer was appropriate⁵⁴ and the transport record was detailed and adequate.⁵⁵

Issues arising during her care at Ntaria clinic

General Care

51. The experts were not critical of the care she received at the Ntaria clinic. Prof Lawton considered that “*there was little more that could have been done reasonably in this setting to expedite Kumanjayi’s care or improve her ultimate prognosis.*”⁵⁶ Prof Joyce noted that the risks of respiratory insufficiency due to sedation were safely managed at the Ntaria clinic.
52. However, NT Health identified three areas for improvement in the care provided:
- a. The clinic failed to enter the 5mg of Droperidol and 2mg of Midazolam administered at Ntaria Clinic on Kumanjayi's PCIS medication chart.⁵⁷ This has the potential to impact a medicine reconciliation, as a pharmacist or doctor attempting to conduct a reconciliation is likely to consider the PCIS medication chart to be authoritative, and may not read through clinic progress notes. I accept this risk is real and PCIS charting should be mandated but note the greater problem in this case was that no medicine reconciliation was attempted.

⁵¹ Folio 12, additional documents, p 6

⁵² Folio 8, p 2650. T189 paramedic Paul Chilcott described this scenario

⁵³ Folio 6 p15

⁵⁴ Folio 26 Report of Professor Lawton p. 34

⁵⁵ Folio 23 Affidavit of R Schultz [268]

⁵⁶ Folio 26 Report of Professor Luke Lawton p.33

⁵⁷ Folio 23 (Affidavit of R Schultz) [279]-[282]; T 666-667 (R Schultz)

- b. Staff at Ntaria Clinic did not provide Kumanjayi with oral antipsychotic cover when her depot injections resumed on 18 November 2023. Additional oral cover was required for therapeutic levels to be reached. The Medicine Review found that a long acting depot injection “*at the point of deterioration with no oral coverage added an antipsychotic to the clinical picture with limited therapeutic benefit.*”⁵⁸
 - c. As Kumanjayi was accepting oral medication in the community this should have been preferred over intravenous sedation while awaiting MRaCC transfer.⁵⁹ This will be discussed in a little more detail later in these findings.
53. NT Health highlighted the responsiveness of the Clinic's AHW and Remote Area Nurse when Kumanjayi required assistance on two occasions after hours, and the opportune treatment of other health conditions by Ntaria clinic staff. I accept this is demonstrative of good care and good practice. Similarly, I accept the submissions on behalf of Dr S that she demonstrated experience, competence and concern when she was looking after Kumanjayi.

Consent, involuntary status and the *Mental Health and Related Services Act 1988* (MHRS Act)

54. On and from 18 November 2023 Kumanjayi was seeking assistance for her declining mental health. Clinic records reveal that Kumanjayi was demonstrating varying levels of insight, she was cooperative, she was accepting all the medication that was offered, she was “*keen to be treated as an inpatient*”⁶⁰ and she wanted to go to ‘Ward 1’.
55. According to Dr S, by 21 November 2023 her overall presentation had improved slightly. However, her family were exhausted and Kumanjayi and her family maintained their requests that she go to hospital. Dr S assessed Kumanjayi and it

⁵⁸ Ex 23 Affidavit of R Schultz [300(a)]

⁵⁹ Ex 23 Affidavit of R Schultz [300(b)]

⁶⁰ Folio 6 p 43

was her clinical judgment that a mental health inpatient admission was both appropriate and necessary and at inquest there was no evidence nor any submissions to the contrary. However, it was necessary to explore the *method* adopted to achieve that admission.

56. The fundamental principles that apply to the provision of mental health care in the Northern Territory are set out in Part 2 of the MHRS Act. These include that:

s9(p) any assessment of the person to determine whether he or she needs to be admitted to an approved treatment facility is to be conducted in the least restrictive manner and environment possible; and

s10(a) the person should only be admitted [as an involuntary patient] after every effort to avoid the person being admitted as an involuntary patient has been taken.

57. These principles are reflected in NT Health policy including in the ‘Clinical Pathway 2018-2022 Mental Health Central Australia Region’⁶¹ which provides that

“voluntary admission should be used where possible, following the principles of the least restrictive environment.”

58. On its face, the Form 9 which was signed around 10am on 21 November 2023 identifies mental disturbance as the basis for satisfaction for involuntary admission. I accept that this was a tick-box error. I accept that when she signed this Form 9, Dr S considered Kumanjayi had a mental illness and the remaining consideration of this issue proceeds on that basis.

59. Form 9s exist to give effect to s 34 of the MHRS Act. Section 34 requires that a medical practitioner must recommend that a person be psychiatrically examined when, after their own assessment of the person, they are satisfied that the person fulfils the criteria for *involuntary admission* on the grounds of mental illness (or mental disturbance).

⁶¹ Folio 19.5, Version 7, p.11 [d ii]

60. Section 14 of the MHRS Act sets out the criteria for involuntary admission on the grounds of mental illness as follows [emphasis added]:

The **criteria** for the involuntary admission of a person on the grounds of mental illness are that:

- (a) the person has a mental illness; and
- (b) as a result of the mental illness:
 - (i) the person requires treatment that is available at an approved treatment facility; and
 - (ii) without the treatment, the person is likely to:
 - (A) cause serious harm to himself or herself or to someone else; or
 - (B) suffer serious mental or physical deterioration; and
 - (iii) the person is **not capable of giving informed consent to the treatment or has unreasonably refused to consent to the treatment; and**
- (c) **there is no less restrictive means of ensuring that the person receives the treatment.**

61. The MHRS Act does not include a definition of capacity or a presumption of capacity to give informed consent,⁶² instead Section 7 of the MHRS Act sets out lengthy criteria for informed consent as follows:

(1) A person cannot give informed consent under this Act unless this section is complied with, and any attempt to waive or circumvent the requirements of this section is of no effect.

(2) A person gives informed consent under this Act:

- (a) when the person's consent is freely and voluntarily given without any inducement being offered; and
- (b) the person is capable of understanding the effects of giving consent; and
- (c) the person communicates his or her consent on the approved form.

⁶² The NT Health Informed Consent Policy Version 17 and Procedure Version 35 does presume capacity in adults. There was no reference to this policy or procedure by any of the clinicians participating in arrangements for Kumanjayi's transfer.

(3) A person can give informed consent only when he or she has been given:

- (a) a clear explanation of the assessment and possible diagnosis, the nature of the proposed treatment, including sufficient information about the type of treatment, its purpose and likely duration to permit the person to make a balanced judgment regarding undertaking it; and
 - (b) an adequate description, without concealment, exaggeration or distortion, of the benefits, discomforts and risks associated with the treatment; and
 - (c) an adequate description of any appropriate alternative form of treatment that is reasonably available; and
 - (d) a clear answer to all relevant questions asked by the person (and the answer has been understood by the person); and
 - (e) advice that the treatment may be refused or consent may be withdrawn at any time while the treatment is being undertaken; and
 - (f) advice that independent legal or medical advice may be obtained in relation to the treatment before giving consent (and reasonable assistance is provided to obtain that advice, if requested); and
 - (g) advice of all rights of review and appeal under this Act; and
 - (h) advice of any relevant financial advantage that may be gained by a medical practitioner proposing the treatment and by the approved treatment facility or approved treatment agency where the treatment is to be undertaken; and
 - (j) advice of any relevant research relationship between a medical practitioner proposing the treatment and the approved treatment facility or approved treatment agency where the treatment is to be undertaken; and
 - (k) explanations, descriptions and advice in a manner or form that the person is used to communicating in (and due regard is to be given to age, culture, disability, impairment and any other factors that may influence the person understanding the explanation).
- (4) A person must be given adequate time to consider the information provided under subsection (3) before being asked to give his or her informed consent.
- (5) A person who is unable to communicate adequately in English but who is able to communicate adequately in another language is to be assisted, as far as is practicable, by a competent interpreter.
- (6) A person whose informed consent is being sought may request that another person be present while the informed consent is obtained.
- (7) The person-in-charge of the approved treatment facility or approved treatment agency at which treatment is proposed to be performed on a person must ensure that this section is complied with.

62. Having considered all the evidence, I was satisfied that there was no attempt to obtain informed consent from Kumanjayi before she was placed on a Form 9 and

there was little evidence of any real exploration of Kumanjayi's capacity to consent. If consideration was given to capacity and consent, it was not clearly documented.⁶³

63. That she was suffering from a mental illness does not answer the question of capacity and consent, nor does it change the position to add that she was suffering from an acute psychosis or that she was 'florid'. As Dr Tabart said, "*being psychotic doesn't preclude capacity.*"⁶⁴ Prof Lawton explained that in Queensland, if he had a patient with schizophrenia who had not been taking their medication and was experiencing hallucinations and paranoia but asking for help, he would not automatically use mental health legislation. He said, "*while this person might have an acute mental health issue, they still have a right to self-determination, same as any other patient. It's only whenthat problem [exists] to a degree which poses a risk to them and also renders them incapable of providing full consent, that we would consider taking their liberty away from them.*"⁶⁵ Accepting that assessing consent can be complex, Prof Lawton continued, "*if the patient is seeking treatment then they probably have the capacity to consent.*"⁶⁶
64. Persons suffering from serious mental health conditions live and work in our society and make informed decisions about health care every day. In her community Kumanjayi was making decisions about her health care. She was asking for and accepting medication and she was asking to be made an Inpatient. If Kumanjayi lived in Alice Springs she could have voluntarily attended ED to seek mental health treatment and, on the evidence before me, I consider it likely that her family would have encouraged and supported her to do so. In those circumstances, no Form 9 would have been required.
65. The Family submitted the real problem was a system in this remote community that left Dr S in a position where signing the Form 9 was the only practical way of

⁶³ The NT Health Informed Consent Procedure Version 35 lists minimum documentation requirements in Appendix 3

⁶⁴ T 656 (Dr Tabart)

⁶⁵ T 443 (Prof Lawton)

⁶⁶ T 444 (Prof Lawton)

getting Kumanjayi to hospital.⁶⁷ Although Dr S was reluctant to make Kumanjayi an involuntary patient, she was led to believe that a) the only way to get her to ASH was via an MRaCC retrieval, and b) for that to occur Kumanjayi had to be on a Form 9. Dr S was not alone in this decision making process, Dr YH and the Clinic Manager supported her decision. I was left with a very strong impression that the system in this remote community accorded too little weight to the principle of ‘least restrictive means’ and gave too much weight to the practicalities of ‘making it happen’,⁶⁸ in part enabled by clunky legislation well overdue for reform.

66. Once she was on the Form 9 I was left with another very strong impression, that there was less hesitation to move to IV sedatives. I am supported by the medication review which identified that as Kumanjayi was accepting oral medicine. This should have been preferred over IV sedation when she was at the clinic waiting transfer.⁶⁹

67. In 2022, NT Health published the “*Mental Health and Related Services Act 1998 Review Consultation Report*”⁷⁰ which reported that stakeholders overwhelmingly agreed that the MHRS Act was outdated and those consulted universally supported the modernisation of mental health legislation in the Northern Territory.⁷¹ A significant issue raised by stakeholders was the need for a definition and statutory presumption of capacity. Submissions also highlighted the lack of transparency and understanding about the difference between voluntary and involuntary admission, and about how the MHRS Act is applied to determine admission status. Submissions were received that compulsory treatment should be a last resort. Processes to protect persons from inappropriate use of involuntary admissions were discussed. The primary recommendation was that the MHRS Act should be repealed and replaced or amended to provide a contemporary mental health framework for the provision of compulsory and in-hospital mental health services in the Northern

⁶⁷ Submissions on behalf of the family p. 5 [21]

⁶⁸ See for example T 97 (Clinic Manager) who agreed the Form 9 was signed for the purpose of transport.

⁶⁹ Folio 27 Medication Review pp 12, 15

⁷⁰ Exhibit 2

⁷¹ Exhibit 2, p 7, 228 episodes of engagement with stakeholders took place between December 2020 and August 2021.

Territory. Recommendation 4(a) was for a presumption of capacity, and that capacity should be clearly defined and be decision specific. Recommendation 5(d) was for an express statutory provision that involuntary (compulsory) admission or treatment should be a last resort. Recommendation 5(e) was for the new Act to set out the criteria and processes for transitioning a person from voluntary to involuntary (compulsory) status.

68. An Exposure Draft Mental Health Bill was circulated in early 2024. The Guide to the Exposure Draft Bill⁷² summarised the new proposed Part 2, Decision-making capacity and informed consent, as follows:

Part 2 sets out the fundamental concept that an adult has full decision making capacity, unless the contrary is proved, and provides a clear definition of capacity to provide informed consent. It also addresses the capacity of children to consent to treatment.

The MHRSA has no presumption of decision making capacity. This is inconsistent with principles of autonomy and recovery. It is also inconsistent with:

(a) the CRPD [the United Nations Convention on Rights of Persons with Disabilities],

(b) mental health legislation in other Australian jurisdictions, and

(c) other Territory legislation, namely the *Advance Personal Planning Act 2013*, the *Guardianship of Adults Act 2016* and the *Health Care Decision Making Act 2023* (uncommenced), all of which provide that an adult is presumed to have decision making capacity.

Clause 27 sets out the presumption of decision making capacity. This presumption applies to adults.

Clause 28 explains that the common law for the decision making capacity of children continues to apply. At common law, parents have the power to consent to medical treatment for a child. This power becomes less as the child matures. The age at which a child has capacity to make a health care decision depends on the individual child. This is sometimes referred to as being 'Gillick competent' (after *Gillick v West Norfolk and Wisbech Area Health Authority Et Anor* [1986] AC 112).

Clause 29 explains the meaning of decision making capacity. Capacity is decision specific and can fluctuate. A person has capacity if they can make a decision with practical and appropriate support.

Clause 29 has been drafted to align, as far as possible, with similar provisions in the *Advance Personal Planning Act 2013*, the *Guardianship of Adults Act 2016* and the *Health Care Decision Making Act 2023* so that in Territory legislation

⁷² Exhibit 3

there is a consistent approach to human rights and the point at which interference with those rights is authorised. It is, however, not as detailed as the provisions in those acts because many of the matters that are considered in determining decision making capacity are considered at an earlier stage in mental health legislation, namely when a person is not to be considered to have a mental illness or a mental disorder (see **clause 19**).

