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CITATION: *Inquest into the death of Kumanjayi Jurrah* [2024] NTLC 12

TITLE OF COURT:	Coroners Court
JURISDICTION:	Alice Springs
FILE NO(s):	A0058/2020
DELIVERED ON:	15 November 2024
DELIVERED AT:	Darwin
HEARING DATE(s):	29 July – 02 August 2024
FINDING OF:	Judge Elisabeth Armitage
CATCHWORDS:	**Child drowning in public pool; failings in policy, procedures and practice concerning supervision of children by Kintore Early Learning Centre and MacDonnell Regional Council; failings in policy, procedures and practice by Kintore Pool and MacDonnell Regional Council; failure by MacDonnell Regional Council and the Commonwealth Department of Education to engage in healing processes with the family and community and restore services to the community; commitment by MacDonnell Regional Council and the Commonwealth Department of**

Education to fund and engage in healing processes; risk assessments; role of Royal Lifesaving Australia in public pools; Guidelines For Safe Pool Operations; Walungurru Law and Justice Group; section 111(1) of the *Local Government Act 2008* (NT) and section 182(1) *Local Government Act 2019* (NT).

REPRESENTATION:

Counsel Assisting:	Paul Morgan
Counsel for MacDonnell Regional Council:	Andrew Harris KC
Counsel for the mother:	John Birrell
Counsel for Commonwealth Education Department:	Matthew Brady KC
Counsel for Team Leader:	Mary Chalmers SC

Judgment category classification:	A
Judgement ID number:	NTLC [2024] 12
Number of paragraphs:	148
Number of pages:	43

IN THE CORONERS COURT
AT ALICE SPRINGS IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. A0058/2020

In the matter of an Inquest into the death of

KUMANJAYI JURRAH

ON: 02 DECEMBER 2020
AT: PINTUPI HOMELANDS HEALTH SERVICE, KINTORE

FINDINGS

Judge Elisabeth Armitage

Introduction

1. Kumanjayi Jurrah was born at Alice Springs Hospital on 10 September 2018 to parents Justina Neal and Simon Jurrah.[1] Kumanjayi was described by his family as a smart little boy, who was active, happy, and always laughing and running around.[2] He loved watching the movie, The Lion King.[3]

2. Kumanjayi was only 2 years old when he drowned at Kintore swimming pool while on an excursion from the local childcare centre on 2 December 2020. His passing has devastated his parents, Justina Neal and Simon Jurrah,[4] his uncle and aunt, Gary Marshall and Marina Jurrah, who were caring for Kumanjayi at the time of his death, and his entire extended family who reside in Kintore and neighbouring communities.

[1] Birth Certificate, Folder 1, Folio 7.
[2] Justina Neal Affidavit affirmed 27 July 2024 (Justina Neal Affidavit) at [5] , Simon Jurrah Affidavit affirmed 28 July 2024 (Simon Jurrah Affidavit) at [5].
[3] Gary Marshall Affidavit affirmed 1 August 2024 (Gary Marshall Affidavit); T252-253 (Day 4).
[4] Justina Neal Affidavit at [13]-[20], Simon Jurrah Affidavit at [11]-[14].

3. His mother, Justina Neal, stated in her evidence at the inquest that:

> Kumanjayi was happy with all his family around. He loved spending time with his family, especially his cousins. They would play games with him and look after him. He was smoked by his grandmother Eileen – that's what made him strong.[5]

4. Gary Marshall stated in his evidence:

> We have love in our hearts thinking of Kumanjayi every day. I don't want this to happen again to other people in the future. I never want anyone else to feel pain like Marina and I feel every day.[6]

5. To all those affected by Kumanjayi's death, and particularly to Ms Neale, Mr Jurrah, and Mr Marshall and Ms Jurrah, I extend my sincerest condolences.

6. This inquest also heard of the wider ramifications that his passing has had on the community of Kintore, including the unresolved grief of those still waiting for answers about what happened on 2 December 2020 [7] and differing views as to whether the pool or childcare centre – which have been closed since the incident – should re-open.[8]

7. This death was a reportable death because it occurred in the Northern Territory and was sudden and unexpected. Kumanjayi had been dropped off at the Kintore "MacKids" Early Learning Centre ("Kintore ELC"), operated by MacDonnell Regional Council ("MRC"). Three childcare workers from the Kintore ELC had taken Kumanjayi, along with five other children from the childcare centre, to the Kintore swimming pool ("Kintore Pool") on a regular (weekly) excursion. The Kintore Pool was also operated by MRC. A lifeguard

[5] Justina Neal Affidavit at [10].
[6] Gary Marshall Affidavit; T253 (Day 4).
[7] T326 (Day 4).
[8] Simon Jurrah Affidavit at [17].

employed by MRC was present during the excursion to the Kintore Pool that day. As is set out in more detail below, Kumanjayi was locked inside the Kintore Pool complex after everyone else had left. Kumanjayi was found shortly after floating in the adult pool and could not be revived. The cause of death was identified in the autopsy report and was not in issue, little Kumanjayi drowned.[9]

8. His care had been entrusted to the Kintore ELC, and he was on an excursion to the Kintore Pool, with both of these local government services operated by MRC. Kumanjayi should have returned safely home that day. It was not mandatory to hold an inquest into this death, but in the circumstances just described, I determined that I should exercise my discretion to hold a public inquest.

Child drownings

9. As recently as September last year, I delivered my findings in an inquest into the drowning death of another two year old child.[10] As I stated then, drowning deaths are, tragically, one of the leading causes of death of Australian children. I also made reference to the numerous inquests and reviews conducted into child drownings, and the fact that most of these deaths were preventable. Among the risks which have been identified from those inquests and reviews, is the risk from inadequate adult supervision. While most of the deaths involved drownings in home swimming pools, and this was a public pool, tragically, this was yet another case involving inadequate adult supervision of a child, and this was another preventable death.

The focus of this inquest

10. Since both the Kintore ELC and the Kintore Pool were operated by MRC, a focus of this inquest was to investigate the relevant policies and procedures that

[9] Post Mortem Examination Report of Dr M Tiemensma dated 7.12.20, (Folder 1, Folio 5).
[10] *Inquest into the Death of Baby Croker* [2023] NTLC 17.

were in place at MRC, to assess how adequate they were, and whether or not they were applied and followed. At the end of these findings, I make a number of recommendations with respect to their policies and procedures.

11. This inquest heard evidence over five days from 29 July 2024. In the course of the hearing it became clear that the death of Kumanjayi has had a devastating and ongoing impact in Kintore, and beyond, for over three and a half years. There was evidence from family members who felt they were not given the information they were entitled to, about what happened to Kumanjayi.[11] There was also evidence that there was not enough support provided to those impacted in the immediate aftermath of Kumanjayi's passing.[12] There were differing views about whether the Kintore ELC and the Kintore Pool should ever re-open. The picture was one of fractured relationships, compounding the grief and suffering resulting from Kumajayi's passing. As a result, I have also made recommendations relating to processes for mediation/restorative justice targeted at the difficult task of rebuilding relationships and determining a way forward on the outstanding issues, including the Kintore Pool and Kintore ELC.

The events of 2 December 2020

12. Kumanjayi was signed into the Kintore ELC at around 7:50am on Wednesday 2 December 2020 by his aunt Marina Jurrah.[13] At Kintore ELC that day, three childcare workers were on duty: the Co-ordinator/Team Leader,[14] and two local employees (Educators 1 and 2) who were both in the position of "Educator – Early Learning"[15] and who reported to the Team Leader.

[11] Affidavit of Simon Jurrah at [14], Affidavit of Magdalena Marshall affirmed 29 July 2024 (Magdaleena Marshall Affidavit at [15]-[16].
[12] T18-19 (Day 1); T37 (Day 1).
[13] Daily Booking Sheet, dated 2 December 2020, Folder 2, Folio 23..
[14] The evidence is that the Team Leader was employed as a Co-ordinator, which is a position that includes supervision of Team Leaders, but she was also fulfilling the role of Team Leader by "acting down" in that position due to a recent vacancy as of 2 December 2020: Team Leader Interview (Folder 3, Folio 10) (p46-47 of 80); T88 (Day 2 , Team Leader).
[15] Folder 2, Folio 26 and Folio 27.

13. On that day there were 5 children (Shelton, Renisha, Amy, Kiana and Sidonia)[16], plus Kumanjayi, attending the Kintore ELC. All were aged between 18 months and five years.

14. Although there were six children in attendance, only three children had been signed in that day.[17] In addition to Kumanjayi, the booking sheet shows the names "Renisha" and "Louis".[18] However, not only were some children in attendance not recorded, but there was no child named "Louis" in attendance. The Co-ordinator/Team Leader said that it was quite common for the documents recording attendance to be completed later in the day, often at lunch time, morning tea time or during a break.[19]

15. Shortly before 10am that day, the three childcare workers left the Kintore ELC and walked to the Kintore Pool with the six children.[20] There had been no briefing that day by the Co-ordinator/Team Leader to the Educators about their responsibilities during the excursion.

