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REPORT TO THE LEGISLATIVE ASSEMBLY

Pursuant to section 46B of the *Coroners Act 1993*

In the matter of the Coroner's Findings and recommendation regarding the death of
Mr Linden Alan Kunoth

Pursuant to section 46B of the *Coroners Act 1993*, I provide this Report on the findings and recommendation of the Territory Coroner, Local Court Judge Greg Cavanagh, dated 27 September 2019, regarding the death of Mr Linden Alan Kunoth (the Deceased) (Attachment A refers).

The Report includes the response to the recommendation from the Chief Executive Officer (CEO) of the Department of Health (Attachment B refers). The matters considered in this Coronial inquest were also closely related to those raised in the Coronial Findings of Mr Jordan Gregory Allen, which was released at the same time.

The Deceased, a 24 year old man, died some time on 17 October 2017 in a storeroom of the residence at 2 Lander Court, Larapinta, Alice Springs. The cause of death was self-inflicted hanging.

Recommendation of the Territory Coroner

Pursuant to section 35 of the *Coroners Act 1993*, the Territory Coroner made the following recommendation in regards to the death of the Deceased:

- '52. The recommendation I make is identical to one of the recommendations in the inquest into the death of Jordan Allen. **I recommend** that the Central Australian Mental Health Service ensure that its approved procedure and Form support appropriate risk assessment prior to the decision to grant leave, that the Form has sufficient space for conditions to be legibly written and appropriate information for the escorting person as to what to do and who to contact if things go wrong.'

Response to Territory Coroner's recommendation

A copy of the Coronial Findings was provided to the CEO of the Department of Health (as the Central Australian Mental Health Service (CAMHS)) on 18 November 2019 in accordance with section 46A(1) of the *Coroners Act 1993*.

A written response to the recommendation at paragraph 52 was received from the CEO of the Department of Health dated 16 December 2019 (Attachment B refers), as required by section 46B(1) of the *Coroners Act 1993*, advising as follows:

CAMHS' Approved Procedure 8 relating to 'Leave of absence, missing of (sic) absconded patients' is currently under review to incorporate a new section on risk assessment. The section will outline that a thorough review of a carer's preparedness to supervise a patient must be undertaken prior to granting escorted leave.

CAMHS has completed a review of its 'Approval of Leave Procedure'. The 'Approval of Leave Procedure' now requires an appropriate risk assessment to be conducted when escorted leave is being considered. An Authorised Psychiatric Practitioner must ensure that a carer reads Leave Form 51 and understands their responsibilities prior to granting escorted leave.

Leave Form 51 is currently under review and proposed changes to the format of the form will be further considered at a meeting in February 2020 of the Northern Territory Approved Procedures and Quality Assurance Committee. A new part B of Leave Form 51 for involuntary patients will include tick boxes for an Authorised Psychiatric Practitioner to tick as the various conditions of leave are explained to a carer. Similarly, a new part C of Leave Form 51 for voluntary patients will include tick boxes for the patient to tick to demonstrate they understand and agree to the various conditions of leave. The form provides sufficient space for important information.

I am satisfied that the Department of Health has considered the recommendation of the Territory Coroner and is taking the necessary steps with respect to the recommendation.

DATE:

21 JAN 2020



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