Clause 30 sets out what it means to give informed consent. People should make their own decisions wherever possible. If a person needs help, they should be provided with support.

69. For capacity and consent the Exposure Draft Bill proposes the following provisions:

29 *Meaning of decision making capacity*

- (1) For this Act, a person has capacity to make a decision about the person's treatment and care for a mental illness or mental disorder (***decision making capacity***) if the person can, with appropriate supports if needed:
 - (a) understand and retain information relevant to the decision; and
 - (b) weigh information relevant to the decision in order to make the decision; and
 - (c) communicate the decision in some way; and
 - (d) understand the effect of the decision.
- (2) In considering a person's decision making capacity under this Act, the following principles must be taken into account:
 - (a) a person's decision making capacity is specific to the decision that the person is to make;
 - (b) a person's decision making capacity may change over time;
 - (c) a person must not be treated as not having decision making capacity unless everything practicable has been done to assist the person to make decisions, including by giving appropriate supports;
 - (d) a person must not be treated as not having decision making capacity merely:
 - (i) because the person makes a decision that could be considered unwise; or
 - (ii) because of the person's age, appearance, disability, condition or behaviour.

30 *Meaning of informed consent*

- (1) A person gives informed consent to treatment and care under this Act if the person:

- (a) has decision making capacity; and
 - (b) has been given enough information for the person to make an informed decision; and
 - (c) has been given a reasonable opportunity to decide whether or
 - (d) not to consent; and
 - (e) has given consent freely and voluntarily; and
 - (f) has not withdrawn the consent to treatment and care or shown an intention to withdraw that consent.
- (2) A person is given enough information to make an informed decision if the person is given:
- (a) an explanation of the proposed treatment and care including:
 - (i) the purpose of the treatment and care; and
 - (ii) the type, method and likely duration of the treatment and care; and
 - (b) an explanation of the advantages and disadvantages of the treatment and care, including information about the associated discomfort, risks and common or expected side effects of the treatment; and
 - (c) an explanation of any beneficial alternative treatments that are reasonably available, including information about the advantages and disadvantages of these alternatives; and
 - (d) answers to any relevant questions that the person has asked; and
 - (e) an explanation of the advantages and disadvantages of not receiving the treatment; and
 - (f) any other relevant information that is likely to influence the person's decision; and
 - (g) for a proposed treatment - the statement of rights that applies to the person.
- (3) A person is given a reasonable opportunity to decide whether or not to consent to treatment and care if the person is given:
- (a) a reasonable period in which to consider the matters involved in the decision; and
 - (b) a reasonable opportunity to discuss these matters with the health practitioner who is proposing the treatment; and
 - (c) the appropriate supports to make the decision; and

- (d) a reasonable opportunity to obtain any other advice or assistance in relation to the decision.

70. If these, or similar, provisions were in force it is plausible that for Kumanjayi the presumption of capacity would not have been displaced and she may have been found to be consenting to a voluntary admission to the Inpatient Unit given she:

- a. Is documented as having insight (or a degree thereof) into her deteriorating mental health condition;
- b. Was attending, requesting and accepting of mental health treatment and medications at the clinic over a number of days;
- c. Had previous experience as an inpatient for schizophrenia and was familiar with the type of care and treatment she would receive;
- d. Was requesting a hospital admission; and
- e. Was considered safe enough to leave the clinic and return home after the Form 9 was signed.

71. During the inquest I learned that about 10% of MRaCC retrievals in the Northern Territory are voluntary. Had Dr S known this, I consider it likely that a voluntary retrieval would have, at a minimum, been considered for Kumanjayi.⁷³

72. The prospect of a voluntary retrieval, though not common in the Northern Territory, is not far-fetched. Prof Lawton explained the legislative regime in Queensland concerning a 'Recommendation for an Assessment', which is the Queensland equivalent of a Form 9.⁷⁴ In addition to being an emergency physician, Prof Lawton works as a medical retrieval co-ordinator in Queensland,⁷⁵ and has experience in transferring mental health patients to hospital.⁷⁶ His evidence was that Kumanjayi would not have been placed on a 'Recommendation for an Assessment' in Queensland,⁷⁷ and he could not think of any time in the last 10 years when he had placed a person on a mental health treatment order when they were voluntarily

⁷³ Folio 38 Affidavit of T. Hutton pp2-3 [9]

⁷⁴ T 443 (Prof Lawton)

⁷⁵ T 445 (Prof Lawton)

⁷⁶ T 447 (Prof Lawton)

⁷⁷ T 447 (Prof Lawton)

seeking treatment and help.⁷⁸ He explained that a person did not need on an order simply because they needed sedation for transfer. Patients can consent to sedation,⁷⁹ in the same way they can consent to other treatments. There are also emergency measures available if required.

73. I accept that whether she was voluntary or involuntary, Kumanjayi required some medications and sedatives to assist with her symptoms at the clinic and during her retrieval.⁸⁰ I also accept the Family's submission that if Kumanjayi was admitted as a voluntary patient that may have reduced the risk of her being characterised as 'aggressive' in her admitting paperwork.⁸¹ This mischaracterisation and its impact on her care and its connection with her death is discussed later in these findings.
74. Having considered all the evidence and submissions on this issue I was left with a clear impression that in this remote location there was a willingness to quickly move to a Form 9 (in furtherance of involuntary status) before thorough and documented consideration was given to assessing Kumanjayi's capacity and consent. In coming to this finding, I do not suggest that the clinic staff and treating doctor had anything other than Kumanjayi's best interests in mind. I consider that the decision to put her on a Form 9 occurred in part because there was limited staff and transport options; locum staff were not familiar with the MHRS Act; it was not understood that MRaCC could do voluntarily retrievals; and the MHRS Act is clunky, non-sequential, over complicated when it comes to consent, lacks a presumption of capacity, and ultimately, is well overdue for modernisation and reform.

Advance Personal Plans

75. The current MHRS Act makes no reference to Advance Personal Plans which are provided for under the *Advance Personal Planning Act 2013 (APP Act)*.

⁷⁸ T 444 (Prof Lawton)

⁷⁹ T 449 (Prof Lawton)

⁸⁰ NT Health's submissions in reply p. 3 [9]

⁸¹ The family's reply submission p. 5 [22]

76. Since 2014, under the *Advance Personal Planning Act 2013*, adult Territorians with decision making capacity have been able to make an Advance Personal Plan, which can be relied on if their capacity to make decisions later becomes impaired. As part of an Advance Personal Plan an adult may:

- make a decision for future health care action (an advance consent decision),
- make a statement of their views, wishes and preferences (an advance care statement); and
- appoint one or more persons to make decisions for the person (a decision maker).

77. However, according to the ‘Guide to Exposure Draft Mental Health Bill 2024,’⁸² although a person can make an Advance Personal Plan setting out their decisions, wishes, views and preferences about future *mental health* treatment and care, Territorians have not made use of Advance Personal Plans for this purpose. The Guide suggests that there may be many reasons for this, including that the form for making an Advance Personal Plan is not well suited to setting out decisions, wishes, views and preferences about future mental health treatment and care.

78. The APP Act is administered by the Attorney-General’s Department. There is an approved Advance Personal Plan form (made under s86 of the APP Act) published on the NT website. The current form focuses on end-of -ife decisions. It is not well designed for mental health treatment and care. A more suitable new or amended form should be developed to meet the needs of mental-health care.

79. Kumanjayi’s family were supportive of expanding the use of Advance Personal Plans for mental health patients. The family suggested that NT Health should create opportunities for mental health practitioners to engage in conversations with mental-

⁸² Exhibit 3 p 5

health patients in community about Advance Personal Plans, and that it should develop educational materials to support these discussions.

80. NT Health confirmed that there is an opportunity for a greater role for Advance Personal Plans in the mental health/ involuntary mental health sphere. It supports the use of Advance Personal Plans by persons diagnosed with a mental illness provided they have capacity to make the Plan; and it encourages the appointment of a decision-maker and consent for health care during episodes of mental illness. NT Health considers that such Plans may prove particularly useful in relation to advance consents permitting NT Health to communicate with family members about health care where there are involuntary admissions to hospital.⁸³
81. The Consultation report⁸⁴ recommended that the new mental health act expressly provide that a person's wishes and preferences, whether made contemporaneously or through an advance statement or directive, must be considered when determining treatment or care (recommendation 4(b)). To this end, embedded into the principle of least restriction and throughout the Exposure Draft Bill are provisions that require health practitioners and the Northern Territory Civil and Administrative Tribunal (NTCAT), at key points when making decisions about treatment and care (including whether to make an order for compulsory treatment) to have regard to a person's wishes, views and preferences, including wishes, views and preferences expressed in an Advance Personal Plan.
82. According to the Guide,⁸⁵ the Exposure Draft Bill supports and promotes the use of Advance Personal Plans. It encourages consideration of the patient's views and wishes as expressed in the Advance Personal Plan:
- a. To provide treatment and care 'in a less restrictive way' (clause 11(4)(a)),

⁸³ Folio 38, p 2

⁸⁴ Exhibit 2

⁸⁵ Exhibit 3 p 6

- b. provides that the matters to have regard to in deciding whether compulsory treatment criteria apply, taking into account: (i) the person's wishes, views and preferences, including the wishes, views and preferences expressed in any Advance Personal Plan made by the person; and (ii) to the extent practicable, the views of nominated support persons, and, if the person has a decision-maker, the views of the decision-maker (clause 88),
- c. where an authorised psychiatrist makes an order for compulsory treatment (clause 100),
- d. in deciding whether to vary an order for compulsory treatment (clause 119 and clause 120),
- e. in making a treatment decision for a person to whom a treatment order applies (clause 200),
- f. when preparing a patient's discharge plan (clause 206),
- g. electroconvulsive therapy may be administered to an adult who has consented to it in an advance consent decision (clause 214(2)),
- h. the Chief Psychiatrist must make and publish guidelines or policies about when it may not be appropriate to give treatment and care to a person in accordance with an Advance Personal Plan (clause 303(1)(b)), and
- i. clause 307(2) provides that the Chief Psychiatrist may approve the form of an Advance Personal Plan that relates to treatment and care under that proposed legislation.

Recommendation No. 2

I recommend to the **Northern Territory Government and the Department of Health** that they take immediate steps to honour the stated commitment in the *Mental Health and Related Services Act 1998* Review Consultation Report to modernise the mental health legislation for the Northern Territory by diligently finalising a new Mental Health Act through to commencement within 12 months of the publication of these findings; noting the extensive consultation and drafting already undertaken.

Recommendation No. 3

I recommend to the **Department of Health** that it amend any relevant policy, procedures, guidelines and / or training to ensure that mental health staff:

- a. understand and practice in accordance with the presumption of capacity (NT Health Informed Consent Policy Version 17);
- b. consider and document consent;
- c. ensure voluntary admission is used where possible;
- d. apply the principles of the least restrictive practice; and
- e. adequately document all decision making under the *Mental Health and Related Services Act 1998* (or its replacement Act).

Recommendation No. 4

I recommend to the **Department of Health** that it:

- a. amend any relevant policy, procedures, guidelines and / or training to ensure that mental health staff understand the applicability of the Advance Personal Planning Act 2013 to mental-health patients and the desirability of engaging in educative conversations with mental health patients about the availability, advantages of and practical effects of Advance Personal Plans for persons suffering from a mental illness,
- b. consult with the Attorney-General's Department and the Public Guardian and Trustee about ways to promote the use of Advance Personal Plans for mental health treatment and care, including by amending the approved form for making an Advance Personal Plan (or by creating a new form) to ensure its suitability for expressing wishes, views and preferences about mental health treatment and care, and
- c. amend any relevant policy, procedures, guidelines and / or training to ensure that Advance Personal Plans are considered when any decision is being made about treatment and management of involuntary mental health patients.

No accompanying family member

83. Kumanjayi's family were very involved in her care. Dr S said that "*the family were wonderful; they were exceptionally caring people,*"⁸⁶ and the Clinic Manager said that she thought "*the family had done a really good job and supported*"

⁸⁶ T 66 (Dr S)

Kumanjayi.⁸⁷ However their involvement ceased when Kumanjayi left Ntaria Clinic. I accept that Kumanjayi's mother, Magdelene, would have liked to have been able to go with Kumanjayi to ASH, whether in the ambulance, or if that was not practical, by some other means.⁸⁸

84. Dr S considered it was always better to have family accompany a patient transferred to hospital; and, as English was not Kumanjayi's first language, Dr S reasonably said that it would have helped Kumanjayi if someone was present who spoke her language.⁸⁹ Similarly, in Dr Marcus Tabart's experience, as Clinical Lead, Mark Sheldon Remote Mental Health Team, Central Australia Region, the care of a person is 'optimised' when family members are present and the use of pro re nata (PRN) medications is less likely. I heard that family attendance is often facilitated by MRaCC.⁹⁰
85. I accept that, in most circumstances, family support is recognised as beneficial and protective for mental health inpatients and it is endorsed by NT Health. In this case, it was not clear why a family member was not invited to accompany Kumanjayi in the ambulance, though it may be that there was insufficient room. I accept that arrangements may have been made the next day for a family member to travel. However, if that was the intent, it was not communicated to the family and it proved to be too late for Kumanjayi. That there was no explicit conversation or plan for an accompanying family member, has added to the family's sense of guilt and regret.

⁸⁷ T 85 (Clinic Manager)

⁸⁸ T 14 (Opening remarks Counsel for Family)

⁸⁹ T 42-43 (Dr S)

⁹⁰ T 633 (M Tabart)

Recommendation No. 5

I recommend to the **Department of Health** that when evacuations occur from remote communities in which NT Health operates, the clinic member requesting transport should engage in and document explicit conversations with:

- a. the retrieval service as to its capacity to transport a family member,
- b. any appropriate family member who can be spoken to as to their willingness to accompany the person being transported, and
- c. any additional arrangements made to facilitate an accompanying family member.