16. CCTV from the Kintore Store showed the two Educators walking in an area frequented by cars towards the Kintore Pool, with the six children. Kumanjayi appears lagging several metres behind and he, and other children, were often not in arm's reach.[21] Initially the Co-ordinator/Team Leader was not with the others, but was some 30 metres behind. Even before getting to the pool, on the CCTV it was evident that supervision was not adequate in that the children were often not in arm' reach, and the Co-ordinator/Team Leader conceded this in her evidence.[22]

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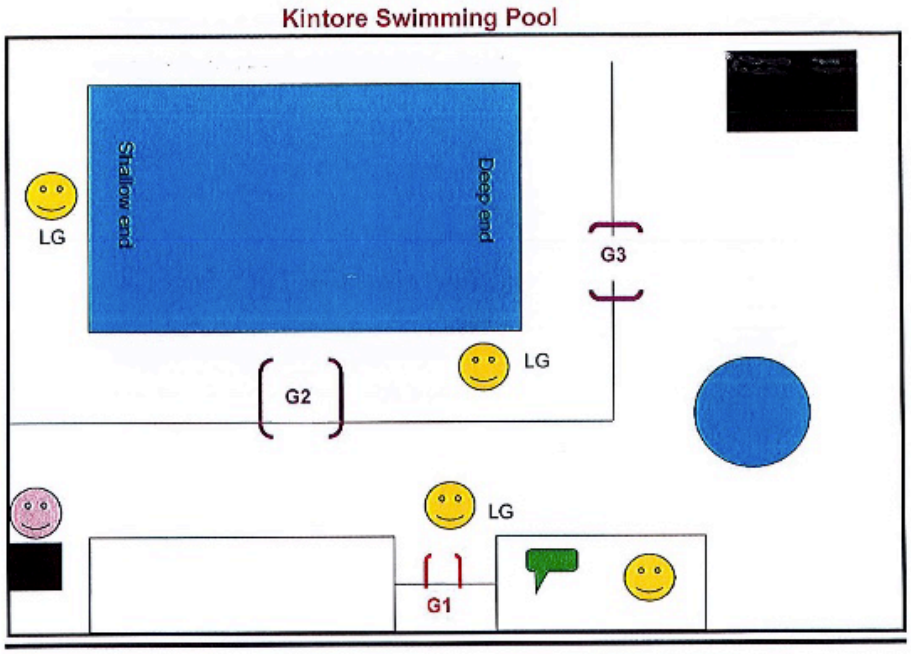
[16] Statutory declaration of Toby Wilson (Folder 5, Folio 12); Educator 2 Interview at 4 (Folder 3, Folio 6); Team Leader Interview at 11-12 (Folder 3, Folio 10).
[17] Daily Booking Sheet, 2 December 2020, Supplemented Documents, Folio 2, p 54.
[18] Daily Booking Sheet, 2 December 2020, Supplemented Documents, Folio 2, p 54.
[19] T95.3, (Team Leader, Day 2)
[20] Team Leader Interview at 25, 28 (Folder 3 Folio 10).
[21] Folder 2 Folio 28 USB "CCTV", Clip 2. Time stamp from 9:45:45am.
[22] T87 (Day 2, Team Leader).

17. At around 10am the group arrived at the Kintore Pool and the lifeguard on duty and Pool Team Leader, Paul Rigney, opened the main entrance gate.[23]

18. The layout of the pool complex and its facilities is shown in the diagram below.[24]



19. The rectangular pool pictured is an 18 metre by 12 metre pool, with a depth between 1.0m and 1.8m (the "adult pool"), and the circular pool is the toddler pool which has a depth of between 20 and 40cm (the "toddler pool").[25] The line shown around the adult pool (under G2 and G3) probably depicts a fence which was removed in 2016. It was not there when Kumanjayi passed away but has since been replaced.

20. Once inside the main entrance, the children and childcare workers proceeded to a vestibule area at the entrance, where they changed the children into swimming clothes/nappies on the street-side of the internal gate to that vestibule area (the

[23] Team Leader Interview at 32-24 (Folder 3, Folio 10), Paul Rigney Interview at 15 (Folder 3, Folio 13).
[24] Source: Kintore Pool Operations Manual, p 8 (Folder 2, Folio 28 USB, MacDonnell Shire Documents).
[25] Kintore Pool Operations Manual, p 9 (Folder 2, Folio 28 USB, MacDonnell Shire Documents).

area marked G1 on the above diagram and depicted in the photo below)[26] and then they all made their way down to the toddler pool.

Photo 1 - the vestibule area where the children were changed into swimming clothes/nappies

21. The children enjoyed playing in and around the toddler pool. Both Educators were seated at the edge of the pool for most of this time. Mr Rigney and the Co-ordinator/Team Leader stood near the pool, and at times they directed the toddlers back to the toddler pool when the toddlers began to move away from that pool.[27] The evidence is that while the children were playing in the toddler pool, the level of supervision was adequate.[28]

22. Around 10:25am the Co-ordinator/Team Leader told the group that it was time to leave and return to the Kintore ELC.[29] The three childcare workers, Mr Rigney, and the six children made their way back to the same vestibule area.

[26] Team Leader Interview at 32-34 (Folder 3, Folio 10).
[27] Team Leader interview at 34-35, (Folder 3 Folio 10); Paul Rigney Interview at 10, 15 (Folder 3, Folio 13), T97 (Day 2, Team Leader).
[28] T 200-201 (Day 3, RJ Houston).
[29] T98 (Day 2, Team Leader); Team Leader Interview at 25 (Folder 3 Folio 10).

23. The three childcare workers began drying the children in the vestibule area and changing the children. Mr Rigney was standing nearby. [30]

24. It is from around this point that there was some divergence in the evidence as to exactly where each person was located and who was attending to which child. In her original interview with police soon after the incident, Educator 2 said that she attended to Kumanjayi and then Shelton and Kiana, and that some children may have been on the pool-side of the internal gate.[31]

25. The Co-ordinator/Team Leader, in an interview with police, said that all children were attended to at this time on the street side of the internal gate to the vestibule area (the street side being where the arrow is located in the Photo 1 above), and that she was attending to Shelton and Kiana and Educator 1 was attending to Sidonia and Amy. [32]

26. With respect to where Kumanjayi was located, in response to a police question shortly after the incident, the Team Leader answered:

> He was standing in front of the bars like with all the group there"…[a]nd behind [Educator 2]. [Educator 2] was doing something with one of the other kids and um then I stopped looking, was noticing him because I was doing Shelton and um Kiana and then I kinda made the assumption as they headed off the he was there.. But like it was crazy I should have actually stopped and had another look and I didn't till we got to that road…[33]

[30] Educator 2 Interview at 7 (Folder 3, Folio 6); Educator 1 Interview at 12 (Folder 3, Folio 7); Team Leader Interview at 18-21, 25, 39 (Folder 3, Folio 10); Paul Rigney Interview at 7, 15 (Folder 3, Folio 13).
[31] Educator 2 interview at 7, 10-11 (Folder 3 Folio 6), 10-11; Exhibit NN-01 (Folder 3 Folio 6).
[32] Exhibit PN-01 (Folder 3, Folio 9); Team Leader Interview at 18-21, 67 (Folder 3, Folio 10).
[33] Team Leader Interview at 16, (Folder 3, Folio 10).

27. In her interview with Police, Educator 1 stated she was attending to Sidonia,[34] but in her evidence at the inquest she said she was attending to Sidonia and Kiana.[35]

28. In an interview soon after the incident Mr Rigney told police that there were children on both sides of the internal gate of the vestibule area.[36]

29. The inconsistency in the evidence around who was where, and who was looking after which child, supports the view that there was no clear allocation of children to particular workers.

30. While at the vestibule area the Co-ordinator/Team Leader did a scan of the area and located all six children.[37] However, it seems that shortly after this scan Kumanjayi became unaccounted for.

31. There was evidence that two children who the Team Leader was looking after started "acting up" in these critical moments, perhaps distracting her.[38]

32. There was also evidence that the mother of one of the children on the excursion came to the pool gate during this time.[39] There were differing accounts about whether she entered through the main pool gate; Educator 2 thought she entered,[40] Educator 1 thought she stayed outside,[41] and the Co-ordinator/Team Leader gave evidence that she came to the gate but did not recall her entering the pool side.[42]

33. Mr Rigney did not mention this mother in his statement soon after the incident.[43]

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[34] Educator 1 Interview at 12-13 (Folder 3, Folio 7).
[35] T77 (Educator 1, Day 2).
[36] PR-01 (Folder 3, Folio 12), Paul Rigney Interview at 19-20 (Folder 3, Folio 13).
[37] Team Leader Interview at 52 (Folder 3, Folio 10); T98, T102 (Team Leader, Day 2);
[38] Additional Documents, Folio 1 Svikart Report, Svikart interview with Team Leader (from 2:01); T102 (Day 2, Team Leader).
[39] Educator 2 Interview at 7-8 (Folder 3, Folio 6) Ecucator 1 Interview at 6-8, 12 (Folder 3, Folio 7).
[40] T57-58 (Day 2).
[41] T76-77 (Day 2).
[42] T111 (Day 2).
[43] Paul Rigney interview at 8-9 (Folder 3, Folio 13).

34. In any event, it seems the mother's attendance was another possible small distraction.

35. The evidence established that the children and childcare workers did not exit from the vestibule area and out of the main pool gates in an orderly fashion. The Co-ordinator/Team Leader described the exit process was as follows:

> I really don't know what happened there…all I know is that the gate was open and somehow – I think [Educator 1] headed off first with a couple of kids and I – I understand there was [Educator 2] next and I was last…[44]

36. As to whether she counted the children out the gate, the Co-ordinator/Team Leader explained:

> Because we started to exit…and instead of waiting for the whole group to be ready, it happened behind my back, and I had to… Didn't count them out the gate because they started going without me and we were running to catch up and I was chasing Shelton and Kiana…[45]

37. Considering all of the available evidence on this point it seems clear that:

    a. there was no allocation of children to particular workers;

    b. the children were not counted out the gate; and

    c. there was no plan in place to minimise or mitigate the risk to supervision of the children posed by common distractions.

38. After the three childcare workers and five children exited the pool, Mr Rigney walked out, locked the external fence gate to the pool at the main entry and

[44] T99 (Day 2).
[45] T102 (Day 2).

drove home.[46] He did not do a final sweep (visual check) of the pools or their surrounds.[47]

39. Tragically, Kumanjayi did not leave with the other children and was locked alone inside the pool area. Consistent with his contented and happy nature it seems he did not call out or cry, but likely continued to explore around the vestibule and pool area. There was nothing to prevent him accessing the main pool.[48]

40. Soon after leaving the pool, Marina Jurrah yelled out to the Team Leader and asked where Kumanjayi was.[49]

41. The Team Leader told Educator 2 to return to the Kintore Pool. After returning the other children to the Kintore ELC with Educator 1, the Team Leader ran back to the Kintore Pool. [50]

42. Upon arriving at the main entrance gate, other community members had already gathered but no-one could force open the locked gate. Some looked for Mr Rigney, but he could not be found. The Team Leader ran to the Council Office because she believed they would have a key to the gate.[51]

43. The Team Leader spoke to council officer, Mark, who alerted youth workers, Daniel and Katherine, that there was an emergency and a child was missing.[52] Katherine heard someone mention the swimming pool.[53]

44. Mark called Mr Rigney's mobile phone but there was no answer.[54]

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[46] Paul Rigney, Initial Statement at 5-6 (Folder 3, Folio 12)
[47] Psul Rigney, Initial Statement,at 5, 10 (Folder 3, Folio 12).
[48] See Photo 1 above.
[49] Marina Jurrah Interview, Folder 3, Folio 1 Team Leader interview at 14 (Folder 3, Folio 10).
[50] Team Leader Interview at 14-15, 26 (Folder 3, Folio 10).
[51] Team Leader Interview at 14, 26 (Folder 3, Folio 10);
[52] T21 (Day 1, Katherine); Satutory Declaration of Mark at 2 (Folder 4, Folio 21).
[53] T21 (Day 1, Katherine)
[54] Statutory Declaration of Mark at 2 (Folder 4, Folio 21).

45. Katherine located a set of council keys in the Council Office and then ran the short distance to the Kintore Pool's main gate, followed by Mark and Daniel.[55]

46. Katherine held the padlock on the main gate in her hands and realised that her keys would not fit, as the padlock required a different style of key.[56]

47. Daniel said that when he arrived at the pool main gate he saw Katherine and Mark trying different keys with the padlock.[57] None of them worked.

48. It is now known that on 26 September 2020, a car crashed into the front pool gates and the lock was replaced.[58] There was some conjecture that copies of the new key had not been distributed. However, as NAAJA pointed out in their submissions, it was unclear from the evidence whether it would ever have been possible for anyone other than Mr Rigney to enter the pool facility through the main gates, because Mr Rigney had stated that there were in fact two locks at the main gate – a "bi-lock" as well as a childproof lock – and Mr Rigney told police that he was the only person who had a key to the childproof lock.[59]

49. After failing to gain access through the main gate, Katherine, Mark and Daniel went to a side gate, but they could not open that lock either.[60]

50. As NAAJA again pointed out in their submissions, there are two possibilities with the side gate – it may have been frozen closed, or they may not have had the right key.

51. It is unnecessary to resolve the precise problems which prevented key access at both gates. There should have been a failsafe plan in place to enable access to the pool in emergency situations such as this, but there was none.

[55] T12-13 (Day 1, Daniel); T22 (Day 1, Katherine).
[56] T22 (Day 1, Katherine)
[57] T13 (Day 1, Daniel).
[58] Statutory Declaration of Mark at 2 (Folder 4, Folio 21).
[59] Paul Rigney Interview at 36-37 (Folder 3 Folio 13).
[60] T22 (Day 2, Katherine); T13 (Day 2, Daniel).

52. As a result of that failure there was a delay in reaching Kumanjayi who was still locked inside.

53. In desperation, two men, Zacharia Michael and Gary Marshall, scaled the pool fence, including the barbed wire on top, and Johnny Corby followed. [61]

54. Zacharia immediately found Kumanjayi floating in the main pool near the steps close to the side gate. He lifted Kumanjayi from the pool and placed him on the pool deck near the steps. [62]

55. Katherine and Daniel also scaled the fence and together they began CPR. Sadly, Kumanjayi did not respond.[63]

56. A registered nurse, Susan, arrived from the Kintore clinic a short time later.[64] When she arrived the gates were still locked, but a community member managed to force the front gate open from inside the pool area. [65] As soon as she entered the pool area, RN Susan took over CPR efforts and instructed Daniel to focus on chest compressions, not breaths. Katherine ran and retrieved the defibrillator stored at the Kintore Pool.[66]

57. The defibrillator was applied to the chest of Kumanjayi at the direction of RN Susan. There were no children's pads for this defibrillator and the adult defibrillator pads were both applied to Kumanjayi's chest rather than one to his back and one to his chest as recommended.[67] The defibrillator nevertheless detected a non-shockable rhythm. With no shock delivered, RN Susan recommenced CPR.[68]

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[61] Statutory Declaration of Gary Marshall at 5-8 (Folder 3, Folio 4); Statutory Declaration of Johnny Corby (Folder 4 Folio 20); Statutory Declaration of Zacharia Michael at 6-9 (Folder 3, Folio 14); T13-14 (Day 1, Daniel).
[62] T22-23 (Day 1, Katherine).
[63] T24 (Day 1, Katherine). Daniel Interview at 3-4, 6 27-28, 31-32 (Folder 4, Folio 17). Katherine Interview at 2-3, 12, 14-16 (Folder 4, Folio 19).
[64] T16 (Day 1, Daniel).
[65] Statement of RN Susan at 4, (Folder 4, Folio 23); Johnny Corby Statement at [10], (Folder 4, Folio 20).
[66] T23 (Day 1, Katherine).
[67] T16 (Day 1, Daniel), Corbett Statement (Folder 4, Folio 33).
[68] Daniel Interview at 33 (Folder 4, Folio 17); RN Susan Interview at 4 (Folder 4, Folio 23).

58. Doctor Sarah arrived with an ambulance and Kumanjayi was taken by ambulance back to the Kintore clinic.[69] Resuscitation efforts continued throughout but were unsuccessful and Kumanjayi was pronounced passed away at 11:39am. [70]

59. The exact time which had elapsed between the group excursion leaving the pool gates and CPR beginning on Kumanjayi is unknown. However, a rough timeline can be constructed from the following:

    a. The Team Leader said that the group got out of the toddler pool at 10:25am to make their way up to the vestibule area.[71]

    b. She estimated it was 5-10 minutes after exiting the toddler pool to the time they exited the pool gates, meaning that they exited the pool gates around 10:30-10:35am.[72]

    c. Daniel said that he made a phone call at 10:38am which lasted about 90 seconds,[73] and that they were alerted to the emergency in the council offices a couple of minutes after that, probably around 10:41am.[74]

    d. It would have taken several more minutes for Katherine to gather the Council keys, run to the pool, try the front gate, try the side gate, scale the fence, reach Kumanjayi and begin CPR.

60. While no precise time line is possible, it would seem unlikely that Katherine could have begun CPR before around 10:45am, and it is likely to have been sometime between 10:45-10:50am.[75] The gap between Kumanjayi being left behind, and CPR commencing is therefore likely to have been 10 minutes or

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[69] T34 (Day 1, Dr Sarah).
[70] Dr Sarah, Statement at 4 (Folder 4, Folio 22); T36.
[71] T98 (Day 2, Team Leader).
[72] Team Leader Interview at 39 (Folder 3, Folio 10)
[73] T 12 (Day 1, Daniel). Note the available CCTV time stamps appeared inaccurate and did not assist in determining time frames.
[74] Daniel Interview at 2, (Folder 4 Folio 17).
[75] Daniel Interview at 31-32 (Folder 4, Folio 17); Katherine Interview at 3 (Folder 4, Folio 19); Paul Rigney Interview at 36-37 (Folder 3, Folio 13); RN Susan Interview at 4 (Folder 4 Folio 23); T16 (Day 1, Daniel); T23 (Day 1, Katherine).

more. Sadly, children can drown in a matter of minutes and there was more than enough time for this tragedy to occur. Everyone knew that time was of the essence, and every second of frantic delay contributed to the likelihood of a tragic outcome.

Kintore ELC

Regulatory context

61. To understand the regulatory arrangements applicable to the Kintore ELC, it is necessary to briefly describe its funding arrangements. From 2 July 2018 onwards and including at the date of the drowning, the Kintore ELC was in receipt of Commonwealth funding under an arrangement known as the Community Child Care Fund Restricted program (CCCFR), with a stated purpose of supporting childcare services to address barriers in participation with a particular focus on disadvantaged and vulnerable communities.[76] Before CCCFR funding, the Kintore ELC received funding under the Budget Based Funding program ("BBF").

62. Early learning centres which received BBF funding prior to 2 July 2018, such as the Kintore ELC, are exempted from the national uniform law which otherwise applies to childcare centres, namely, the *Education and Care Services National Law* (the "National Law") and the regulations made under the National Law, (the "National Regulations").[77] Instead the Kintore ELC was regulated by various requirements for approval and continuation of its Commonwealth funding, including by s 49(2) of the Child Care Subsidy Minister's Rules, and via the conditions of the grant agreement between the Commonwealth and the MRC, under which the service was funded (the "Funding Agreement"). The service was also regulated by other provisions of

[76] Affidavit of Anne Twyman affirmed on 29 July 2024 (Anne Twyman Affidavit) at [9]-[10].
[77] Anne Twyman Affidavit at [36]-[39]; The Kintore ELC was also not regulated by Northern Territory legislation.

the Family Assistance Law, which includes requirements relating to nominated persons for management and control.[78]

63. Section 49(2) of the Minister's Rules is concerned with quality and safety. That section requires that the relevant service provide high quality child care appropriate to the needs of families and community, having regard to the provider's ability and commitment to meet the following six requirements:

    (a) Providing a tailored individual education program for children;

    (b) Developing a program that acknowledges and strengthens the cultural identity of children;

    (c) Ensuring children are **adequately supervised**;

    (d) Ensuring reasonable **precautions are taken to protect children from harm and injury**; and

    (e) Ensuring at least one staff member who holds current first aid qualifications is on duty at all times.

    (Emphasis added)

64. Further, s 49(9) of the Minister's Rules requires that each provider is to have, within 6 months after approval of the service, a written Quality Improvement Plan that assesses the services strengths and weaknesses against each of the seven key quality areas of what is known as the National Quality Standards ("NQS").[79] The NQS sets a national benchmark for early childhood education and care services and outside school hours care services in Australia.

65. Therefore, while the National Law and National Regulations did not apply to the Kintore ELC, Kintore ELC (and other similarly funded childcare services) were still subject to quality and safety requirements. Additionally, those

[78] Anne Twyman Affidavit at [38], T286.
[79] T285 (Day 4, Anne Twyman).

services are required to be "working towards" the standards set by the National Laws and National Regulations.[80]

66. Separately, under the funding agreement with the Commonwealth (the "Funding Agreement"), MRC was required to prepare an annual compliance and operations report concerning the Kintore ELC (and a number of other services operated by MRC in remote communities and funded pursuant to the CCCFR), to the Commonwealth.

67. The obligations under s 49 and the Funding Agreement apply at the provider level, in this case, to MRC.

68. Due to the Commonwealth's role in the CCCFR program under which the Kintore ELC was funded, the Commonwealth (through the Department of Education, who provides the funding) was granted leave to appear at the inquest. That was appropriate because, among other things, the regulatory regime for the Kintore ELC was linked to the funding arrangements. It became apparent from the Commonwealth's evidence at the inquest, that it had taken the death of Kumanjayi very seriously and had responded by commissioning a number of reviews, engaging the regulator in the Northern Territory to conduct site visits, and having training modules developed by the Australian Children's Education and Care Quality Authority (ACECQA). Ms Anne Twyman, who appeared for the Commonwealth at the inquest, was an impressive witness, who informed the inquest in detail of the specific steps that have been taken in response to this tragedy, and what is proposed going forward.