Arrival at Alice Springs Hospital

Events in ED summarised

86. Kumanjayi's arrival in ED was unexpected. Dr Peter Wirth, FACEM, an emergency consultant on duty at the time of Kumanjayi's arrival, learned of Kumanjayi's imminent arrival at close to 6.30pm either from MRaCC or a nurse. He contacted the CATT nurse who confirmed that mental health were not expecting Kumanjayi and that there were no beds available in the Inpatient Unit.⁹¹ Dr Wirth said getting unexpected or 'no warning patients' was not an uncommon occurrence and receiving patients with an expectation that a bed was waiting for them only to learn that there was no bed was "*the bane of our life.*"⁹² Dr Wirth sounded frustrated when giving evidence about this and he was irritated on the night of Kumanjayi's arrival.

⁹¹ T 175; Folio 6 Medical- ASH Admission p. 40

⁹² T 177 (P Wirth)

87. The retrieval doctor gave a long and complex⁹³ hand over to Dr Wirth, as Kumanjayi was placed in a resuscitation bay and connected to monitoring. Dr Wirth said that he did not have an accurate picture of what medication she had been given prior to her arrival,⁹⁴ and the RCA found that the handover was poorly documented.⁹⁵
88. Dr Wirth decided to let the Ketamine infusion wear off and it finished at 7.08pm. He charted four doses of 2mg intravenous Midazolam in the event Kumanjayi woke.⁹⁶ Kumanjayi was given two bolus doses at 7.08pm and 7.13pm for agitation, likely to do with her emergence from Ketamine.⁹⁷
89. From approximately 7pm, Dr Arthur Graf, the on-call Psychiatry Registrar, and the CATT clinical nurse specialist (**CATT nurse**), attended on Kumanjayi in the resuscitation bay. Neither had been notified in advance of Kumanjayi's arrival. They began the process of her admission to the Inpatient Unit.⁹⁸ It was Dr Graf's responsibility to conduct a mental health assessment, and, when appropriate, progress her from ED to the Inpatient Unit.
90. Almost an hour later, at 7.49pm, Dr Wirth phoned the on-call consultant psychiatrist, Dr Marcus Tabart, to discuss what he considered to be a lack of coordination and communication around Kumanjayi's arrival and the apparent unavailability of a bed in the Inpatient Unit. Dr Wirth thought the CATT seemed unable to make a decision about Kumanjayi's care. The conversation was heated and tense.⁹⁹ Dr Wirth asked Dr Tabart to expedite an Inpatient bed for Kumanjayi.¹⁰⁰ Dr Tabart asked to speak to Dr Graf and Dr Wirth handed the phone over. Dr Graf told Dr Tabart that a bed was available in the Inpatient Unit.¹⁰¹

⁹³ Folio 6 Medical- ASH Admission p. 58

⁹⁴ T184-187 (P Wirth)

⁹⁵ Folio 18 RCA p 24

⁹⁶ Folio 6 (medical records -ASH), p 35, 37

⁹⁷ T192, 186 (P Wirth)

⁹⁸ T412 (A Graf), T220 (CATT Nurse), folio 6, coronial brief 1 (medical- ASH admission) p 35

⁹⁹ T191 (P Wirth)

¹⁰⁰ T 189-190 (P Wirth)

¹⁰¹ Folio 18 (M Tabart) [56]-[57]

91. By 8:03pm, the CATT nurse noted that Kumanjayi remained sedated, the Inpatient Unit had been informed of Kumanjayi's admission, and the Admission Alert Form was still to be sent. Dr Graf was still to complete the required mental health assessment and admission documents.¹⁰²
92. At 8.05pm an ED nurse noted that Kumanjayi's oxygen saturations were dropping as low as 88% on room air. Oxygen prongs were applied and saturations increased to 98%.¹⁰³ At 8.20pm the nurse noted symptoms of Obstructive Sleep Apnoea (OSA) and Kumanjayi remained on oxygen prongs. This is the *third* time respiratory issues were identified and managed.
93. The CATT nurse completed the 'MH CAHS Admission Alert Form' at about 8.20pm. As Kumanjayi was still sedated, this form was largely completed from information gleaned from previous admissions and the referral information from Ntaria. In this document Kumanjayi was documented as being a high risk to self, a medium risk to others and a medium risk to staff based on her history and lack of insight, including that she was "*known to be aggressive toward staff.*"¹⁰⁴ The CATT nurse acknowledged a reliance on "*historical information,*"¹⁰⁵ instead of a current assessment of her presentation.
94. At 8.30pm Kumanjayi woke, sat up and started to scream, "*where are you Jesus, I want a blue tongue, not red.*" She was waving her arms around and she stood up. It was noted by an ED nurse that although she was loud, she was "*not posing a threat to self or others.*"¹⁰⁶
95. At about this time Dr Graf and the CATT nurse returned to assess Kumanjayi. Dr Graf considered that Kumanjayi was very anxious, agitated, loud and delusional.¹⁰⁷ The CATT nurse described her as being responsive to questioning, she told them her

¹⁰² Folio 6 (medical – ASH admission) p 44

¹⁰³ Folio 6 (medical- ASH admission) p 35

¹⁰⁴ Folio 6 (medical – ASH admission) p 9

¹⁰⁵ T225 (CATT nurse)

¹⁰⁶ Folio 6 (medical – ASH admission) p 35, T271

¹⁰⁷ T412-413 (A Graf)

name, she knew where she was, and she was waving her arms around perhaps because “*she felt she could see Jesus.*”¹⁰⁸

96. At or around 8:40pm Dr Graf phoned Dr Tabart to discuss Kumanjayi’s medication management, and in particular, what PRN medication should be prescribed in case she became distressed. Dr Tabart advised Dr Graf that if Kumanjayi escalated, was distressed and a possible threat to herself or others, then verbal de-escalation techniques should be utilised. If that did not work, then an oral tablet of Diazepam was to be offered. In the event that oral medication was not effective Dr Tabart advised that up to 10mg Droperidol and 10mg Midazolam could be administered.¹⁰⁹ Dr Tabart said that this PRN was pre-emptive, common and accepted medical practice, “*an involuntary patient with psychosis is going to have some sort of PRN for rapid tranquilisation.*”¹¹⁰
97. An ED nurse, the CATT nurse, Dr Graf and likely the incoming FACEM discussed further sedation for Kumanjayi. The ED nurse said that the Mental Health Registrar (Dr Graf) asked, “*can we drop her,*” referring to the intramuscular sedation Droperidol.¹¹¹ The incoming FACEM charted IV Droperidol 5mg. The ED nurse refused to administer Droperidol as “*[Kumanjayi] was not a threat to self or others*” and “*patients cannot go to the ward sedated.*”¹¹² Dr Wirth overheard the exchange and described the nurse as “*an absolute heroine*” for “*challenging Arthur, ‘Why are we sedating this poor lady when she doesn’t, by our criteria, need sedation?’*”¹¹³
98. The CATT nurse also overheard the ED nurse refusing to administer further sedation and shared the view that Kumanjayi did not need further sedation.¹¹⁴ According to

¹⁰⁸ T222 (CATT nurse)

¹⁰⁹ T 604-605, 611 (Dr Tabart)

¹¹⁰ T 612 (Dr Tabart)

¹¹¹ T 620 (Dr Tabart) described the term ‘drop’ as very pejorative, awful and completely inappropriate

¹¹² Ex 6, ED Nurse Reflection; Folio 6 (medical – ASH admission) p 35; see also T198 (P Wirth)

¹¹³ T 191 (P Wirth); see also Folio 9 p1, Escort ED nurse said that in her handover from the ED nurse “she also explained that she refused to give Droperidol”

¹¹⁴ T 229 (CATT Nurse)

the ED nurse, the Mental Health Nurse (the CATT nurse) suggested oral Temazepam 10mg, which was charted and given at 9.03pm.¹¹⁵

99. Upon further assessment, Kumanjayi's vital observations, repeat ECG and pathology results were within acceptable limits and at about 8.50pm Dr Wirth considered her stable, safe and medically cleared for transfer to the Inpatient Unit.¹¹⁶ Dr Wirth advised Dr Graf and the CATT nurse, and gave a similar handover to the incoming FACEM.

100. At around this time, Dr Graf completed the 'First Psychiatric Examination' section of the 'Form 10 Psychiatric Examination Outcome'.¹¹⁷

101. Dr Graf also completed the 'Admission to Inpatient Unit Psychiatric Assessment' form (**the Inpatient Unit Admission Form**). In the 'Medication prior to admission' section, he noted "*400mg imi depot of Aripiprazole non-compliant for 3-4 months but it was given 2 days ago in community.*" No other medication was recorded in that section, though in 'Summary Formulation', Dr Graf recorded "*She was given ketamine in ED because of aggressive behaviour. Midazolam 2mg +2mg +2mg given in ED.*"¹¹⁸

102. In the Inpatient Unit Admission Form Dr Graf recorded in her 'history of presenting complaints' that she was "*agitated, responding to internal stimuli. Aggressive, poor insight, wandering at night insomnia, keeping all family awake. Religious preoccupation, talking to Jesus.*"¹¹⁹ She was identified as being medically cleared in ED, high risk to self and others. The initial discharge plan was for a "*Form 10 involuntary admission into HDU PRN medication including Droperidol and Olanzapine as charted.*"¹²⁰

¹¹⁵ T276 (Ed Nurse); Folio 6 (medical – ASH admission) p 37

¹¹⁶ T 181, 188 (P Wirth)

¹¹⁷ Folio 6 (medical – ASH admission) p 104

¹¹⁸ Folio 6 (medical – ASH admission) p 104

¹¹⁹ Folio 6 (medical – ASH admission) p 5, T418-422

¹²⁰ Folio 6 (medical – ASH admission) pp 5-7

103. The Inpatient Unit Nursing Team Leader (TL) was receiving a handover from the outgoing Team Leader and learned that Kumanjayi was being admitted into the Inpatient Unit. Similarly to ED, the Inpatient Unit had not been given advance notice of her arrival. The TL was told that Kumanjayi had relapsed schizophrenia, was acutely psychotic, distressed, agitated and had been aggressive.¹²¹ The source of this information was the 'MH CAHS Admission Alert Form' (which, as noted early, was completed largely from historical information as Kumanjayi was still sedated when it was written). At approximately 9:10pm, the CATT nurse phoned the TL to advise that Kumanjayi was being transferred.¹²² At that time the TL was still receiving her handover and she said that "*if you bring her you will have to wait outside.*"¹²³ I understand that it is not desirable to interrupt handovers with admissions.

104. There were numerous problems with her admission at this time:

- a. A medical review,¹²⁴ which should have highlighted Kumanjayi's oxygen and breathing concerns, either did not occur or was not documented.
- b. Kumanjayi's medicines were not reconciled. Dr Tabart said that a medication reconciliation should have occurred as part of the assessment process by the admitting team, in this case the psychiatric registrar (Dr Graf).¹²⁵
- c. Her medications were not charted on the Electronic Medicines Management Application (eMMA).
- d. Her paper file was not available.

105. The Escort Ed nurse said that she was told to take Kumanjayi without her medical file (which was still being written in by the FACEM) because Kumanjayi was

¹²¹ T 288 (TL)

¹²² T 231 (CATT NURSE); Folio 21 p1 (PCA)

¹²³ T 233 (CATT NURSE)

¹²⁴ Folio 18 RCA p 17, as required by 'Crisis Assessment Treatment Team Clinical Guidelines Manual'

¹²⁵ T 601 (Dr Tabart)

calm.¹²⁶ Despite all these significant anomalies, at about 9.30pm Kumanjayi was transferred by wheelchair to the Inpatient Unit in the company of a Security Guard, the CATT nurse, Dr Graf, and an Escort ED nurse.

106. A careful review of the CCTV footage of Kumanjayi's transfer revealed no signs of agitation or aggression by Kumanjayi during the transfer process.

Dr Graf's version of events in ED

107. Dr Graf said that he was on call. He received a phone call from the CATT nurse who told him the Kumanjayi had been brought in by ambulance. Dr Graf attended the hospital and saw a large file containing Kumanjayi's previous admissions. He was not certain whether there was any paperwork on the file concerning the present admission, but he knew that she had received Droperidol and Midazolam at the clinic. He saw Kumanjayi sleeping and was present when Dr Wirth phoned Dr YH and Dr Tabart. Dr Wirth handed the phone to Dr Graf and Dr Graf spoke to Dr Tabart. Contrary to Dr Tabart's evidence, Dr Graf said he learned that Kumanjayi had been sedated with Ketamine from Dr Tabart.¹²⁷ Dr Graf said he was not familiar with Ketamine and asked Dr Tabart to assist with PRN medication. Dr Tabart told him Droperidol 10mg and Midazolam 10mg PRN.¹²⁸

108. Dr Graf said that when Kumanjayi woke he approached with the CATT nurse. She was very loud, agitated and delusional. He said he ordered and she accepted a 10mg oral dose of Temazepam and after about 20 minutes she settled. Somewhat inconsistent with Dr Graf's evidence, the Temazepam was charted by Dr Wirth and signed as given by the CATT nurse.¹²⁹

109. He said he spoke to Kumanjayi again about 15 minutes later and she was disorganised, agitated, anxious, delusional, and hallucinating.

¹²⁶ Folio 9 p1 (Escort ED nurse)

¹²⁷ Although see T 599, Dr Tabart said that it was Dr Graf who told him that Kumanjayi had been on Ketamine

¹²⁸ T 402-408 (Dr Graf)

¹²⁹ T 413 (Dr Graf); Folio 6 p 37

110. Dr Graf was responsible for filling out her Inpatient Unit Admission Form. In his evidence:

- a. He agreed that it was incomplete. For example, he agreed that he did not document her mental state at the time he conducted his mental state assessment and claimed in evidence that “*sometimes the computer doesn’t record....doesn’t save.*”¹³⁰
- b. He accepted that he wrote, “*she was given Ketamine in ED because of aggression,*” and in evidence conceded this was a mistake. Ketamine had not been given in ED and he had not seen any aggressive behaviour in ED.¹³¹
- c. He failed to record that he had ordered and she had received Temazepam in ED, which he agreed was another mistake.¹³²
- d. He said that when he recorded her risk assessment as ‘high’ he relied on information from the ED nurses. He agreed that he should have added that so far as he had observed Kumanjayi was not a threat.¹³³ He could not recall which nurse told him Kumanjayi was aggressive. When he was shown the ED nurse’s written assessment which documented “*nil risk of self-harm/harm to others,*” he agreed that, inconsistent with his previous evidence, this is what he was told.¹³⁴
- e. The discharge plan noted PRN medication of Droperidol and Olanzapine as charted but they were not charted, but he failed to note Midazolam.¹³⁵ He also agreed he missed noting other medications that had been given to Kumanjayi.