Management arrangements for the Kintore ELC

69. The management structure for the Kintore ELC was as follows. The 'Manager Children's Services' at MRC was an Alice Springs-based position, occupied by

[80] T 286 (Day 4, Anne Twyman).

Margaret Harrison from March 2013 until September 2021.[81] Ms Harrison reported to 'Director Community Services' also based in Alice Springs,[82] occupied by Rohan Marks (who was also acting as acting CEO on 2 December 2020).[83]

70. Reporting to Ms Harrison were the 'Co-ordinator Children's Services' positions, also based in Alice Springs.[84] The role of the Co-ordinators was to oversee the delivery of the programs in the remote communities. In addition to Kintore, the remote communities included Mount Liebig, Papunya, Haasts Bluff, Hermannsburg, Areyonga, Santa Teresa, Titjikala, and Finke.[85] In each remote community, including Kintore, the service was headed by a Team Leader who each reported to a Co-ordinator. The Team Leader in each location was the most senior person based in each community, and responsible in the community for the delivery of the service.[86] Finally, there was the position of 'Educator Early Learning'. These were the childcare workers (Educators) reporting to the Team Leader in each remote location.[87]

71. On 2 December 2020, the positions at the Kintore ELC based in Kintore were occupied by a Team Leader, Educator 1, and Educator 2. The Team Leader's substantive position was Co-ordinator but she had been filling in for about a week as the Team Leader because the previous Team Leader had resigned.[88] Accordingly, at that time she was both the Co-ordinator (covering Kintore, Papunya, Mount Liebig and Haasts Bluff), as well as the Team Leader in Kintore.[89] Apparently this was not unusual, I heard that Co-ordinators regularly filled in for Team Leaders.

[81] T 168 (Day 3, Margaret Harrison)
[82] Supplemented Documents, Folio 1 at 25.
[83] T133.
[84] Supplementary Documents, Folio 1, p 23.
[85] Statement of Margaret Harrison at 3, Additional Documents, Folio 6.
[86] Supplemented Documents, Folio 1 at 21.
[87] Supplementary Documents, Folio 1 at 30.
[88] Third Team Leader Interview, Brief, Folio 3, Tab 10 46-47, T88.
[89] T88, (Day 2, Team Leader).

Policies and procedures in place at the Kintore ELC as at 2 December 2020

72. During the hearing of the inquest, there was differing evidence around the policies and procedures which were in place at MRC (and at Kintore ELC) on 2 December 2020.

73. A document titled 'MacKids Operations Manual', and dated July 2020 was tendered into evidence.[90] That document contains detailed policies and procedures, including for excursions, based on the National Law and National Regulations with respect to various matters. The excursion policy requires that a risk assessment be conducted for excursions and that parental authorisation is obtained.[91]

74. Given that much of this document was based largely on the National Law and National Regulations, the contents of the 'MacKids Operations Manual' are relatively detailed and, at an upper management level, appear to contain appropriate policies and procedures including those around safety and supervision.[92]

75. With respect to the status of the 'MacKids Operations Manual', Ms Harrison gave evidence to the effect that:

    a. there were earlier forms of policies and procedures that she and others developed over time;[93]

    b. in 2018 MRC purchased an off the shelf set of policies which could be modified to suit their purposes;[94]

[90] Folder 2, Folio 28 USB, MacDonnell Shire Documents.
[91] Page 86 of the MacKids Operations Manual, July 2020 (Folder 2, Folio 28 USB, MacDonnell Shire Documents).
[92] Dr Allison Elliot, expert report at 5.
[93] T 173-174, Exhibit 8 (tendered).
[94] T 174.

c. the 'MacKids Operations Manual' dated July 2020 was the result of that modification;[95]

d. it was not necessary for council to ratify that document – it only required the Director in charge, to approve it;[96]

e. that document came into force in July 2020;[97]

f. Co-ordinators all had a copy of the document;[98]

g. Team Leaders had been emailed the document;[99]

h. Team Leaders were brought into Alice Springs for training around three times a year and its implementation would have been talked about then.[100]

76. In cross-examination Ms Harrison conceded that there had been no formal approval of the document,[101] but did not resile from the position that Co-ordinators were aware of the document.[102]

77. However, three separate Co-ordinators said that the first time they say they saw the 'MacKids Operations Manual' was after the drowning incident.[103] In particular, the Kintore Co-ordinator/Team Leader gave evidence that MRC did not have formal policies and procedures in place for the early learning centres. In evidence there was this exchange:

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[95] T 174.
[96] T123.
[97] T123.5
[98] T124.6
[99] T125.5
[100] 124.8
[101] T266.6
[102] T589
[103] Affidavit of Helen M, Affidavit of Helen F. The Team Leader, Kintore, says she first saw it attached to a disciplinary letter from Rohan Marks and Ms Harrison in February 2021.

> Q. And so just to clarify. You're saying there was no document which had the status of a policy document that team leaders in remote communities would have access to, is that right?
>
> A. That's correct. When I started, there was nothing and my understanding was that there had been some kind of draft ones. But Margaret said that hadn't been ratified by the council. So basically there were no ratified reported policies for the childcare services.[104]

78. MRC produced an earlier (July 2016) version of the 'MacKids Operations Manual' during the hearing. It was evident that policy development had been ongoing over the years. Notably, as pointed out by MRC in submissions, both the 2016 versions and 2020 versions of the document included excursion policies, which required risk assessments for excursions.

79. That there was a need for an 'excursion policy' was well understood. The 'MacKids Operations Manual' dated July 2020 included the following requirements regarding a risk assessment:

> We will conduct a risk assessment prior to any excursion...Risk assessments are required for excursions that are regular …if a risk assessment has not been conducted within the last 12 months of the excursion date. Regular outings are walks, trips to places that we visit regularly which always have the same risks. We will consider the following as part of the risk assessment:
>
> - Any risk that the excursion may pose to the safety, health and wellbeing of any child and identify how these risks will be managed and minimized
>
> - Proposed route and destination

[104] T90 (Day 2, Team Leader).

- Any water hazards
- Any risks associated with water based activities
- Transportation (to and from)
- The ratio of educators and children which must comply as a minimum with the ratios in the Staffing Arrangements Policy…;

and contained an 'Authorisation for Excursion Form', which alerted parents/guardians to the risk assessment, and required their written consent.

80. Also tendered into evidence was a sample 'Excursion risk management plan'.[105] That sample plan was a plan for a regular excursion every Wednesday "walking from the Early Learning Centre to the pool by the most direct route and returning by the same route". That document then set out in detail precisely the sort of risks and risk-mitigation necessary for such an excursion, including:

    a. Educators/adults allocated to children to be responsible for and help during the excursion;

    b. supervising adults must be within an arm reach [sic] of all children in the water at all times;

    c. children need to be constantly accounted for at all times whilst on the excursion.

81. In spite of those manuals, plans and pro-forma examples, there was no written risk assessment produced in evidence for the regular excursion from the Kintore ELC to the Kintore Pool. There were some references to one having been completed by a former team leader (who had recently resigned) at Kintore.[106] However, the inability of the Kintore ELC and MRC to locate any written document means that it is more likely that one did not exist. Even if some

[105] Folder 2 Folio 28 USB, MacDonnell Shire Documents folder.
[106] T115 (Day 2, Team Leader).

written document had existed at some point, there was no effective risk management plan (or similar) in place for the excursion to the Kintore Pool on 2 December 2020. There was also no evidence that any 'Authorisation for Excursion' had been completed or signed by any parent or guardian.

82. In summary, on the evidence presented, while there were in existence (ratified or otherwise) relevant policies and procedures on the issues, there was no documented risk assessment for the excursion to the Kintore Pool and nor was there any written parental/guardian authorisations for any child.

83. A further major shortcoming, identified by Dr Alison Elliot, a childcare expert who produced an expert report for the inquest at the request of NAAJA, was that there were no documents in everyday language to simplify and explain the key aspects of the 'Mackids Operational Manual' relating to day-to-day care issues, including supervision and safety. Dr Elliot considered a number of documents in evidence, including a document titled 'Handbook for New Early Learning Educators' as well as a document titled 'MacKids Induction Manual', but she concluded these did not fulfill this function particularly with respect to safety and supervision.[107] I agree with that conclusion.

84. Regardless of the status of the 'MacKids Operations Manual', as at 2 December 2020 there was a failure to properly implement policies and procedures at the Kintore ELC in a language and manner applicable to that service, and in particular, there was a failure to ensure that safety and supervision policies and procedures were documented in an appropriate format at the Kintore ELC. I note the evidence of the current CEO of MRC, Ms Belinda Urquhart, that MRC has commenced taking steps to translate policies and procedures into language in recent times.[108]

[107] Dr Alison Elliott, Expert Report dated July 23 2024 (Elliot Expert Report) at 5[27]-6[30], 7[38], 10[52], 13[72], 14[74]. Dr Elliott did identify the "End of Day Lock Up Story" page of the Handbook for New Early Learning Educators as a significant inclusion in that document. See 10[55].
[108] Affidavit of Belinda Urquhart dated 8 July 2024 (Urquhart Affidavit) at [14(d)], (Additional Documents, Folio 5).

85. While the focus was on the policies and procedures around excursions, the evidence raised other areas of concern with respect to Kintore ELC. It has already been pointed out that the sign-in sheet on 2 December 2020 did not accurately record the children in attendance, and that this was not unusual. That obviously raises concerns as to how children can be appropriately cared for if they are not properly accounted for.[109] Dr Elliot in her report described this as a "systemic failure".[110]

86. Further, issues with supervision at Kintore ELC more generally were identified by MRC itself in its 2019/2020 Quality Improvement Plan, which stated the following "weakness" under "Children's Health and Safety": [111]

> Educators to improve supervision of children to be aware of all children and what they are doing.
>
> Training and mentoring of supervision levels required.

87. There was also evidence that a child, who had not been signed in, was subsequently left locked inside another early learning centre operated by MRC, for over two hours. [112] It is concerning, because that incident occurred less than two months prior to Kumanjayi's drowning. This further supports the position that there were more general and widespread issues with supervision at the early learning centres operated by MRC.

Training of staff

88. The Co-ordinator/Team Leader started at MRC in September 2019. The Co-ordinator/Team Leader had significant experience in the early learning sector, including as a trainer of educators in childcare for around three years, prior to commencing in the Co-ordinator role at MRC.[113] There was no documentary

[109] Elliot Expert Report, at [97].
[110] Elliot Expert Report at [96].
[111] Additional Documents, Folio 14.
[112] CCCF Service Serious Incident Report dated 21 October 2020 (Additional Documents, Folio 36, Tab 13)
[113] T86 (Day 2); Folder 2, Folio 28 USB, MacDonnell Shire Documents, Team Leader (CV).

evidence of any formal induction for the Co-ordinator/Team Leader when she commenced as Co-ordinator in September 2019, but she said that she completed an orientation.[114]

89. The Co-ordinator/Team Leader completed a renewal of first aid qualifications and a CPR refresher on 9 March 2019. A CPR refresher, which is due each year, was not completed in 2020 due to the COVID-19 pandemic.[115]

90. Although she was not appraised of the 'MacKids Operations Manual' there was evidence that the Co-ordinator/Team Leader was part of the rollout of an 'Excursion Risk Management Plan', and she had tasked other Team Leaders to develop them, for routine excursions (to be updated annually).[116] The Co-ordinator/Team Leader gave evidence that she believed that a finished version of the risk management plan for the Kintore Pool excursion had been provided to Ms Harrison, but she had never seen it herself,[117] although she understood that the principles around the supervision of children in early learning centres were "to keep children in sight and hearing at all times, and work…wherever possible, particularly with younger children, to keep them within arm's length [sic] of you."[118]

91. There was also no documentary evidence that either of the Kintore Educators had completed a formal induction, or training specific to supervision or excursions. Educator 1 said that she had not been trained about any rules for looking after the children.[119] Educator 2 said that she had received some training on the job about feeding and bathing the children, but not about supervision and excursions, and in particular there was no evidence that she had

[114] Investigation Report of Gottlieb Thomas Svikart dated 24 January 2021 (Svikart Report) at 5.
[115] Team Leader Interview at 55-56 (Brief Folio 6, Tab 10); T 116 (Day 2, Team Leader).
[116] T109 (Day 2, Team Leader).
[117] T93 (Day 2, Team Leader).
[118] T86 (Day 2, Team Leader).
[119] Educator 1 interview at 15 (Folder 3, Folio 7); T73 (Educator 1, Day 2)

been trained on how to keep the children safe during the excursions to the Kintore Pool.[120]

92. The Co-ordinator/Team Leader had only arrived in Kintore the week before the incident to fill in as Team Leader.[121] However, this excursion had been occurring every Wednesday for some time,[122] meaning that the lack of a risk assessment, consent forms, and training of Educators can be understood as a systemic issue, rather than a failing of any one person.

93. As this case has tragically proven, a reliance on common sense and the work ethic of the care workers was insufficient to mitigate the risk posed by this excursion. Instead, the well-known process of a thorough risk-assessment ought to have ensured that specific risks from this activity were properly identified and addressed through risk mitigation measures.

Checks and balances at the Kintore ELC

94. MRC in closing submissions pointed to the 2016 version of the 'MacKids Operations Manual', which mandated a risk assessment, and submitted in closing submissions that the "failure of these important checks and balances cannot be said to be the result of inadequate training or unsatisfactory policy development or distribution..." [123] I disagree.

95. There ought to have been a system at MRC to ensure that:

    a. a risk management plan had been documented and implemented, and

    b. that the staff received appropriate training on it.

96. In her evidence, Ms Harrison further conceded that there ought to have been a system for ensuring that the Co-ordinators had checked that the risk

[120] T49, T67, T71-72 (Educator 2, day 2) Educator 2 interview at 12 (Folder 3, Folio 6).
[121] T93 (Day 2).
[122] T73 (Day 2, Educator 1).
[123] MRC Closing Submissions at [40].

assessments had been completed, and the failure to have such a system in place "was a shortfall". [124]

Conclusions on the Kintore ELC

97. Had appropriate policies and procedures, including a risk management plan of the type contemplated by the 'MacKids Operation Manual' of 2016 or 2020 been properly implemented for the weekly excursion to the Kintore Pool, the risks of this excursion, including the risk at the time of changing in the vestibule area, would likely have been considered, and steps taken to reduce the risk. It is a cruel irony that the sample risk management plan in evidence set out precisely the sort of risk mitigation measures which likely would have prevented the death of Kumanjayi if properly implemented. In particular, steps such as ensuring that particular adults had been briefed on their role, and that they were given specific responsibility for particular children, and ensuring that children were accounted for at all times (which one would expect would include measures such as counting them out at the time of exit), would have made it far less likely that a child could be left behind.

98. It is clear from the events on the day that there were a number of possible distractions for the childcare workers once they reached the vestibule area to change the children and depart. However, it is precisely those kinds of scenarios that a risk assessment could identify and seek to deal with – it cannot be said that the sorts of distractions that occurred in the vestibule area were out of the ordinary.

99. The Co-ordinator/Team Leader blamed herself for this tragedy, readily admitting to police in an interview soon after the incident that "its my fault 'cause I didn't double check afterwards",[125] and stating "I'm responsible for all the kids so I'm responsible for this."[126] During the inquest she also made

[124] T157 (Day 3, Margaret Harrison).
[125] Team Leader Interview at 7 (Folder 3 Folio 10).
[126] Team Leader Interview at 7(Folder 3 Folio 10)

appropriate concessions, including that the supervision on the walk to the pool was inadequate.[127] I accept her evidence as a truthful and honest account.

100. But despite any failings which might be attributed to the Co-ordinator/Team Leader on the day, one must not lose sight of the fact that this excursion was occurring regularly, including prior to the Co-ordinator/Team Leader's arrival in Kintore. Since the regular excursion started, there was no objective evidence that there was ever a documented risk management plan for this obviously high-risk activity. Without such a plan to mitigate the risk, the risk of such a tragedy occurring was always going to be high.

101. The failure of the MRC to have a documented risk assessment for this excursion, which was properly implemented through appropriate training, was a significant failing that contributed to the death of Kumanjayi.

102. That failing was part of a more general failure by MRC to implement and promulgate a clear set of policies and procedures for the Kintore ELC, and to ensure that Co-ordinators, Team Leaders and Educators were given the necessary training to keep children safe.

The pool

Requirements for policies and procedures for public pools such as Kintore Pool

103. The Kintore Pool was also operated by MRC. Accordingly, another focus of the inquest was on the policies and procedures in place at the Kintore Pool, whether they were adequate, and whether they were followed on the day.

104. The inquest was assisted by the expert report and evidence of RJ Houston, General Manager, Capability and Industry, of Royal Life Saving Society - Australia. Mr Houston is a specialist in, among other things, public pool safety and management.

[127] T87.5 (Day 2, Team Leader).

105. Mr Houston explained that the safety standards applicable to remote public pools in the Northern Territory, such as the Kintore Pool, are based on the Guidelines for Safe Pool Operations (GSPO). The GSPO are published by Royal Life Saving Australia through a subscription service and constitute a set of detailed specifications and recommendations establishing best practice design and operations for aquatic locations in Australia. In addition, Royal Life Saving Australia (or its State and Territory arms) offer safety assessments of aquatic centres. Both the subscription service and the assessments are voluntary. He explained that the GSPO emphasises a risk-based approach, assessing the likelihood and consequences of incidents while considering the context and resources available to the facility.[128]

106. Kintore Pool received an aquatic safety assessment in 2014 from Royal Life Saving NT Branch (2014 Aquatic Safety Assessment),[129] which recommended (among other recommendations) that:

> … a risk assessment be completed to determine supervision needs at the facility to manage patron safety. The risk assessment should consider but not be limited by the following:
>
> - users of the facility and swimming ability
> - type of activities undertaken
> - size, number and layout of pools
> - the design of the pools themselves….
>
> This risk assessment should be recorded and retained as part of the facilities [sic] overall risk management process.[130]

[128] T194 – 196 (Day 3, RJ Houston).
[129] (Folder 1, Folio 11).
[130] 2014 Aquatic Safety Assessment, Appendix B (Safety Improvement Plan), Item No 13.1, (Folder 1, Folio 11).

107. Based on the GSPO and the 2014 Aquatic Safety Assessment there should have been a policy in place which required a risk assessment of this excursion. MRC conceded that this was not done.[131]

108. Mr Houston explained that such the policy and risk assessment should be communicated to the public, including any adult with a child in their care coming to the pool: [132]

> Every parent, guardian, user group that enters a pool, best practice would be that they receive a briefing on the Keep Watch at Public Pools sort of policy, which means if you have two children under five with you, you have to keep them within arm's reach.

109. Mr Houston pointed out that there was "shared responsibility" between the childcare workers and the lifeguard at the Kintore Pool for the safety of the children. A risk assessment should have identified the shared responsibility and clarified how it was to be shared.[133] For example, while it would probably not be appropriate for the lifeguard to be supervising children in a change room[134] it would be common to have a final sweep of the facility by the lifeguard (including of change rooms) as part of documented closing procedures.[135] Indeed, MRC submitted that this was a matter of "basic common sense",[136] conceded that there was no risk assessment for this excursion in place,[137] and acknowledged that Kumanjayi would likely have been located unharmed had there been a final sweep by the life guard.[138]

110. Mr Houston said that the failure to have a risk assessment for this excursion was a significant omission.[139] Indeed, it was alarming that following the 2014

[131] MRC Closing Submissions at [118].
[132] T198.
[133] T207.
[134] T204
[135] T204.
[136] MRC Submissions, para 118.
[137] MRC Submissions at para 118.
[138] MRC Submissions, para 119.
[139] T207.

Aquatic Safety Assessment there was no evidence of any response to the improvement recommendations.

The policies and procedures that were in place at the pool as at 2 December 2020

111. Although there was an Operations Manual for the Kintore Pool,[140] it was not clear whether the version tendered in evidence was in force as at 2020. [141] In any event, the tendered operations manual did not contain the policies and procedures of the type described as necessary by Mr Houston, and in particular, did not contain any risk assessments for any of the activities at the pool, nor any guidance on patron supervision. I agree with the submission of NAAJA that the Operations Manual is clearly inadequate.

112. A document titled 'Swimming pool daily facility management plan' was also tendered.[142] This document contains a list of closing duties which included blowing a whistle three times, to signal the pool is closing, and conducting a check of the toilets, but it also failed to address the critical issues of patron supervision or risk assessments.

113. Although a version of the GSPO was held at the pool as at 2 December 2020[143] it was not clear whether that document was complete or up to date. Even so, as explained by Mr Houston, the GSPO represents the standards and guidelines by which a suite of policies and procedures, including a risk assessment for this particular pool and excursion, should have been developed, and there were no such policies and procedures.