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¹³⁰ T 420 (Dr Graf),; Folio 6 p 6

¹³¹ T 421, 424 (Dr Graf)

¹³² T 422 (Dr Graf)

¹³³ T 425 (Dr Graf)

¹³⁴ Folio 6 p 33; T 500 (Dr Graf)

¹³⁵ T 427 (Dr Graf)

¹³⁶ T 428 (Dr Graf); Folio 6 p 5

111. Dr Graf denied advocating for Droperidol or saying “*can we drop her*” to the ED nurse.¹³⁷

Issues with her care in the Emergency Department

No advance notice of arrival

112. NT Health acknowledged that the Emergency Department, CATT and the Inpatient Unit only learned of Kumanjayi’s arrival when she was effectively on the doorstep of ASH.¹³⁸

113. Although Dr YH had received a referral from the Ntaria clinic, it was not his responsibility to notify ED. Notification of transfer was and is normally undertaken by MRaCC, which makes sense as they are best placed to inform of collection and arrival times. I heard that MRaCC would normally enter details of the patient and expected arrival time in the ‘Expects List’ which appears on the ED’s Team Leader’s computer, and MRaCC also often gives a verbal (phone) alert. There is no evidence of these notifications for Kumanjayi.¹³⁹

114. The NT Health Coordination Group, which includes the Director of Central Australian Retrieval Service, identified that on this occasion the failure to notify the mental health unit and ED was a human error. The Ntaria clinic calls were put through the switch to Dr YH. Dr YH was a junior registrar not familiar with all processes. He appropriately sought assistance from the Consultant Psychiatrist, who was a locum and also unfamiliar with the procedure. The Ntaria call should have been directed to the Clinical Director of Psychiatry who is responsible for alerting the CATT and the Inpatient Unit of arrivals.¹⁴⁰ The Coordination Group considered the current policies and procedures were sufficient to ensure the hospital received appropriate and sufficient notice of arrivals. Dr Wirth seemingly does not agree. He

¹³⁷ T 461 (Dr Graf)

¹³⁸ Folio 23 Affidavit of R Schultz [351]-[360]

¹³⁹ T 668 (R Schultz)

¹⁴⁰ T 594 (Dr Tabart)

told me that unannounced arrivals were not uncommon and led to “*a missed opportunity to have us prepared.*”¹⁴¹

115. It was identified that MRaCC policies and procedures were not readily accessible to hospital staff, and I was advised that they have now been uploaded to the all-staff accessible drive.¹⁴²

116. The lack of notice of Kumanjaya’s arrival contributed to a stressful environment creating a sense of urgency to her departure from ED; discord between ED staff, the CATT and the Inpatient Unit; and hasty, incomplete handovers. NT Health accepts that this should not have been the case and considered it “*deeply regrettable.*”¹⁴³ If the current notification of arrival procedures are considered adequate, then compliance must be the issue. It seems there is a need to monitor or audit compliance to ensure Dr Wirth’s concerns about unannounced arrivals are not repeated.

Resolving differing versions of events in ED

117. Dr Graf’s contemporaneous documentation contained numerous inaccuracies and was incomplete including in respect of critical matters. Most importantly, Kumanjaya’s mental health assessment was not documented, the medications she had received were incompletely documented, and the medications he determined she could receive were incompletely documented. I found his evidence more generally to be inconsistent across his varying accounts and unreliable.

118. Dr Graf was ultimately responsible for her admission into the Inpatient Unit and critical procedures were overlooked before her admission including that there was no medical review, no medicine reconciliation, she was transferred without her medical file, and her medications had not been entered on eMMa.

¹⁴¹ T 193 (P Wirth)

¹⁴² Folio 23 Affidavit of R Schultz [358] – [360]

¹⁴³ Folio 23 Affidavit of R Schultz [271]

119. As to whether Dr Graf was proposing Droperidol IM in preference to oral medication in response to Kumanjayi's behaviour in ED, I positively accept the evidence of the ED nurse. Her evidence was supported by her contemporaneous medical notes and the evidence of Dr Wirth and the CATT nurse.

A mischaracterisation of aggression

120. Kumanjayi's family were particularly distressed to learn that the Inpatient Unit Admission Form completed by Dr Graf described Kumanjayi as "*aggressive*."¹⁴⁴ The family pointed out that this was inconsistent with their experience of her before she left home, how she was described at Ntaria,¹⁴⁵ how she was described while in the ambulance on the way to ED,¹⁴⁶ recorded observations of her behaviour in ED,¹⁴⁷ and with what can be seen on the CCTV of her transfer to the Inpatient Unit.¹⁴⁸

121. Statements made by Dr Graf to investigating police after her passing, that Kumanjayi had been "*aggressive to family*" and "*aggressive during...transport*" and had to be sedated in ED because "*she was very aggressive and agitated*,"¹⁴⁹ were not consistent with other witnesses' observations. I do not accept these descriptions as being accurate and I am satisfied that Kumanjayi was not aggressive.

122. The family pointed out that in addition to being inaccurate, the use of such subjective and imprecise descriptors like 'aggressive' had the potential to be misleading. Prof Lawton agreed.¹⁵⁰ The family thought that medical records should more precisely describe behaviours, such as 'threw three punches' or 'swore' at staff. That submission appears to be largely consistent with the NT Health 'Clinical Documentation Policy version 23' which requires documentation to be precise,

¹⁴⁴ Folio 6 (medical – ASH admission) pp 5- 6

¹⁴⁵ See for example Folio 6 p 32 Referral from Dr S to Dr YH

¹⁴⁶ Folio 6 pp10, 13,15 MRaCC transfer documents

¹⁴⁷ For example, Folio 6 (medical – ASH admission) p 3, 35

¹⁴⁸ Original Brief Folio 9

¹⁴⁹ Folio 3 Verified Statement A Graf p. 2

¹⁵⁰ T 437 (L Lawton)

concise, factual and accurate.¹⁵¹ The policy defines ‘accurate’ as requiring ‘objective facts’ to be recorded.¹⁵² Dr Graf’s documentation did not comply with this policy.

123. The family’s concern is not one of mere semantics. The consequence of Dr Graf’s mischaracterisation was that he seemed to believe that Kumanjayi’s behaviour warranted greater antipsychotic and sedative medication than did other staff. While she was in ED, the ED nurse bravely and fortuitously stepped in to prevent further intravenous sedation. However, the ED nurse was not present when Dr Graf handed Kumanjayi over to the Inpatient Unit (without the ED file). During this handover he told the Inpatient Unit staff that Kumanjayi was aggressive. This incorrect information proved to be a catalyst for the fatal decision to provide further medication under the RTP. The problems with handovers more generally will be discussed in greater detail later in these findings.

Incomplete ED documentation

124. Incomplete and inadequate medical records led to gaps in communication among clinicians. This made it harder to make appropriate decisions about Kumanjayi’s care and contributed to the failure to identify her as a high-risk patient. NT Health made frank admissions concerning the problematic ED records.

- a. There was minimal documentation of her admission to ED. For instance, the medical records did not clearly document important information and concerns identified by the retrieval doctor, including that Kumanjayi had a prolonged QT interval and as a result Kumanjayi should not be administered further Droperidol, Olanzapine, or benzodiazepines.¹⁵³
- b. Significant information was recorded retrospectively and was not available to other staff contemporaneously.¹⁵⁴ This included her ‘medical clearance’, which was documented retrospectively by a FACEM who had not

¹⁵¹ Folio 19.2 p 9

¹⁵² Folio 19.2 p 10

¹⁵³ Folio 23 Affidavit of R Schultz [268]

¹⁵⁴ Folio 23 Affidavit of R Schultz [266]

reviewed Kumanjayi, relying on a handover that the clearance had been completed.

- c. Kumanjayi was transferred from ED to the Inpatient Unit without her medical file, her medications were not on eMMA, and a comprehensive medical review by an ED doctor (which is a requirement under the CATT Clinical Guidelines Manual (**CATT Manual**)) had not been conducted or documented.¹⁵⁵ A medical review was particularly important as medical concerns had been identified in ED including oxygen desaturation requiring oxygen administration, signs suggestive of OSA, and heart fluctuations. A well-documented medical review should have resulted in a more thorough and comprehensive handover to the Inpatient Unit staff, including by alerting them to her breathing risks and the need for close observations.

Mental health inpatient unit arrival and administration of medication

125. The Inpatient Unit consists of a Low Dependency Unit (**LDU**) and a High Dependency Unit (**HDU**). There are nurses' stations in each of these areas. Patient entry to the HDU is via a corridor through the LDU. On the evening of 21 November 2023, the Inpatient Unit was staffed with mental health nurses (**MHN**) TO and PD and the Team Leader (**TL**). A Patient Care Attendant (**PCA**) was also on shift that night.

126. When considering what happened to Kumanjayi in the HDU it is necessary to understand that an important, and seemingly commonly used, procedure is the 'Rapid Tranquilisation Mental Health Procedure' (**RTP**). The RTP was helpfully summarised in the RCA as follows:¹⁵⁶

The *Rapid Tranquilisation Mental Health Procedure* stipulated when rapid tranquilisation should be utilised in the Inpatient Unit, and the monitoring that is to be completed following the administration of sedatives. Rapid tranquilisation refers to the use of rapid-onset, short acting, oral or intramuscular medication to safely manage a consumer who is acutely disturbed and presenting a significant

¹⁵⁵ Folio 23 Affidavit of R Schultz [291c]

¹⁵⁶ Folio 18 p 13

immediate risk to themselves and/or others, when this cannot be achieved by less invasive measures.

The *Procedure* relevantly stated, regarding indications for the use of rapid tranquilisation:

*Rapid tranquilisation is indicated when **ALL** other techniques of calming or managing the individual consumer have been exhausted and have failed to reduce the level of risk to the consumer or to others or when the extreme nature of the emergency requires an instant response.*

*Rapid tranquilisation should be viewed as the **LAST** option to maintain the safety of the consumer and others in the care environment.*

It recorded that all efforts should be made to prevent the need for rapid tranquilisation, including adequate prescription of regular PRN (as required) medication, and appropriate nursing care.

Medical staff prescribing rapid tranquilisation were required to, among other things, 'Ensure there are no drug interactions and that the total doses do not exceed maximum doses within the previous 24 hours, as per this procedure', 'Ensure the current medication chart is amended to reflect the administration of rapid tranquilisation', and 'Liaise with the Nurse in charge regarding the frequency of review of consumer's arousal levels and response to rapid tranquilisation medication, including ongoing physical monitoring as per procedure'. Further, medical staff were required to document decisions within the clinical record.

A physical examination was to be undertaken if possible before any medication is administered and consideration given to any contraindications or precautions.

Further, the *Procedure* required consideration of any medications that may have been administered in the hours preceding: '**Calculate the total daily dose of all medications given in the 24 hours preceding before administering any additional medication. It is particularly important to obtain information regarding medication administration on the point of transfer from one site to another (e.g. ED or community treatment).**'

Staff were required to offer oral medication before resorting to Intramuscular administration, and to avoid polypharmacy within the same class of medication.

127. The RTP clearly specifies that Midazolam IM and Droperidol IM are options for sedation and the *maximum* dose for each was 10mg:

--
Midazolam IM 5mg - 10mg + Droperidol IM 2.5mg
- 10mg every 90mins
(MAX dose: 30mg midazolam and 20mg
droperidol/24hrs)

128. Kumanjayi travelled in a wheelchair from ED, accompanied by Dr Graf, an Escorting ED nurse, the CATT nurse and a security guard. It is clear from the

hospital CCTV that this journey was unremarkable.¹⁵⁷ The CCTV was played in court with the permission of family.¹⁵⁸ Although there is no audio, Kumanjayi can be seen communicating with those who are escorting her and holding hands with the CATT nurse. There are no aggressive or concerning behaviours.

129. She arrived at the main entrance of the Inpatient Unit at about 9.15pm.¹⁵⁹ When Kumanjayi moved through to HDU she was variously described as relaxed,¹⁶⁰ loud and vocal but calm,¹⁶¹ heightened and distressed,¹⁶² but importantly no one said she was aggressive.¹⁶³

130. It was upsetting to the family and challenging for the inquest to hear the key witnesses, MHNs PD and TO, the TL and Dr Graf, give differing accounts as to what took place in the HDU. Evidence among these witnesses was inconsistent as to who was making decisions, what their responsibilities were, who authorised the IM Droperidol and Midazolam that was given to Kumanjayi and why, and how observations thereafter were conducted. The versions cannot all be accurate and true.

131. As an overview I am satisfied that:¹⁶⁴

- a. Kumanjayi arrived at the high dependency unit around 9.15pm with escorts Dr Graf, the CATT nurse, an Escorting ED nurse and a security guard.
- b. There was only one other patient in the HDU.