114. The absence of clear and documented policies and procedures at Kintore Pool, including a risk assessment for this particular excursion, was a significant failing on the part of MRC and contributed to the death of Kumanjayi.

[140] Folder 2, Folio 28 USB, MacDonnell Shire Documents, "Kintore Pool Operations Manual"
[141] 2014 Aquatic Facility Safety Assessment at 10 (Folder 1, Folio 11).
[142] Swimming pool daily facility management plan at 315 (Supplemented Documents, Folio 1).
[143] Aquatic Facility Safety Assessment at 10 (Folder 1, Folio 11); 2021 Aquatic Facility Safety Assessment at 7 (Folder 1, Folio 12).

Pool fence

115. When the pool originally opened in 2008, there was an internal fence around the adult pool. That fence was not maintained. It fell into disrepair and was removed in late 2016.[144] As NAAJA pointed out in their submissions, it was seemingly removed without any assessment as to whether that was appropriate.[145] There were no MRC records documenting the reason for the removal, or of risk assessments or plans to mitigate risk either before or after its removal.

116. After this tragedy, some community members were in favour of the internal fence being reinstalled and, although the pool remains closed, a new internal fence has been installed by MRC.

117. As to the wisdom of an internal pool fence, Mr Houston explained that usually there are no internal fences in a public pools because the fence can obstruct a lifeguards view of the pool (by itself or, for example, when objects are propped against it or towels hung over it) and it can hinder access in emergencies. But he emphasized that the question of whether there should be an internal fence should be part of a systematic approach to risk. In other words, there should be a risk analysis and risk assessment to determine whether the benefits of having such a fence outweigh the risks, and to identify how the risks can best be managed.[146] There is no evidence that such a risk management assessment was conducted before the fence was reinstated by MRC. If the decision was made without the benefit of consultation with Royal Life Saving Australia, then that is astonishing and disturbing and demonstrates a continuing lack of understanding by MRC as to how to safely manage remote pool assets.

[144] Urquhart Affidavit at [8]; Simon Murphy, Statutory Declaration (Folder 4, Tab 34).
[145] NAAJA Closing Submissions at [147[.
[146] T 225-228.

Pool gate locks

118. Concerning the failure to have a back-up access plan to the pool, Mr Houston said that this risk and a response to this risk should have been identified and addressed in an emergency management plan, as one part of the suite of policies and procedures governing the pool. Such a plan might, for example, require that a spare key is held in a key safe near the gate.[147] However, as there was no emergency management plan, this type of risk was not considered or addressed.

119. Any delay in accessing the pool increased the risk to Kumanjayi. The failure to have an emergency management plan for accessing the pool was a significant failing by MRC which likely contributed to the death of Kumanjayi.

The pool management

120. At the time of this tragedy, the MRC Co-ordinator of Aquatic Facilities and Projects (the Pool Co-ordinator) had been in the role since 2019[148] having worked her way up from the role of receptionist in 2011. For three remote pools, including Kintore, she described her role as being in charge of approving time sheets for pool team leaders, getting the materials they requested, hiring staff and supporting the pool Team Leaders.[149] The Pool Co-ordinator was hired to the role with no pool related training or expertise and she relied on the pool Team Leaders to manage the pools on the ground.[150]

121. Mr Rigney, the lifeguard, was also the Team Leader at the Kintore Pool. He commenced that role in 2017[151] and reported to the Pool Co-ordinator. He did not appear at the inquest and police efforts to locate him were unsuccessful. Mr Rigney was said to be an experienced lifeguard and swimming teacher, who had completed a significant amount of training including, on 15 October 2020, refresher training in the Royal Life Saving competencies in first aid, emergency

[147] T 232-233.
[148] Statement of Pool Co-ordinator at 5, Additional Dcouments, Folio 7.
[149] Statement of Pool Co-ordinator at 2 , Additional Documents, Folio 7.
[150] Statement of Pool Co-ordinator at 3, Additional Documents, Folio 7.
[151] Rigney employment documents, Folder 2 Folio 28 USB MacDonnel Shire Documents.

care, administering oxygen, supervising clients in aquatic locations, and advanced water rescues. He also had a current Pool Lifeguard certificate awarded from that organisation on 15 October 2020 which was valid for one year.[152]

122. In an interview with police soon after the drowning, Mr Rigney stated that his duties were to "supervise swimmers that come into the swimming pool, clean the swimming pool, maintenance of the swimming pool and pump area." However, Mr Rigney was unable to say specifically what was required in terms of supervision of swimmers, [153] including requirements around headcounts.[154]

123. As the Pool Co-ordinator did not have the expertise or training to enable her to assess the adequacy of the safety arrangements at the pools she was responsible for, [155] this meant that the Pool Team Leader and the pools policies and procedures were not subject to proper scrutiny or oversight. The lack of any checks and balances in the management and oversight of the Kintore Pool, and in particular, the failure to have someone with the appropriate experience overseeing and checking the operational safety and compliance of the pool, was a significant contributing factor to the failure to have policies and procedures around the excursion from the Kintore ELC to the Kintore Pool.

124. The 2014 Aquatic Safety Assessment[156] conducted by Royal Life Saving Society Australia of the Kintore Pool returned an overall safety score of 27%.[157] As noted above, the assessment identified that there was no risk assessment in place to determine and address supervision needs at the facility and included a recommendation to conduct a risk assessment in relation to supervision needs. There was no evidence that any of this was ever considered or acted upon by MRC. It can therefore be inferred that the lack of proper management

[152] Rigney employment documents, Folder 2 Folio 28 USB MacDonnell Shire Documents.
[153] Rigney employment documents at 26, Folder 2 Folio 28 USB MacDonnell Shire Documents
[154] Rigney employment documents at 29, Folder 2 Folio 28 USB MacDonnell Shire Documents.
[155] Pool Co-ordinator Statement at 14, Additional Documents, Folio 7.
[156] 2014 Safety Assessment at 10 (Folder 1, Folio 11).
[157] 2014 Safety Assessment at 10 at 7 (Folder 1, Folio 11).

oversight of the Kintore Pool by MRC was ongoing for many years, and was occurring before both the Pool Co-ordinator and Mr Rigney took up their responsibilities with respect to the pool.[158]

125. In response to the drowning of Kumanjayi, a further safety audit was conducted in 2021. At that time the total safety score was 34%.[159]

126. Mr Houston, expressed his "serious concern" that there had not been traction and movement on the 2014 recommendations.[160] It is inexcusable that fundamental steps such as conducting the supervision risk assessment were not actioned before Kumanjayi's passing.

127. The CEO of MRC, Ms Urquhart, said that the management of MRC pools is now outsourced to the YMCA. However, regardless of who is operating its swimming pools, MRC is ultimately responsible to ensure they are properly and safely operated. This is not a responsibility that can be outsourced. MRC believed that Mr Rigney was well qualified to manage the pool and yet he failed to implement policies and procedures identified as necessary in the GSPO and the 2014 safety assessment. MRC is responsible for establishing a proper system of oversight to ensure that its pool policies and procedures are sufficient, adequate and implemented.

Should the excursion have been permitted at all?

128. The evidence called for me to consider whether a pool excursion could ever be appropriate for this young cohort. Dr Elliot thought not. She said that "it was not appropriate to take a group of infants, toddler and pre-schoolers to a public swimming pool as part of an early learning program at Kintore ELC."[161] She

[158] Ms Lang started in her role in 2019 (Statement of Zoe Lang, Additional Documents, Folio 7, p 4-5), and Mr Rigney started in 2017 (Folder 2 Folio 28 USB, MacDonnell Shire Documents, Rigney (CV).
[159] Aquatic Facility Safety Assessment conducted 2 March 2021 (Folder 1, Folio 12).
[160] T197 (Day 3, RJ Houston).
[161] Elliot Expert Report at [42].

could not identify an educational purpose and she considered it too great a risk to justify. She said:

> had there been appropriate planning and risk analysis for the excursion to the Kintore Pool, it's unlikely that the excursion would occurred [sic] as it would not have been considered an appropriate or safe activity for very young children.[162]

129. On the other hand, Mr Houston said that:

> [i]n the context of these pools in remote communities, these pools were built for child care workers and kids to come and be able to use the pool. This is a sanctuary in a sense and a relief from the heat in some cases. They're meant to be social connectors. They're meant to be a place of fun and physical activity. So there should be sufficient procedures in place to make sure that anyone that comes to visit the pool can do so safely.[163]

130. Mr Houston also gave evidence of the benefits to remote communities and children that pools bring, with reference to the Western Australian experience. He explained how, in Western Australia, a co-ordinated and "holistic" approach between government, the community and schools, brought health and other benefits to those communities:

> So there's this really integrated, kind of, approach to working together with other services and really thinking holistically about the function that the pool can play, not just for swimming and water safety and a place to cool off, but as a kind of a social and health - I suppose, assistance in those communities as well. And there's - there's some data, there's some really great research that's come out of WA, looking at those health benefits. It's a bit old now, but… for example … [w]hen

[162] Elliot Expert Report st [42].
[163] T199.

> the pool closes at the end of the season, the school attendance goes down and the health conditions tend to go up as well. So there's some - there's some really great evidence to show the power of these pools in community where they're well-resourced and well-supported.[164]

131. In light of Mr Houston's evidence, it would be surprising if children in an early learning context in remote Northern Territory communities could not take part in safe and beneficial programs and activities at remote swimming pools.

132. However, the only way that one might properly reach a conclusion about whether an excursion of this type should occur is by conducting a risk assessment, as contemplated by both the GSPO for the pool, and as required by the 'MacKids Operations Manual' of July 2020 for the day care centre. It is therefore neither necessary nor appropriate for me to make a finding on this question. In respect of any future decisions, risk assessments must be conducted and will guide the answer.

Svikart report

133. Part of MRC's response to the drowning of Kumanjayi was to commission a 'Report on Drowning Incident at Kintore on 2 December 2020' by Gottlieb Thomas Svikart, dated 24 January 2021 ("Svikart Report").[165] The stated scope of the report was "to examine events on the day in the context of interviews and the documents provided and to identify any conspicuous failures in staff performance practice or policy."[166] In light of Ms Harrison's evidence it is odd, to say the least, that he was not provided with the 'MacKids Operations Manual' (of any date) for consideration in his review.[167] Nor was he provided with the 2014 Aquatic Safety Assessment. Accordingly, he was not made aware of the requirements for risk assessments as set out in both those documents,[168]

[164] T240.
[165] Additional Documents, Folio 1.
[166] Additional Documents, Folio 1, p1.
[167] Svikart Report, Additional Documents, Folio 1, p2.
[168] The risk assessment sample he was provided with does not refer to the mandated excursion policy, or any other policies.

and his investigation ignored critical information. Given the obvious limitations of his report I did not find it helpful.

Other matters raised

134. In its written submissions NAAJA raised its concern that criminal charges which had been brought against the Team Leader were dismissed pursuant to s 111(1) of the *Local Government Act 2008 (*NT) (the "2008 Act").[169] That section provided:

> No civil or criminal liability attaches to a staff member for an honest act or omission in the performance, or purported performance, of official functions under this or another Act.

135. The 2008 Act was repealed and replaced by the *Local Government Act 2019* (NT) (the "2019 Act") in 2021, which contains a similar immunity from both civil and criminal liability at s 182(1):

> A person is not civilly or criminally liable for an act done or omitted to be done by the person in good faith in the exercise of a power or performance of a function as a member of staff of a council.

136. NAAJA's submissions were to the effect that equivalent provisions in other jurisdictions in Australia only provide protections for civil liability. The Northern Territory is the only jurisdiction which protects against criminal liability.

137. NAAJA referred me to the statutes and case law in other jurisdictions as well as the second reading speeches and explanatory memoranda for the 2008 and 2019 Acts in the Northern Territory, to support their submission that there is no policy justification for the broad immunity available from criminal liability in the Northern Territory.

[169] *Michael Court v [Team Leader]* [2024] NTLC.

138. I agree with NAAJA's submission that there appears to be no good policy reason for providing immunity from criminal liability in this form in the 2019 Act, and that this provision appears to be somewhat of an anomaly.

139. I therefore include a recommendation relating to possible law reform of this provision.

Unresolved matters and possible ways forward

140. On the Sunday 28 July 2024, the day before the inquest began, the Walungurru Law and Justice Group graciously invited myself and interested parties to visit Kintore. The purpose of the visit was to meet with families, listen to community grief and concerns and briefly explain the inquest process. It was also an opportunity to conduct a view.

141. The community meeting was very well attended by Kumanjayi's extended family and a ceremony conducted at the pool was a testament to their love for Kumanjayi and the strength of their culture. I am grateful and humbled to have been included in their ceremony and I extend my sincere thanks.

142. It was heartbreakingly apparent that the grief of the family and the community was still raw and acute, and there were many unresolved issues and frustrations. The family were upset that they still did not know the true story about what happened to Kumanjayi.

143. I was alarmed to learn that neither the pool nor the day care centre had re-opened since his passing. This was affecting the whole community and, most particularly, all the other young children were missing out on these important developmental opportunities. There were very different perspectives about these ongoing closures.

144. Douglas Lovegrove, of the Aboriginal Justice Unit in the Department of the Attorney-General and Justice, facilitated the contact with the Walungurru Law

and Justice Group, and gave evidence of the details of the visit.[170] His evidence, together with other evidence heard over the five days of the inquest confirmed much of what was said at the community visit. For example, Kumanjayi's father, Simon Jurrah, said it hurt him only to find out a little bit at a time.[171] Kumanjayi's grandmother, Magdelena Marshall, also stated in her evidence:

> The hardest thing for us is not understanding the full story about what happened to Kumanjayi and why it happened. It has been a long time snice Kumanjayi passed and we still don't have answers.[172]

145. During the course of the inquest it became clear that a concerted process to heal fractured relationships and to explore the possibility of reopening facilities had been grossly neglected and was long overdue. Melinda Tew and Gary Childs, from the Community Justice Centre, gave evidence concerning the possible benefits of facilitated mediation services. Both the Commonwealth and MRC have recognised that a process of mediation and repair is likely to take a long time and needs adequate long term funding and professional support.

146. Albeit belatedly, it is pleasing that since the evidence has concluded the Commonwealth and MRC have been working together to facilitate a mediation process. On 24 September 2024 the Commonwealth and MRC advised they are continuing to take steps, in conjunction with the Walungurru Law and Justice Group, to progress a mediation/restorative justice process in Kintore. I trust this will continue in good faith and with sufficient longer term funding after the findings have been handed down. I request that a final report be provided on the process and its outcomes and, if such a report is received, it will be published as a response alongside these findings on the inquest website.

[170] T321 – 327 (Day 5).
[171] Affidavit of Simon Jurrah at [14].
[172] Affidavit of Magdalena Marshall dated 29 July 2024 at {15].

Formal findings

147. Pursuant to section 34 of the *Coroner's Act 1993* I make the following findings:

    a. The identity of the deceased is Kumanjayi Jurrah;

    b. The death occurred at the Pintupi Homelands Health Service, Kintore Community (also known as Kintore clinic), on 2 December 2020, at 11:39am;

    c. The cause of death was accidental drowning.

Recommendations

148. I make the following recommendations:

1. That expert mediation services be engaged by MRC to assist in determining:

a. what are the concerns of the community and family,

b. what restoration they consider is necessary; and

c. whether, and if so how, the childcare and pool services can be restored in Kintore.

2. Concerning the Kintore Pool, that MRC ensure that:

a. there is consultation with Royal Life Saving Northern Territory with respect to any re-commissioning of the Kintore Pool;

b. any recommendation made by Royal Life Saving Northern Territory with respect to the re-commissioning be properly considered and appropriate actions taken.

3. Concerning any of the pools it operates (including Kintore Pool should it re-open), MRC to ensure that:

a. regular auditing by way of aquatic safety assessments is conducted by Royal Life Saving Northern Territory for those pools (including pools subject to management agreements with the YMCA);

b. MRC develop, in consultation with Royal Life Saving Northern Territory, emergency management plans to ensure that access to swimming pools is possible at all times;

c. any recommendations made by Royal Life Saving Northern Territory with respect to a. and b. above be properly considered and appropriate actions taken;

d. to the extent that any of steps a – c above require involvement from the YMCA as contracted manager of any pool, that MRC ensures that the YMCA is involved as appropriate and necessary.

4. Concerning childcare services, MRC is to ensure it has policies and procedures formally in place which reflect appropriate safety standards and is to ensure that the relevant staff, including Co-ordinators, Team Leaders and Educators are provided with the training and guidance necessary to ensure that the standards can be achieved in practice.

5. MRC to work pro-actively in engaging with the relevant Commonwealth department in order to implement Recommendation 4.

6. MRC to develop appropriate critical community incident management policies and procedures for dealing with critical incidents such as the incident on 2 December 2020, including restorative procedures and practices.

7. That the Attorney-General refer the question of possible reform of s182 of the *Local Government Act* 2019 (NT), to the Northern Territory Law

Reform Committee for consideration as to whether the immunity from criminal liability available under that provision should be removed or amended.

Australian Government
Department of Education

PIC CC 24-030

A New Tax System (Family Assistance) (Administration) Act 1999

Public Interest Certificate

I, Rachel O'Connor, A/g First Assistant Secretary, Early Learning Programs and Youth Division, of the Department of Education (the department), make this instrument under paragraph 168(1)(a) of the *A New Tax System (Family Assistance) (Administration) Act 1999*.

Dated 26th June 2024

Disclosure of information in the public interest

1 Commencement

This instrument commences on the day it is signed.

2 Certification

In accordance with:

(a) paragraph 168(1)(a) of the *A New Tax System (Family Assistance) (Administration) Act 1999*; and

(b) section 9 of *the Family Assistance (Public Interest Certificate Guidelines) (Education) Determination 2018* (PIC Guidelines);

I certify that it is necessary in the public interest to disclose the information mentioned in section 4 to the class of persons mentioned in section 5 for the purpose mentioned in section 3 in circumstances where:

- the information is potentially relevant to the Inquest into the death of Kumanjayi Jurrah being conducted by the Office of the Coroner (Northern Territory) (the Inquest); and
- disclosure of the information for the purpose of the conduct of the Inquest has been sought by the Office of the Coroner (Northern Territory) under correspondence dated 16 May 2024 and 18 June 2024.

3 Purpose for which information may be disclosed

The information mentioned in section 4 is being disclosed for the sole purpose of enforcement related activities - namely only for the preparation

for, and the conduct of, the proceedings in the form of the Inquest - set out in section 9 of the PIC Guidelines.

Enforcement related activities (s 9 of the PIC Guidelines)

I am satisfied, in accordance with section 9 of the PIC Guidelines, that:

- disclosure of the information mentioned in section 4 would facilitate an enforcement related activity, namely the preparation for, and conduct of, the proceedings in the form of the Inquest by the Coroner and the Coroner's counsel-assisting; and
- the class of persons mentioned in section 5 is an authority of the Northern Territory.

4 Information able to be disclosed

The information to be disclosed for the purposes described in section 3 are:

- the document titled, "Investigation of the operation of child care services by MacDonnell Regional Council" signed by Stephen Moger, Department of Education and information attached thereto.

5 Recipients of information

The information identified in section 4 may be disclosed to:

- the Office of the Coroner (Northern Territory) limited to:
    - the Northern Territory Coroner conducting the Inquest;
    - Counsel Assisting the Northern Territory Coroner conducting the Inquest;
    - such staff of the Officer of the Coroner involved in the conduct of the Inquest;
- interested persons to whom leave has been granted under s 40 of the *Coroners Act 1993* (NT) to appear in the Inquest; and
- any person assisting any interested person referred to above in the conduct of the Inquest.

Australian Government
Department of Education

PIC CC 24-036

A New Tax System (Family Assistance) (Administration) Act 1999

Public Interest Certificate

I, Emma Hill, Assistant Secretary, Access and Inclusion Branch, of the Department of Education (the department), make this instrument under paragraph 168(1)(a) of the *A New Tax System (Family Assistance) (Administration) Act 1999*.

Dated 19/7/24

Disclosure of information in the public interest

1 Commencement

This instrument commences on the day it is signed.

2 Certification

In accordance with:

(a) paragraph 168(1)(a) of the *A New Tax System (Family Assistance) (Administration) Act 1999*; and

(b) section 9 of *the Family Assistance (Public Interest Certificate Guidelines) (Education) Determination 2018* (PIC Guidelines);

I certify that it is necessary in the public interest to disclose the information mentioned in section 4 to the class of persons mentioned in section 5 for the purpose mentioned in section 3 in circumstances where:

- the information is potentially relevant to the inquest into the death of William Jurrah being conducted by the Office of the Coroner (Northern Territory) (the Inquest); and
- disclosure of the information has been sought by the Office of the Coroner (Northern Territory) under correspondence dated 9 July 2024.