¹⁵⁷ Folio 9, coronial brief 1 of 2 (CCTV compilation)

¹⁵⁸ Folio 9 CCTV

¹⁵⁹ There is an 8 minute time difference between the times recorded in the CCTV and the door transaction report, subject of folio 13, coronial brief 1. The issue of the time differences in the CCTV and folio 13 was not examined in evidence at the inquest. There is no evidence of the distance between the cameras and doors swiped the subject of the transaction report at folio 13; NT Health Aide Memoir entry no 2

¹⁶⁰ T 237 (CATT NURSE)

¹⁶¹ Folio 9 p 2 (Escort ED nurse)

¹⁶² T292 (TL)

¹⁶³ T537 (MHN TO)

¹⁶⁴ Times are taken from NT Health Aide to the CCTV footage noting that there is a difference in times between this and the door code records

- c. MHNs PD, TO and the TL assumed responsibility for her care.
- d. Dr Graf gave a verbal handover to the TL in the LDU nurses' station.
- e. No physical observations of Kumanjayi were completed in the HDU.¹⁶⁵
- f. Kumanjayi's medical chart did not accompany her from ED.
- g. Dr Graf struggled to enter his eMMa login details, the system used to document medication. He is seen on the CCTV leaving the Inpatient Unit at about 9.19pm. That means he was in the Inpatient Unit for about 4 minutes.
- h. Kumanjayi was simultaneously given Droperidol 10mg and Midazolam 10mg, intramuscularly (**IM**), in the HDU by MHN PD and the TL. MHN TO and the CATT nurse were present.
- i. Kumanjayi was placed on a mattress in front of the HDU nurse's station.
- j. At about 9.22pm the Escorting ED nurse is seen on CCTV near elevators in the direction of the emergency department (likely collecting Kumanjayi's missing medical records).
- k. The Escorting ED nurse returns at 9.26pm, with the medication chart from ED.
- l. The CATT nurse left the HDU at 9.27pm.
- m. The Escorting ED nurse is seen on CCTV exiting the Inpatient Unit at 9.34pm with the wheelchair.
- n. Dr Graf returns to the Inpatient Unit at 9.43pm.
- o. The medications (Droperidol 10mg and Midazolam 10mg imi) were entered onto the ED medication chart by Dr Graf after they had been administered. The time recorded for the charting of the medication is 9.30pm. The time

¹⁶⁵ Folio 6 (ASH admission) p 79

recorded for administration is 9.30pm and this is countersigned by the TL. Oral Olanzapine of 10mgs x 2 is charted at the same time by Dr Graf, but it is not countersigned for administration.

According to the Escorting ED Nurse

132. The Escorting ED nurse said that when she entered the HDU with Kumanjayi the CATT nurse and CATT Registrar (Dr Graf) were present and three MHNs were in the nurses' station. When it was identified that her medical file was missing, the Escorting ED nurse left at 9.22pm to get Kumanjayi's paperwork from the ED and she believed the CATT nurse and the CATT Registrar (Dr Graf) were still with Kumanjayi, who was still sitting in the wheelchair calmly chatting.¹⁶⁶ Although I accept her as an honest witness, she must be mistaken about Dr Graf still being there as the CCTV has him exiting at 9.19pm.
133. When she returned with Kumanjayi's file at 9.26pm, Kumanjayi was on a mattress in front of the HDU nurses' station. The CATT nurse and CATT Registrar (Dr Graf) were not in the HDU. The Escorting ED nurse gave a handover to MHN TO and told her that an ED nurse had not wanted to give Kumanjayi Droperidol in ED, and instead Temazapin was given, which she verified by reference to the ED medication chart. MHN TO told the Escorting ED nurse that no medication was charted on eMMa and requested that this be followed up with the CATT Registrar (Dr Graf). The Escorting ED nurse had a brief chat with the TL and MHN PD, as she had previously worked with them both.
134. The PCA gave the wheelchair to the Escorting ED nurse¹⁶⁷ and when the Escorting ED nurse left with the wheelchair at 9.34pm (to return it to ED), Kumanjayi was calmly laying on the mattress.
135. As she returned to ED she saw the CATT Registrar (Dr Graf) and told him the MHNs were requesting that medication be charted on eMMa asap. He said he was

¹⁶⁶ Folio 9 p2 (Escort ED nurse)

¹⁶⁷ Folio 21 p 1 (PCA)

on his way to the Inpatient Unit and would take care of it.¹⁶⁸ (This is consistent with the CCTV which has Dr Graf returning to the Inpatient Unit at 9.43pm.)

According to the CATT nurse

136. The CATT nurse saw Dr Graf in the LDU nurses' station.¹⁶⁹ As Dr Graf was not in HDU with Kumanjayi, the CATT nurse did the handover in the HDU nurses' station to the TL, MHN PD and MHN TO. Although he told them he did not believe Kumanjayi needed any further sedation or tranquilisation,¹⁷⁰ he overheard the MHNs discussing further sedation/tranquilisation.¹⁷¹ He saw the TL make a phone call and ask to speak to Dr Graf urgently.¹⁷² He was shocked and he also felt that Kumanjayi had been abandoned so he went out to be with her.

137. The CATT nurse said that he did not see anyone conduct a nursing assessment of Kumanjayi in the HDU.¹⁷³ He then witnessed the three Inpatient Unit staff approach Kumanjayi and administer intramuscular medication.¹⁷⁴ He was shocked by this and left the Inpatient Unit. He did not see Dr Graf on his way out at 9.27pm but he saw Dr Graf in the CATT office.¹⁷⁵

According to the TL

138. The TL commenced work at about 9pm. She was receiving a handover from the outgoing TL, including a limited hand over about Kumanjayi,¹⁷⁶ when she received a call and was informed of Kumanjayi's imminent arrival on the ward. When

¹⁶⁸ Folio 9 p2 (Escort ED nurse)

¹⁶⁹ 251 (CATT NURSE)

¹⁷⁰ T 237 (CATT nurse)

¹⁷¹ T 250 (CATT nurse)

¹⁷² T 241 (CATT nurse), and within 5 minutes or so he saw

¹⁷³ T 240 (CATT nurse) and within a few minutes

¹⁷⁴ T 250 (CATT nurse)

¹⁷⁵ T243-245, 251 (CATT nurse)

¹⁷⁶ T 289 (TL); The handover was based on the information contained in the MH CARS Admission Alert Form Folio 6 pp8-9, which was completed by the CATT Registrar when Kumanjayi was in ED and still under sedation. This form was compiled from information gleaned previous admissions and the current referral from Ntaria and not from a direct patient assessment. Previous admissions included the information "*Known to be aggressive towards staff.*"

Kumanjayi arrived, she received a handover from Dr Graf in the LDU nurse's station. Dr Graf told her that Kumanjayi was aggressive, acutely psychotic and agitated.¹⁷⁷ He told her that 30mg of Olanzapine had been given in ED and Kumanjayi could have a further 20mg staggered during the night. The TL said that Dr Graf told her that the Olanzapine had not been effective. The TL asked what the second line of management was, and he said, "*Let's give her 10mg Droperidol and 10mg Midazolam.*"¹⁷⁸ The TL understood she was being directed to give this medication immediately and under close questioning maintained that this was not a PRN (pro re nata, or as needed) direction.¹⁷⁹ The TL asked if the medicine was charted on eMMA and Dr Graf said that he would chart it. In Dr Graf's presence the TL phoned MHN PD and told him to prepare the medication.

139. The TL said that Dr Graf accompanied her to HDU and repeated the verbal order to give these medications 10/10, stat.¹⁸⁰ Counsel for Dr Graf suggested that this evidence was incorrect. Referencing to the times on the CCTV and noting that Dr Graf was only in the Inpatient Unit for about 4 minutes, Counsel for Dr Graf proposed that Dr Graf did not go into the HDU nurses' station and repeat the verbal medication order. Instead, it was suggested that after the handover in the LDU Dr Graf left the Inpatient Unit. To those suggestions the TL said, "*he didn't leave, he actually went with us, and he gave that verbal order to me and [MHN PD]. It was loud and clear. He did.*"¹⁸¹

140. The TL said that Dr Graf sat at a computer in the HDU nurses' station and she assumed he was charting the medication on eMMA. At about the same time she overheard the CATT nurse and MHN TO having a heated discussion in the corner of the nurses' station.¹⁸²

¹⁷⁷ T288, 316 (TL)

¹⁷⁸ T293

¹⁷⁹ T344 (TL)

¹⁸⁰ T294, 295, 332, 341, 333 (TL)

¹⁸¹ T 341-342 (TL)

¹⁸² T 295, 317, 331 (TL)

141. The CATT nurse left the nurses' station and sat on a lounge in the HDU.
142. The TL agreed that inconsistent with the RTP,¹⁸³ there were no alternative deescalation or calming techniques attempted with Kumanjayi before she was sedated.¹⁸⁴
143. The TL said that while it might normally be appropriate to conduct a mental health assessment before giving medication, in this case the doctor had ordered the medication and the approach taken was pressured and rushed.¹⁸⁵ The medication was prepared and administered by the TL and MHN PD while Kumanjayi was still sitting in the wheelchair. Her ED cannulas were removed and she was assisted to a mattress.
144. The TL re-entered the HDU nurses' station. Dr Graf was there and she assumed he had been there all along.¹⁸⁶ He told her he could not access eMMA but would instead chart the medication on her ED medication chart. Dr Graf left briefly. When he returned the Droperidol 10mg imi and Midazolam 10mg imi was charted on Kumanjayi's ED medication chart which had been fetched by the Escorting ED nurse.¹⁸⁷
145. Shortly after giving the medication, the TL said she checked Kumanjayi's breathing, but made no record, and then returned to the LDU nurses' station.

According to MHN PD

146. MHN PD's evidence was difficult to hear over the audiovisual link and the transcript contains many inaudibles. Noting that limitation, MHN PD said that Kumanjayi presented at HDU agitated, disorganised, and tangential.¹⁸⁸ She was moving her

¹⁸³ Folio 19.18 Rapid Tranquilisation Mental Health Regions Procedure Version 14

¹⁸⁴ T 323 (TL)

¹⁸⁵ T 319 (TL)

¹⁸⁶ T 337 (TL)

¹⁸⁷ T297, She countersigned T299 and Coronial Brief 1, Folio6, (p37 of 110)

¹⁸⁸ T353 (TL)

hands and he thought that she might jump out of the wheelchair.¹⁸⁹ He received a phone call from the TL advising him of medication that was to be prepared. He said that Dr Graf and the TL then entered the HDU and Dr Graf gave the order for 10mg Droperidol and 10mg Midazolam, stat dose.¹⁹⁰ When challenged on this by Counsel for Dr Graf, MHN PD said *“I did not speak to him about medication, he was the one who spoke to me...I said is this patient charted? He said ‘No’. And then [the] TL said to him ‘can you please repeat to him what you said to me in LDU’ and he said [inaudible].”*¹⁹¹ MHN PD did not look into Kumanjayi’s history,¹⁹² he simply followed this instruction and, with the TL, he administered the medication intramuscularly.

147. MHN PD said that Dr Graf could not access the eMMa system so he left to chart the medication in ED. He came back quite quickly and the medication that had already been given was then recorded in paper form.¹⁹³

According to MHN TO

148. MHN TO was in the LDU when the call came through that Kumanjayi would be arriving. With MHN PD she went to the HDU and sat at the computer. Soon after, Kumanjayi arrived in a wheelchair with the TL, the CATT nurse, the Escorting ED nurse and a security guard. She briefly checked to see if Kumanjayi was settled and noted that she was loud but not hostile or threatening. She then returned to the computer to continue with administrative processes.¹⁹⁴

149. Inconsistent with the evidence of MHN PD, she did not recall being allocated Kumanjayi as her patient, though agreed allocation of patients was a normal

¹⁸⁹ T353-354

¹⁹⁰ T357 (MHN PD)

¹⁹¹ T 379 (MHN PD)

¹⁹² T 359 (MHN PD)

¹⁹³ T 358 (MHN PD)

¹⁹⁴ T 387 (MHN TO)

practice. Inconsistent with the evidence of the CATT nurse and the TL, she denied receiving a handover from the CATT nurse.¹⁹⁵

150. She did not do a set of observations on Kumanjayi and under examination by Counsel for the family agreed that there was nothing about Kumanjayi's presentation that prevented her from doing observations.¹⁹⁶

151. As no medications were charted on eMMA and she could not find a medical clearance, MHN TO said she raised these concerns with those in the room.¹⁹⁷ She saw the TL and MHN PD preparing medications and the TL organised a telephone order.¹⁹⁸

152. MHN TO said she watched the medicine being administered. She accepted it was important for her to know what Kumanjayi was given as it was relevant to the observations that she was to conduct.¹⁹⁹ She agreed that it was not common for medications to be administered without charting or medication records,²⁰⁰ but maintained that she said she did not ask any questions about the medication or why it was given.²⁰¹ She said there was no discussion with Kumanjayi about the medications and no effort to obtain her consent, because she was on a Form 9 and a Form10.

153. MHN TO said that Dr Graf arrived about 30-45 minutes after the medication was given to Kumanjayi.²⁰² At around the same time the Escorting ED nurse returned with the ED file and gave MHN TO a handover. ²⁰³ Noting the CCTV times, MHN TO's timing cannot be correct.

¹⁹⁵ T 388 (MHN TO)

¹⁹⁶ T 564 (MHN TO)

¹⁹⁷ T 388 (MHN TO)

¹⁹⁸ T 389, 390 (MHN TO)

¹⁹⁹ T 398 (MHN TO)

²⁰⁰ T 391 (MHN TO)

²⁰¹ T 537 (MHN TO)

²⁰² T 393,3934 (MHN TO)

²⁰³ T 395 (MHN TO)

154. When asked directly, “*what was she injected with?*” MHN TO said “*I don’t know*” but explained “*the practice was for Droperidol and Midazolam,*” and she presumed that was what was given. Later in her evidence she said, “*they traditionally gave 10mg of Droperidol and Midazolam.*”²⁰⁴ Later again she referred to this as “*the standard practice,*”²⁰⁵ but then attempted to qualify that answer.²⁰⁶ She conceded that when interviewed by police on 8 December 2023 she nominated Droperidol and Midazolam as the medication provided and said, “*that it was a little bit overreactive considering this client.*”²⁰⁷

155. MHN TO agreed that she filled out Kumanjayi’s ‘Patient Nursing Intake Assessment Form’ and ticked the box for ‘urgent review for Rapid Tranquilisation Procedure’²⁰⁸ but still maintained not to know what drugs were given.²⁰⁹

156. MHN TO agreed that shortly after midnight she completed the following progress note (extracted below) which stated that 10mg of Droperidol and Midazolam had been administered but again still maintained that she did not know for certain what medications had been administered.²¹⁰

²⁰⁴ T 535 (MHN TO)

²⁰⁵ T 567 (MHN TO)

²⁰⁶ T 568 (MHN TO)

²⁰⁷ Folio 6 Verified interview with TO dated 8 December 2023

²⁰⁸ Folio 6 p 77

²⁰⁹ T 539 (MHN TO)

²¹⁰ T 560 - 561 (MHN TO)

Progress Note Search Results

Name: [REDACTED] (Female) Id: 0697412 DOB: 29/12/1988 (34 yrs) Case id
562642 GM/MHG Central Aust Mental Health Inpatient Unit

Note Date: 22/11/2023; Author Id: [REDACTED] Author Role: Mental Health Nurse; Event Date: 22/11/2023;
Entered Date: 22/11/2023, 00:08; Created By: [REDACTED]
ADMISSION OF CLIENT FROM CATT ED TO MHIU HDU ROOM 2

CLIENT

HRN

0697412

Admission via legal status

Form 10

S39 (i) (a)

2nd APP to be due on 22/11 @ 21:00 hours please

CATT Admission synopsis

Client MRACC this pm, originally from Hermannsburg, under CM at CAMHS due to relapse of diagnosis, escalation of psychotic phenomena, deterioration of schizophrenia, client has been noncompliant with medication, missed depot of Aripiprazole 400mg.

PLEASE NOTE DEPOT HAS NOW BEEN ADMINISTERED ARIPIPRAZOLE 400MG IN THE COMMUNITY 2 DAYS PRIOR TO THIS PRESENTATION.

DIAGNOSIS

Schizophrenia

Secondary psychosis in context of diagnosis

CURRENT

Presented to HDU via wheelchair in presence of x 1 security guard, CATT worker. Client appeared disorganised in thought processes, heightened elevation of mood, verbally elevated, not threatening towards MHIU staff. Not objectively seen responding to stimuli. Due to rapid capacity of admission process, EMMA medications not available. On call Reg notified immediately by MHIU accepting admission nurse to administer stat dose of 10 mg Droperidol with 10 mg Midazolam due to acute presentation on arrival and high risk to ALL staff present. This administration resulted in immediate effect of sedation and settling affect. Client was cooperative, non-resistive and compliant with consent of administration.

Please review CCIS for administration expiry and relevant documentation. Post administration full range of motion intact. Nil immediate side effects evident.

- Unable to provide full MSE on arrival due to acute requirement for immediate IMI administration

PLAN

Admission consent document remains outstanding please team

POC urine remains outstanding

Continue with 15/60 visual observations as per ward HDU policy

2nd APP due on 22/11 @ 21:00

According to comprehensive assessment next depot now due 18th December of 400 mg Aripiprazole

*** End Of Report ***

According to Dr Graf

157. Dr Graf said that he accompanied Kumanjayi to the Inpatient Unit. Shortly after her passing, Dr Graf spoke to police in a recorded interview and he told them that while she was being escorted to the Inpatient Unit Kumanjayi was “agitated,”

“uncooperative” and she went straight to the HDU *“because of her behaviour, you know the aggressive”* and *“she presented a risk to herself and to others definitely.”*²¹¹ During the inquest he was shown the CCTV of that transfer and agreed that, inconsistent with his earlier account, Kumanjayi was very friendly during the transfer, she was holding hands with the CATT nurse, and she was not a threat to anybody.²¹²

158. Dr Graf went into the LDU nurses’ station to speak to the TL while Kumanjayi was taken through to the HDU. He informed the TL about the medications Kumanjayi had already received and his intention to chart oral Olanzapine PRN. According to Dr Graf, the TL told him that from her past experience oral Olanzapine would not work with Kumanjayi and she said, *“‘doctor we will need 10/10’, she used that a little you know jargon...which means 10mg of Droperidol and 10mgs of Midazolam.”*²¹³ Dr Graf said that the TL said, *“we will need...PRN medication.”* He said he agreed to chart this (the Droperidol and Midazolam) as PRN but urged caution and he decided not to chart Olanzapine as it had been refused by the TL. However, inconsistent with this evidence (that the TL asked for PRN medication), on 13 December 2023 Dr Graf provided a chronology of events for 21 November 2023 which he had prepared. In that chronology he documented, *“I was not asked for any PRN and I did not order any PRN.”*²¹⁴

159. Dr Graf then left the Inpatient Unit and headed to the CATT office (located in ED) and attempted to chart the medication on eMMa.²¹⁵ When that failed and he returned to the Inpatient Unit for the *second* time and met the TL, MHN PD and MHN TO, and requested a physical medication chart. He was told IT could reset his PIN so he

²¹¹ Add Doc Folio 3 Verified Transcript (Dr Graf) pp 3-4

²¹² T 485 (Dr Graf)

²¹³ T 466-468 (Dr Graf); Ex 8, Chronology Version 2

²¹⁴ Folio 11 (Dr Graf Chronology version 1) p 3; a similar account was given by Dr Graf to AHPRA in his complaint about TL dated 6 December 2023; T 525 (Dr Graf)

²¹⁵ T 520 (Dr Graf); Folio 24

returned to the CATT office. Eventually, he charted the medication as PRN on eMMa.²¹⁶

160. Inconsistent with the CCTV and door pass records,²¹⁷ and his versions to Police and AHPRA,²¹⁸ Dr Graf said he returned to the HDU for the *third* time at about 10.30pm.

161. He saw Kumanjayi sleeping on the mattress in front of the HDU nurses' station. He told the TL that he had charted the Droperidol and Midazolam on eMMa as PRN. The TL told him that it had already been given and he needed to chart it on the paper chart as it needed to be recorded that it had been given. Although Dr Graf maintained that the 'stat' Droperidol and Midazolam was given without his authorisation and there was "*no verbal order at all*" he charted the medication and back timed it to 9.30pm. Though he now had access to eMMa, he said he had forgotten to chart the Olanzapine on eMMa, and so he also charted it on the paper chart at the same time.²¹⁹ He failed to record these as retrospective entries.²²⁰

162. Inconsistent with his evidence that there was "*no verbal order at all*", when Dr Graf spoke to police shortly after Kumanjayi's passing he said that the medication was "*standard,*" he "*discussed that with the nurse in charge,*" "*we took the decision together...we thought it would be appropriate*" and he agreed that he gave "*a verbal order. Verbal.*"²²¹

163. Although he was concerned that Kumanjayi had been given the maximum dose of Droperidol and Midazolam he said he was assured by the TL that the nurses would follow the observation protocols and accepted that assurance. He did not report the

²¹⁶ T 468-469 (Dr Graf)

²¹⁷ T 515 (Dr Graf)

²¹⁸ T 517 (Dr Graf)

²¹⁹ T 472-474 (Dr Graf); Folio 6 p 37; Folio 35, Dr Graf's complaint to AHPRA dated 6 December 2023 about the TL

²²⁰ T 480, 488 (Dr Graf)

²²¹ Add Doc Folio 3 Verified Transcript (Dr Graf) pp 8-9; T 502 (Dr Graf), later in his evidence he said that his use of the word standard was not accurate

medication concerns to Dr Tabart or make a RiskMan report about this serious medication error.²²² Instead, he left the Inpatient Unit and went home.

According to Dr Tabart

164. Dr Tabart told me that if the Registrar was of the view that a patient had received medication that was not authorised then that should be escalated to the Consultant.²²³ Further, Dr Tabart would have expected Dr Graf to review the patient and ensure there was appropriate monitoring,²²⁴ and the incident should have been reported on RiskMan.²²⁵

Issues arising from her arrival in the HDU and the administration of RTP

Inadequate and rushed handover

165. NT Health acknowledged that there were repeat failings to comply with its ‘Clinical Handover’ policy²²⁶ and procedure²²⁷ throughout Kumanjayi’s journey through ED and into the HDU. Accepting the evidence of Dr Graf and the TL that he gave a short handover to the TL in the LDU, and the evidence of the CATT nurse that he gave a handover to MHN TO in the HDU, both of these handovers were conducted without her medical records and without medicines being charted on eMMA. Even to a lay person these are obvious and critical failings giving rise to significant risk. According to Ms Schultz, these were rushed handovers which *“ultimately led to medication treatment that was too early. It led to incomplete information being handed over. It more than likely led to miscommunication of risk.”*²²⁸

²²² T 511 (Dr Graf), and claimed not to know about such reports

²²³ T 614 (Dr Tabart),

²²⁴ T 630 (Dr Tabart)

²²⁵ T 6301 (Dr Tabart)

²²⁶ Folio 19.3

²²⁷ Folio 19.4

²²⁸ T 670 (R Schultz)

166. These and other ‘transition of care’ failings, were identified and summarised in the RCA and I accept the following findings in the RCA (emphasis added).²²⁹

Transitions of care and handover are recognized to be a high-risk point for the loss of critical, clinical information.

NT Health’s *Clinical Handover Policy* describes the process for effective and consistent clinical communication whenever accountability and responsibility for a patient’s care is transferred, enabling timely and relevant clinical handover that supports and enhances patient experiences and outcomes. It applies to all NT Health clinicians.

Clinical handover must occur whenever a patient’s care is transferred between healthcare locations, clinicians, or different levels of care within the same location.

...

There were several handovers of [Kumanjayi’s] care in the 24 hours preceding her death. The panel identified the following concerns with respect to handover:

...

- **There is no evidence that a structured handover of [Kumanjayi’s] care from the ED to the Inpatient Unit occurred. There is no evidence that critical information regarding the administration of previous medications administered was handed over to the Inpatient Unit. The Inpatient Unit would not have seen the documentation detailing the administration of medications prior to the transfer, as these were written on a paper chart, and the Inpatient Unit uses EMMA. The cumulative effect of all the medications would not have been possible to review due to the many systems in use.**
- This transition of care is a high-risk point for continuity of care. Shortly following [Kumanjayi’s] admission to the Inpatient Unit, she was administered Droperidol 10mg and Midazolam 10mg. [Kumanjayi’s] medical records were not transferred with her, and it was noted by Inpatient Unit staff that due to the rapid transfer, the medications were not available on EMMA.

It is the panel’s opinion that the handover of care from the Emergency Department to the Inpatient Unit fell beneath the standard that is expected by the Central Australian Regional Health Service and was contrary to the *Clinical Handover Policy*.

Failure to conduct a medicine reconciliation

167. To assist the RCA (and ultimately this inquest), an independent Medicine Review was undertaken to examine the quantity, type, and circumstances of the medication administered to Kumanjayi, and to provide opinion, commentary, and recommendations regarding future medication administration.

168. The Medicine Review identified issues of concern including:

- a. The movement between systems (PCIS, MRaCC records, Emergency

²²⁹ Folio 18 RCA p 21

Department paper records, eMMA, CCIS), made medicine and observations difficult to track efficiently and safely. Because the documentation was challenging to follow, this increased the risk of inappropriate decision-making about medication.

- b. The records do not make clear whether critical information relevant to medication decisions (including observations, test results co-morbidities and risk factors) were handed over.

169. Critically, the Medicine Review made it clear that:

- a. The use of two or more antipsychotics should be avoided on the basis of risk associated with QT prolongation (particularly when a patient's physical state predisposes to cardiac arrhythmia) and on the day of her passing Kumanjayi was exposed to three different antipsychotics (Aripiprazole, Droperidol, Olanzapine). After receiving the Droperidol, Kumanjayi had received 198% of the recommended maximum dose of antipsychotics over the preceding 24 hours. The benefit of using high dose or multiple antipsychotics has not been demonstrated but the risks and the potential for adverse events are well known.
- b. There was no clear reason for her receiving multiple benzodiazepines (Diazepam, Midazolam, Temazepam). The use of these mixed medicines was done without a clear plan.

170. The failure to complete a timely medicine reconciliation was contrary to policy, which required a medication history to be compiled as soon as possible after admission, and within 24 hours.²³⁰ That the task was complicated by different records systems made it all the more imperative that it be done. Proper completion of that process would have clarified the medications already administered to

²³⁰ Folio 23 Affidavit of R Schultz [274]-[278]; T 668(R Schultz); 'Medication History, Reconciliation and Review CAHS procedure; 'Medication Management CAR / Barkley Region Procedure'

Kumanjayi and informed clinical decision-making regarding the appropriateness of any further medication, including in the Emergency Department and, later, in the Inpatient Unit.²³¹ In the event that any emergency or continuing medication is required before a medicine reconciliation is completed, this should be administered while the patient remains in ED under close observation, and before transfer to the Inpatient Unit.

171. I was satisfied that the medications, Midazolam 10mg IM and Droperidol 10mg IM, administered to Kumanjayi fell within the RTP. The RTP itself required that the total daily dose of all medications given in the preceding 24 hours be calculated *before* administering any additional medication. This was not followed.

Recommendation No. 6

I recommend to the **Department of Health** that:

- a. Full medicine reconciliations are to be completed on eMMa by the admitting Psychiatric Registrar or Consultant Psychiatrist or another suitably qualified senior medical practitioner. This is to form part of the essential Inpatient Admission documentation. No Inpatient is to be admitted without this being completed.
- b. No Inpatient PRN medication is to be charted before the medicine reconciliation is completed.
- c. The medicine reconciliations are to be randomly and regularly audited by a Senior Pharmacist to ensure their accuracy. Appropriate remedial action is to be taken with any practitioner who is identified as being non-compliant with

²³¹ Folio 23 Affidavit of R Schultz [274]-[278]

procedures for the charting and / or recording of medicines
and /or if there is an inaccurate or incomplete reconciliation.

Who authorized the RTP?

172. There were different versions as to who authorised the Midazolam and Droperidol. I was satisfied on the evidence that this medication was verbally authorised by Dr Graf before it was administered. After it was administered he charted it on the ED medication chart and back dated the time to reflect the approximate time of his verbal authorisation.

173. In making this finding I was satisfied to the requisite standard by the following evidence:

- a. Dr Graf mischaracterised Kumanjayi as aggressive in the ED and proposed Droperidol.
- b. This mischaracterisation continued in the Inpatient Unit Admission form, in his verbal handover to the TL in the LDU nurse's office and in his recorded account to police on the morning of her passing. It was this mischaracterisation that provided the justification for the RTP.
- c. Shortly after her passing, Dr Graf said in his recorded statement with police, that the medication was "*standard*", he "*discussed that with the nurse in charge,*" "*we took the decision together,*" and that he gave "*a verbal order. Verbal.*"
- d. When this order was given while still in the Inpatient Unit Dr Graf attempted to chart his authorisation on eMMA but was unable to access eMMA.
- e. Dr Graf subsequently charted the medication on the ED medication chart and signed the chart.
- f. After he learned that the medication was given (according to Dr Graf without his authorisation) and before Kumanjayi's passing, Dr Graf did not report

through any channel or document anywhere that the administration of the medication was unauthorised. Had such a gross medication error occurred I would have expected it to be immediately reported and / or documented.

174. There was inconsistent evidence as to whether the RTP medication was authorised to be given immediately, ‘stat’, as recalled by the TL and MHN PD, or whether it was PRN medication, only to be given if required. Having carefully considered all the evidence, including the possibility for misunderstanding, I was satisfied on the balance of probabilities that Dr Graf’s authorisation was for immediate effect or ‘stat’. I reached this finding based on the following evidence:

- a. If he had only authorised the medication as PRN, Dr Graf could have relied on his eMMA entry. There was no need to chart it in the ED medication chart. The TL could still have documented that it was administered (including that the administration followed a verbal authorisation). However, Dr Graf *did* chart it as ‘stat’ on the ED medication chart
- b. After he learned that the medication was given (according to Dr Graf without his authorisation) and before Kumanjayi’s passing, Dr Graf did not report through any channel or document anywhere that the administration of the medication was unauthorised. Had such a gross medication error occurred I would have expected it to be immediately reported and / or documented.
- c. The Progress notes (extracted above) completed by MHN TO before concerns with Kumanjayi were identified, record that “*on call Reg notified immediately by MHIU accepting admission nurse to administer stat dose...*”

175. The TL and MHN PD said that Dr Graf repeated this authorisation in person in the HDU nurses’ station. Dr Graf denied giving the order in the HDU. The CATT nurse said that Dr Graf was not in the HDU but he overheard a phone call by the TL to Dr Graf with MHN PD present. MHN TO also gave evidence of a telephone order. Having considered all the versions in the context of all the other evidence, I was not able to accept any of them to the requisite standard of satisfaction. This does not

alter my finding that Dr Graf verbally authorised the RTP medication in the LDU when he was giving a hand over to the TL.

176. The RCA²³² considered the ‘NT Health Management Framework.’ This Framework makes explicit the risks associated with telephone and verbal medication orders, *“they have a higher potential for errors as these orders can be misheard, misinterpreted and/or transcribed incorrectly,”* and so it limits use to *“exceptional circumstances”*. To further minimise the risk of error, the Framework requires the person receiving the order to document the order. In this case, the TL failed to document the order. More fundamentally, as Dr Graf was present on site, there were no exceptional circumstances that could justify him giving a verbal or telephone order in the first place.

Resolving some further differences in the evidence

177. The only witness who disputed knowledge as to what medication was given was MHN TO. However, from the following evidence, I was satisfied that she did know what medication was given.

- a. MHN TO ticked the ‘urgent review for Rapid Tranquilisation Procedure’ box on Kumanjayi’s ‘Patient Nursing Intake Assessment Form’.
- b. MHN TO completed progress notes shortly after midnight and before concerns with Kumanjayi were identified, which included a justification for and the administration of the medication; *“stat dose of 10mg Droperidol with 10mg Midazolam due to acute presentation on arrival and high risk to ALL staff present.”*
- c. During the course of her evidence, she referred to those medications as *“the standard practice.”*

²³² Folio 18 p 102

- d. As she was one of the nurses conducting observations on Kumanjayi it was improbable that she would have proceeded without knowing what medications had been provided.

178. As to Dr Graf, in summary I was satisfied as follows:

- a. Dr Graf entered the Inpatient Unit at 9.15pm. He was there for about four minutes. During this period, he gave a handover to the TL in the LDU nurses' station, he gave a verbal authorisation for the RTP medication, and either in the LDU or the HDU nurses' station, he attempted to enter this medicine onto eMMA. When he could not access eMMA he left the Inpatient Unit at 9.19pm.
- b. Shortly after 9.22pm the Escorting ED nurse saw Dr Graf in ED and reminded him that the Inpatient Unit staff were still asking for the medication to be entered in eMMA and he said he would attend to that. The Escorting ED nurse retrieved Kumanjayi's paper file and took it to the HDU nurses' station arriving at 9.26pm.
- c. At 9.27pm the CATT nurse left the Inpatient Unit and went to the CATT office. He saw Dr Graf there. In his evidence Dr Graf said he was attempting to chart the medication on eMMA. Dr Graf returned to the Inpatient Unit at 9.43. He then charted the RTP medications on the ED medication record and back timed the entry to 9.30pm.

179. Given these findings it was not necessary for me to determine whether Dr Graf returned to the Inpatient Unit for a third time later that evening but I note that a third visit is not captured by the CCTV and nor did Dr Graf refer to it in accounts provided to police and AHPRA.

A standard practice

180. Although RTP is only to be used as a last resort, I was very concerned to hear evidence that its use was more frequent. I formed a strong impression that its use

was normalised to the point that the risks were trivialised or overlooked. I reached this conclusion from the following evidence.

- a. The medication was given nicknames.
 - (i) Dr Graf used the pejorative term “*give her the drop.*”
 - (ii) Dr Graf said the TL referred to, “*10/10...jargon....which means 10mg or Droperidol and 10mg of Midazolam.*”
- b. MHN TO referred to it as “*standard practice,*” “*the practice*” and what “*they traditionally gave.*”
- c. Dr Tabart said, “*any involuntary patient with psychosis is going to have some sort of PRN for rapid tranquilisation.*”²³³
- d. Although no retrospective audit was done to determine the extent of RTP usage in the Inpatient Unit in ASH before Kumanjayi passed away, Dr Tabart told me that there had been a focus on its use since Kumanjayi’s passing. It was his understanding that “*there has been a substantial reduction in the use of parenteral medication in the last two years, a substantial reduction.*”²³⁴ That evidence supports my conclusion that there had previously been an overuse of RTP.

181. I was satisfied that the inappropriate use of RTP in Kumanjayi’s case was not an isolated event but formed part of a more systemic practice.

A failure to conduct appropriate observations and a Code Blue is called

182. The RTP sets the standard of monitoring required when RPT medications are administered. As Kumanjayi was an adult, asleep and Midazolam was administered, the monitoring requirements were:

²³³ T 612 (Dr Tabart)

²³⁴ T 607 (Dr Tabart)

Rapid Tranquilisation Clinical Monitoring

Utilise the TEMHS RTP Monitoring Chart

R15 visual observations should be carried out for each consumer
Continuous pulse oximetry should be used whenever possible

...

If the consumer is ASLEEP/DROWSY:

Standard monitoring of vital signs (respiratory rate, pulse, BP) is every
15 minutes for 2 hours post last dose of medication then every 4 hours
until medical review.

**Additionally in Midazolam Use: Respiratory rate to be monitored
every 5 minutes for the first hour
then every 15 minutes for 2
hours then every 4 hours until medical review**

**Alternative monitoring may be initiated as directed by the treating
doctor if there is a risk of aggression. Reasons for inability to
perform standard monitoring should be clearly documented in notes.**

183. The RTP specifies that “*continuous pulse oximetry should be used whenever possible*” but this was not done even though pulse oximetry was available.
184. The RTP specifies that the ‘TEMHS RTP Monitoring Chart’ be used, but this was not referred to by any of the Inpatient Unit staff on duty that night. Instead, the standard ‘HDU:24 hr (15/60z) Client Observations’ chart was used, which was Exhibit 7.
185. The clearest evidence as to when observations were conducted and by whom is contained on this Client Observations’ chart. Although Kumanjayi was on a mattress in front of the nurses’ station in the HDU, on this chart she is recorded in the column headed Room 2 as shown below:

Room	1	2	3	4	sig	Room
2100	W				AM	0030
2115	W				AM	0045
2130	W	W			W	0100
2145	W	W			W	0115
2200	W	W			W	0130
2215	W	W			W	0145
2230	B	W			W	0200
2245	B	W			W	0215
2300	B	W			W	0230
2315	B	W			W	0245
2330	B	W			W	0300
2345	B	W			W	0315
2400	B	W			W	0330
0015	B	W			W	0345

* met call initiated

186. The MHN conducting the observations initials this document in the column headed 'sig'. MHN PD's initials are seen at 2145, 2200, 2215, 2230 and 2245. MHN TO claimed not to be able to identify all of the initials at 2300, 2315, 2330, 2345, 2400, and 0015. She denied that her initials were next to the midnight observation, though was unable to identify any other MHN present who could have signed. She agreed she initialled the next entry at 12.15am when the Code Blue was called. However, I was satisfied that all of these were her initials because:

- MHN TO agreed that some of these initials were hers and that she initiated the Code Blue and made the entry "*met call initiated.*"
- There were only two nurses stationed in HDU that evening and there was no evidence of anybody else signing this document at those times.
- MHN completed and initialled other documentation and I have compared the initials on this chart with her initials elsewhere, including, for example, on page 92 of Folio 6, extracted below:

Name:	h Van
Designation	RN
Signature	CV

187. MHN TO's reluctance to concede her initials is understandable. Prof Lawson considered there was 20-30 minutes of circulatory failure before the Code Blue was in action. This timeframe is consistent with MHN PD's observation that Kumanjayi was no longer snoring at midnight. The only available conclusion is that MHN TO was the nurse most directly responsible for observing Kumanjayi over the period when her respiration was deteriorating and when it ceased.

According to the TL

188. After Kumanjayi was placed on the mattress, the TL said that she did not give any specific direction to MHNs PD or TO about ongoing nursing observations as they were both experienced nurses and she assumed observations would be conducted as per the RTP.²³⁵ However, while a portable pulse oximetry was available TL said "*we don't have the resources to be doing that*"²³⁶ and we don't leave it on because it can be used as a weapon.²³⁷ I was satisfied that the failure to use pulse oximetry was accepted by the TL and systemic.

189. The TL went to the LDU and returned to the HDU at 11.45pm. MHN PD was in the nurses' station and MHN TO was returning to the nurses' station from the floor (consistent with MHN TO's initials on the Observation Chart at 11.45pm). The TL said that the PCA would cover their breaks from midnight, but he needed to be back in LDU by 3am. The TL then returned to the LDU.

²³⁵ T 303 (TL)

²³⁶ T 307 (TL)

²³⁷ T 321 (TL)

190. At 12.17am the TL heard the emergency alarm. Because false alarms are common, she phoned the HDU. When the phone went unanswered she entered the HDU and saw MHN TO doing CPR on Kumanjayi.²³⁸ The TL returned to the LDU to get the resus trolley and the PCA put out the witch's hat to alert Code Blue responders to the location of the emergency. Within 2 minutes the resuscitation team arrived and took over.

191. The TL phoned Dr Graf and informed him what was happening. When Dr Graf later arrived, he went into the nurses' station to call his consultant. The TL did not have a conversation with him.²³⁹

According to MHN PD

192. MHN PD said that MHN TO was allocated Kumanjayi as her patient while he had primary responsibility for the patient in room 1.²⁴⁰

193. He said that during the evening he heard Kumanjayi snoring on the mattress. He conducted visual observations of her every 15 minutes from 9.45pm – 10.45, and he initialled the Observation chart.²⁴¹ He said that when Kumanjayi was snoring he assumed she was breathing and he did not make a close observation.²⁴² He went on his break just after midnight and he checked on Kumanjayi on his way out. She was no longer snoring. He said he looked at her for 'seconds' and he thought she was breathing. He did not make a note of this check on the Observation chart and he went on his break.²⁴³

²³⁸ T 309 (TL)

²³⁹ T 311 (TL)

²⁴⁰ T 360, 361 (MHN PD)

²⁴¹ Ex 7 HDU 24hr (15/60) Client Observations

²⁴² T 374 (MHN PD)

²⁴³ T362, 363, 375 (MHN PD)

According to MHN TO

194. MHN TO asked the TL if she needed to wake Kumanjayi to conduct physical observations but the TL said to let her sleep and they could be done in the morning.²⁴⁴

195. MHN TO said that both she and MHN PD conducted 15 minute visual observations on both clients. They discussed Kumanjayi's snoring and the possibility of sleep apnoea.²⁴⁵ Neither nurse seemed to appreciate that her snoring and the cessation of her snoring were matters of concern.

196. MHN TO said that while she knew of the RTP she had not been trained on it. She did not know that it required continuous pulse oximetry²⁴⁶ and pulse oximetry was not commonly used.²⁴⁷

According to the PCA

197. The PCA went to the HDU at midnight to cover for MHN PD who was going on his break. The PCA entered through a door that goes directly into the nurses' station in HDU (that is he did not walk past Kumanjayi). From within the nurses' station, he saw MHN PD look at Kumanjayi before he left the HDU on his break.²⁴⁸ The PCA remained in the nurses' station. He did not hear Kumanjayi snoring. He could not really see her on the floor, except if he stood up specifically to look. At 12.15am MHN TO conducted the next Observation. MHN TO commenced CPR and the PCA called the Code Blue.

Issues in the lead up to Kumanjayi's passing.

The Rapid Tranquilisation Procedure (RTP) was not followed

²⁴⁴ T 570 (MHN TO)

²⁴⁵ T 550, 551 (MHN TO)

²⁴⁶ T 571 (MHN TO)

²⁴⁷ T 573 (MHN TO)

²⁴⁸ T 5988 (PCA)

198. Unsurprisingly, NT Health positively found that the RTP was not followed.²⁴⁹ The only conclusion available on the evidence is that every staff member involved in the administration of RTP medications (Dr Graf, the TL, MHN PD, and MHN TO who was a witness) and Kumanjayi's subsequent monitoring (MHNs PD and TO) failed to follow the procedure. I find that the RTP medication was not justified as a 'last resort'. Kumanjayi was not a "*significant immediate risk to [herself] or others,*" and even if she was exhibiting behaviours which required a response, no other techniques for calming or managing her were attempted. The actions taken against her were the opposite of a 'least restrictive' approach. The failure to follow the RTP was systemic.

199. As to the extent of non-compliance with the RTP, I accept these findings from the RCA:²⁵⁰

- The rational for using RTP was not clearly documented.
- There was no evidence that ALL other techniques of calming or managing Ms SB had been exhausted before the medication was administered. PRN medication and nursing care had not been attempted in the Inpatient Unit environment.
- No physical examination of Ms SB was undertaken, prior to the administration of the medication. The documentation states that physical observations were unable to be recorded, however it is not clear why this was so.
- No medication reconciliation was documented prior to the administration of this medication, nor was the medication chart updated.
- Oral sedation was not trialled in the Inpatient Unit, as is set out in the guideline above, in circumstances where Ms SB had accepted oral medication in the Emergency Department.
- The intramuscular medication that was administered was in greater quantities than that stipulated by the guideline above.
- Ms SB was contra-indicated for the medications she received. It is not clear that this was considered.

²⁴⁹ T 670 (R Schultz)

²⁵⁰ Folio 18 p 16, 1718

- Ms SB was not clinically monitored, as required, following the administration of medication. Though some visual observations were reportedly completed, physical observations were not completed, as they were required to be.
- There is no evidence that vital signs / physical observations were completed
- The panel understands that it was standard procedure in the Inpatient Unit at ASH for visual observations to be recorded on a 'HDU: 24 hr (15/60) Client Observations form'. This is not in keeping with procedure where rapid tranquilisation has occurred and requires immediate rectification.

Recommendation No.7

I recommend to the **Department of Health** that it amend all relevant policy, procedures, guidelines and /or training on any form of Rapid Tranquillisation for use in Inpatient Units to ensure all its guidance reflects best practice, including that:

- a. there can be no doubt that any form of Rapid Tranquillisation is a last resort;
- b. that it can be administered only with the express approval of the Consultant Psychiatrist (or a similarly qualified and experienced Psychiatrist);
- c. it mandates the type and frequency of nursing observations required;
- d. it mandates the use of any other physical monitoring device including continuous pulse oximetry;
- e. it excludes Rapid Tranquilisation from PRN charting; and
- f. it includes regular auditing of the use of Rapid Tranquilisation to ensure compliance with the policy.

Reform

200. Following Kumanjayi's passing, NT Health led evidence of changes it had implemented to address the factors considered to have contributed to Kumanjayi's

death. The changes are set out in Part E of the Institutional Response,²⁵¹ and are summarised below.²⁵²

Review, Training, and enhanced supervision in the Tranquilisation Procedure

201. In the month following Kumanjayi's death, intramuscular tranquilisation in the Inpatient Unit was suspended except under the close supervision of a Consultant Psychiatrist, until training was delivered to all Inpatient Unit staff. A training course titled 'Rapid Tranquilisation Training' was developed. It is one-hour of face-to-face compulsory training for permanent and casual staff. The training aims to educate staff about the risks associated with tranquilisation, the circumstances in which tranquilisation is appropriate, and the critical importance of conducting regular physical observations once tranquilisation has occurred. The course includes assessment and staff must sign an endorsement register to confirm they have read and understood the RPT.
202. At the close of the inquest, the RTP was currently under expedited review. It will be retitled the 'Acute Behavioural Disturbance Procedure' and is expected to reflect best practice. For example, the revised version is not expected to include a pathway for use of Midazolam and/or Droperidol for tranquilisation of a patient. While medical practitioners will still be permitted to order the administration of those medications when deemed necessary and appropriate, it will no longer be the 'standard approach' to rapid tranquilization.
203. Once the revised procedure comes into effect, all new NT Health Inpatient Unit nursing staff will be required, as part of their onboarding process, to attend face-to-face training on the use of the revised procedure.
204. To ensure that there is appropriate supervision of all RTP use, the Regional Executive Director and the Mental Health General Manager now receive daily

²⁵¹ Folio 23 Affidavit R Schultz

²⁵² This summary is largely drawn from NT Health written closing submissions dated 30 March 2026, [118]-[144]

reports identifying the number of patients who have received tranquilisation in the previous 24 hours (if any), and whether appropriate clinical monitoring was undertaken.

Implementation of Observation Charts

205. Following Kumanjaya's death, individual Inpatient Unit patient charts have been modified to include the 'Adult (>18 years) Observation Chart' and the 'Visual Observation Chart NTMHAOD' to streamline the recording of physical and visual observations of Inpatient Unit patients.

Mandatory Recognise and Respond to Deterioration Training for Inpatient Unit Staff

206. All Inpatient Unit staff are now required to complete the 'Recognise and Respond to Deterioration Training' (**RRD**) which aims to improve the ability of Inpatient Unit staff to identify a deteriorating patient via clinical assessment and observation. The training includes an online component followed by face-to-face simulation-style training and is delivered to clinical staff across the Alice Springs Hospital.

Further Guidance for Responsibility to undertake Medicine Reconciliation

207. NT Health identified that further guidance was required for medicine reconciliations of mental health patients admitted through the Emergency Department. Led by the Alice Springs Hospital Senior Pharmacist of Medication Safety and the Mental Health Clinical Director, in 2025 a Working Group was established. The Working Group determined:

- a. Psychiatry Registrars are responsible for conducting a medicine reconciliation for admissions to the Inpatient Unit; and
- b. The medicine reconciliation should be conducted on eMMA.

208. These changes were set out in a Proposal Paper and provided to the Psychiatry Registrars. On 25 September 2025 and 18 December 2025, the Senior Pharmacist

and Clinical Director held meetings with the Psychiatry Registrars to communicate the expectation and to provide practical guidance on how to undertake a reconciliation on eMMA.

209. A new medication order option in eMMA titled 'Medications Given on Transfer - Mental Health CAHS' has been added which streamlines the recording of medications administered during retrieval and ensures that this is readily visible across the hospital through eMMA.

Improve the transition of mental health patients from the Emergency Department to the Inpatient Unit

210. In Kumanjayi's case, a breakdown in the handover to the Inpatient Unit was identified, including that the process was rushed, documentation was incomplete, and key information was missing.
211. To address this a CATT ED Mental Health Transfer Checklist has been introduced which requires staff to record key information, including whether the medication reconciliation has occurred, whether the current medications are charted in eMMA, and a patient's recent physical observations.

Review Inpatient Unit staff overtime processes and conduct roster audits

212. Although not elsewhere discussed in these findings, concerns were identified about Inpatient Unit staff working substantial overtime in the weeks preceding Kumanjayi's death. There had been non-adherence to rostering guidelines and fatigue management policies resulting in excessive working hours.
213. Inpatient Unit nursing rostering responsibilities now sit with Inpatient Unit Managers, with roster approval required from the Director of Nursing. The roster is now also overseen by the MHAOD General Manager and the Human Resources Coordinator Director of Nursing and overtime hours in excess of safe working hours must now be approved by one of these senior staff.

214. Rostering audits reveal that rostering has improved since these changes were introduced. However, more work was required and the Inpatient Unit Director of Nursing is responsible for implementing further improvements and for monitoring. Repeat audits are expected in the future to ensure roster management continues to improve.

Implementation of the Clinical Skills Update Program for Inpatient Nursing Staff

215. To enhance the clinical skills of mental health nurses who may not have participated in an acute clinical setting for a period of time or who otherwise want to improve their clinical skills, an optional 'Clinical Skills Update Program' is now available. This involves a three-day placement in the ED, Medical Ward, or Surgical Ward. Inpatient Unit staff will shadow acute-care nurses to enhance their clinical skills in areas such as acute assessment, responding to deteriorating patients, wound management and intravenous medication skills.

216. Awareness and participation in the Program will be encouraged by the Inpatient Unit through orientation, email communication and discussion in regular scheduled meetings between management and staff.

Restrictions on solely qualified nurses in the Inpatient Unit

217. Through consultation with the Regional Executive Director and the Mental Health General Manager, there are now restrictions on the number of solely qualified nurses per shift which may be allocated to each area of the Inpatient Unit (HDU and LDU). No more than one solely qualified nurse per shift can be rostered to each of the HDU and the LDU. This recommendation ensures that a Registered Nurse is on shift within each area of the Unit in the event that a patient deteriorates and requires an immediate clinical response.

RED Regional Meeting

218. Regional Executive Directors from each NT Health region now meet monthly. The meeting is an opportunity for information sharing about issues identified across the

regions (including RCA recommendations), and the solutions proposed in response, with a view to implementing those solutions across the Territory, where appropriate.

Late receipt of evidence

219. As is not uncommon, at the end of the evidence the Court received an email dated 5 February 2026 from a previous patient of NT Health who was an inpatient during one of Kumanjayi's earlier admissions. This correspondent shared some of his observations of engagements between Inpatient staff and Kumanjayi. The admission of this email into evidence was objected to by NT Health. While I found much of their submission unpersuasive, I accept that there may be a perceived element of unfairness were I to admit the email without providing an opportunity for further exploration of it. Accordingly, I decline to admit the evidence. NT Health is well aware of the issues raised in that email and I encourage NT Health to reflect on and respond to the concerns raised, if they have not already done so.

Conclusion

220. Kumanjayi should not have passed away. With appropriate care, her health should have improved and she should have gone home to her children. Her death was preventable. Her passing must not be in vain. Lessons must be learned. Changes must be implemented and sustained to prevent similar deaths in the future.

221. A copy of these findings will be provided to AHPRA.

Formal Findings

222. Pursuant to *section 34 of the Coroners Act*, I find as follows:

- a. The identify of the deceased was Kumanjayi Brogus born 29 December 1988 in Alice Springs, Northern Territory.
- b. The time of passing was at 1.15am on 22 November 2023. The place of death was the mental health high dependency Inpatient Unit, Alice Springs Hospital in the Northern Territory.

- c. The cause of death was combined drug toxicity, in combination with a failure to conduct appropriate physical monitoring, resulting in airway obstruction, asphyxia and hypoxia.
- d. The deceased was an Aboriginal female.
- e. The particulars required to register the passing will be provided to the Office of Births, Deaths and Marriages.

Recommendations

Recommendation No. 1

I recommend to the **Department of Health** that it establish a Senior Executive cross regional committee responsible for considering, tracking and implementing Root Cause Analysis and Coronial recommendations. All decisions (and reasons for those decisions) accepting, rejecting, amending, or implementing recommendations should be adequately documented. Six monthly progress reports tracking the progress of recommendations should be provided to the CEO.

Recommendation No.2

I recommend to the **Northern Territory Government and the Department of Health** that it take immediate steps to honour the stated commitment in the *Mental Health and Related Services Act 1998* Review Consultation Report to modernise the mental health legislation for the Northern Territory by diligently finalising a new Mental Health Act through to commencement within 12 months of the publication of these findings; noting the extensive consultation and drafting already undertaken.

Recommendation No. 3

I recommend to the **Department of Health** that it amend any relevant policy, procedures, guidelines and / or training to ensure that mental health staff:

- a. understand and practice in accordance with the presumption of capacity (NT Health Informed Consent Policy Version 17);
- b. consider and document consent;
- c. ensure voluntary admission is used where possible;
- d. apply the principles of the least restrictive practice; and
- e. adequately document all decision making under the *Mental Health and Related Services Act 1998* (or its replacement Act).

Recommendation No. 4

I recommend to the **Department of Health** that it:

- a. amend any relevant policy, procedures, guidelines and / or training to ensure that mental health staff understand the applicability of the *Advance Personal Planning Act 2013* to mental health patients and the desirability of engaging in educative conversations with mental health patients about the availability, advantages of and practical effects of Advance Personal Plans for persons suffering from a mental illness,
- b. consult with the Attorney-General's Department and the Public Guardian and Trustee about ways to promote the use of Advance Personal Plans for mental health treatment and care, including by amending the approved form for making an Advance Personal Plan (or creating a new form) to ensure its suitability for expressing wishes, views and preferences about mental health treatment and care, and
- c. amend any relevant policy, procedures, guidelines and / or training to ensure that Advance Personal Plans are considered when any decision is being made about treatment and management of involuntary mental health patients.

Recommendation No. 5

I recommend to the **Department of Health** that when evacuations occur from remote communities in which NT Health operates, the clinic member requesting transport should engage in and document explicit conversations with:

- a. the retrieval service as to its capacity to transport a family member,
- b. any appropriate family member who can be spoken to as to their willingness to accompany the person being transported, and
- c. any additional arrangements made to facilitate an accompanying family member.

Recommendation No. 6

I recommend to the **Department of Health** that:

- a. Full medicine reconciliations are completed on eMMA by the admitting Psychiatric Registrar or Consultant Psychiatrist or another suitably qualified senior medical practitioner. This is to form part of the essential Inpatient Admission documentation. No Inpatient is to be admitted without this being completed.
- b. No Inpatient PRN medication is to be charted before the medication reconciliation is completed.
- c. The medicine reconciliations are to be randomly and regularly audited by a Senior Pharmacist to ensure their accuracy. Appropriate remedial action is to be taken with any practitioner who is identified as being non-compliant with procedures for charting and / or recording of medicines and / or if an inaccurate or incomplete reconciliation is identified.

Recommendation No.7

I recommend to the **Department of Health** that it amend all relevant policy, procedures, guidelines and / or training on any form of Rapid Tranquilisation for use in Inpatient Units to ensure all its guidance reflects best practice, including that:

- a. there can be no doubt that any form of Rapid Tranquillisation is a last resort;
- b. that it can be administered only with the express approval of the Consultant Psychiatrist (or a similarly qualified and experienced Psychiatrist);
- c. it mandates the type and frequency of nursing observations required;
- d. it mandates the use of any other physical monitoring device including continuous pulse oximetry;
- e. it excludes Rapid Tranquilisation from PRN charting; and
- f. it includes regular auditing of the use of Rapid Tranquilisation to ensure compliance with the policy.