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3 Purpose for which information may be disclosed

The information mentioned in section 4 is being disclosed for the sole purpose of enforcement related activities - namely only for the preparation for, and the conduct of, the proceedings in the form of the Inquest - set out in section 9 of the PIC Guidelines.

Enforcement related activities (s 9 of the PIC Guidelines)

I am satisfied, in accordance with section 9 of the PIC Guidelines, that:

- disclosure of the information mentioned in section 4 would facilitate an enforcement related activity, namely the preparation for, and conduct of, the proceedings in the form of the Inquest by the Coroner and the Coroner's counsel-assisting; and
- the class of persons mentioned in section 5 is an authority of the Northern Territory.

4 Information able to be disclosed

The information to be disclosed for the purposes described in section 3 are:

- the 51 documents identified at Schedule 1 to this public interest certificate.

5 Recipients of information

The information identified in section 4 may be disclosed to:

- the Office of the Coroner (Northern Territory) limited to:
  - the Northern Territory Coroner conducting the Inquest;
  - Counsel Assisting the Northern Territory Coroner conducting the Inquest;
  - such staff of the Officer of the Coroner involved in the conduct of the Inquest;
- interested persons to whom leave has been granted under s 40 of the *Coroners Act 1993* (NT) to appear in the Inquest; and
- any person assisting any interested person referred to above in the conduct of the Inquest.

Schedule 1 - Table of documents

	Document Title	Date/ Year Received
1.	Titjikala Early Learning Centre - Quality Improvement Plan 2019-2020FY	2019-2020FY
2.	Titjikala Early Learning Centre - Quality Improvement Plan 2019-2020FY (Final)	2019-2020FY
3.	Papunya Early Learning Centre - Quality Improvement Plan 2019-2020FY	2019-2020FY
4.	Kintore Early Learning Centre - Quality Improvement Plan 2019-2020FY	2019-2020FY
5.	Hermannsburg Early Learning Centre - Quality Improvement Plan 2019-2020FY	2019-2020FY
6.	Haasts Bluff Early Learning Centre - Quality Improvement Plan 2019-2020FY	2019-2020FY
7.	Finke Early Learning Centre - Quality Improvement Plan 2019-2020FY	2019-2020FY
8.	Docker River Early Learning Centre - Quality Improvement Plan 2019-2020FY	2019-2020FY
9.	Areyonga Early Learning Centre - Quality Improvement Plan 2019-2020FY	2019-2020FY
10.	Mount Liebig Early Learning Centre - Quality Improvement Plan 2019-2020FY	2019-2020FY
11.	Email between Ms Margaret Harrison and Ms Kylie Davenport regarding incident - 20 March 2020	20 March 2020
12.	Santa Teresa Early Learning Centre - Incident Report	April 2020
13.	Titjikala Early Learning Centre - Serious Incident Report	21 October 2020
14.	Email between Ms Margaret Harrison and Ms Kylie Davenport regarding serious incident - 26 October 2020	26 October 2020
15.	Kintore Early Learning Centre - Quality Improvement Plan October 2020-2021	2020-2021FY
16.	Email between Ms Margaret Harrison and Ms Kylie Davenport regarding serious incident - 7 December 2020	7 December 2020
17.	Email between Ms Margaret Harrison and Ms Kylie Davenport regarding incident - 10 December 2020	10 December 2020
18.	Email between Ms Margaret Harrison and DESE regarding serious incident - 10 December 2020	10 December 2020

19.	Mount Liebig Early Learning Centre - Quality Improvement Plan 2020-2021FY	2020-2021FY
20.	Titjikala Early Learning Centre - Quality Improvement Plan 2020-2021FY	2020-2021FY
21.	Papunya Early Learning Centre - Quality Improvement Plan 8 February 2021	2020-2021FY
22.	Santa Teresa Early Learning Centre - Quality Improvement Plan 12 February 2021	2020-2021FY
23.	Haasts Bluff Early Learning Centre - Quality Improvement Plan 12 February 2021	2020-2021FY
24.	Areyonga Early Learning Centre - Quality Improvement Plan 5 March 2021	2020-2021FY
25.	Hermannsburg Early Learning Centre - Quality Improvement Plan 19 March 2021	2020-2021FY
26.	Finke Early Learning Centre - Quality Improvement Plan 26 March 2021	2020-2021FY
27.	Docker River Early Learning Centre - Quality Improvement Plan 26 March 2021	2020-2021FY
28.	Areyonga Early Learning Centre - Quality Improvement Plan 2021-22FY	2021-2022FY
29.	Mount Liebig Early Learning Centre - Quality Improvement Plan 2021-2022FY	2021-2022FY
30.	Haasts Bluff Early Learning Centre - Quality Improvement Plan 2021-2022FY	2021-2022FY
31.	Finke Early Learning Centre - Quality Improvement Plan 2021-22FY	2021-2022FY
32.	Papunya Early Learning Centre - Quality Improvement Plan 2021-22FY	2021-2022FY
33.	Titjikala Early Learning Centre - Quality Improvement Plan 20 February 2022	2021-2022FY
34.	Hermannsburg Early Learning Centre - Quality Improvement Plan 20 February 2022	2021-2022FY
35.	Santa Teresa Early Learning Centre - Quality Improvement Plan 20 February 2022	2021-2022FY
36.	Areyonga Early Learning Centre - Quality Improvement Plan 2022-2023FY	2022-2023FY
37.	Mount Liebig Early Learning Centre - Quality Improvement Plan 2022-2023FY	2022-2023FY

38.	Haasts Bluff Early Learning Centre - Quality Improvement Plan 2022-2023FY	2022-2023FY
39.	Finke Early Learning Centre - Quality Improvement Plan 2022 (with comments)	2022-2023FY
40.	Docker River Early Learning Centre - Quality Improvement Plan 2022-2023FY	2022-2023FY
41.	Areyonga Early Learning Centre - Quality Improvement Plan 2023-2024FY	2023-2024FY
42.	Mount Liebig Early Learning Centre - Quality Improvement Plan 2023-2024FY	2023-2024FY
43.	Papunya Early Learning Centre - Quality Improvement Plan 2023-2024FY	2023-2024FY
44.	Hermannsburg Early Learning Centre - Quality Improvement Plan 1 April 2023	2022-2023FY
45.	Finke Early Learning Centre - Quality Improvement Plan 2023	2023-2024FY
46.	Haasts Bluff Early Learning Centre - Quality Improvement Plan 17 July 2023	2023-2024FY
47.	Hermannsburg Early Learning Centre - Quality Improvement Plan 18 March 2024	2023-2024FY
48.	Docker River Early Learning Centre - Quality Improvement Plan 6 April 2024	2023-2024FY
49.	Santa Teresa Early Learning Centre - Quality Improvement Plan 8 April 2024	2023-2024FY
50.	Quality Improvement Plan Matrix 2024	Updated 12 July 2024
51.	Titjikala Early Learning Centre - Quality Improvement Plan 2024 (Working Version)	2023-2024FY

Australian Government
Department of Education

PIC CC 24-034

A New Tax System (Family Assistance) (Administration) Act 1999

Public Interest Certificate

I, Emma Hill, Assistant Secretary, Access and Inclusion Branch, of the Department of Education (the department), make this instrument under paragraph 168(1)(a) of the *A New Tax System (Family Assistance) (Administration) Act 1999*.

15 July 2024

Disclosure of information in the public interest

1 Commencement

This instrument commences on the day it is signed.

2 Certification

In accordance with:

(a) paragraph 168(1)(a) of the *A New Tax System (Family Assistance) (Administration) Act 1999*; and

(b) section 9 of *the Family Assistance (Public Interest Certificate Guidelines) (Education) Determination 2018* (PIC Guidelines);

I certify that it is necessary in the public interest to disclose the information mentioned in section 4 to the class of persons mentioned in section 5 for the purpose mentioned in section 3 in circumstances where:

- the information is potentially relevant to the inquest into the death of William Jurrah being conducted by the Office of the Coroner (Northern Territory) (the Inquest); and
- disclosure of the information has been sought by the Office of the Coroner (Northern Territory) under correspondence dated 7 June 2024 and 9 July 2024.

3 Purpose for which information may be disclosed

The information mentioned in section 4 is being disclosed for the sole purpose of enforcement related activities - namely only for the preparation for, and the conduct of, the proceedings in the form of the Inquest - set out in section 9 of the PIC Guidelines.

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Enforcement related activities (s 9 of the PIC Guidelines)

I am satisfied, in accordance with section 9 of the PIC Guidelines, that:

- disclosure of the information mentioned in section 4 would facilitate an enforcement related activity, namely the preparation for, and conduct of, the proceedings in the form of the Inquest; and
- the class of persons mentioned in section 5 is an authority of the Northern Territory.

4 Information able to be disclosed

The information to be disclosed for the purposes described in section 3 are:

- the document titled, "Commonwealth Standard Grant Agreement between the Commonwealth represented by the Department of Education and Training and MacDonnell Regional Council" executed by the Commonwealth on 29 June 2018.
- the document titled, "Deed of Variation in relation to MacDonnell Regional Council" executed by the Commonwealth on 13 December 2018.
- the document titled, "Deed of variation in relation to Community Child Care Fund" executed by the Commonwealth on 28 February 2019.
- the email from Alison Kelly to Jeff Macleod titled, "2018-19 - MAC - Email - Compliance and Operations Report" dated 6 March 2019, with only the attachment titled, "Compliance and Operations Report 2018/2019" disclosed.
- the email from Margaret Harrison to Kylie Davenport titled, "Compliance and Operations reports for Kintore, MtLiebig, Papunya, Santa Teresa and Titjikala Early Learning Centres" dated 27 March 2019, with only the attachment titled, "Kintore 2018-2019 Compliance and Operations report" disclosed;
- the email from NT CCCF Restricted Team titled, "ACTION - Quality Improvement Plans", dated 9 July 2019.
- the email from Margaret Harrison to Education NT CCCF titled, "QIPs for Areyonga, Docker River, Haasts Bluff, Hermannsburg, Kintore, Mt Liebig Early Learning Centres" dated 1 September 2019, with only the attachment titled "QIP 2019 Kintore Final" disclosed.
- the document titled, "Deed of Variation No.3 in relation to Community Child Care Fund" executed by the Commonwealth on 14 October 2019.
- the email from NT CCCFR Team titled, "For action: Compliance and Operations Report due 31 March 2020" dated 28 February 2020, with the attachment titled "CCCFR COR template 19-20".
- the email from NT CCCFR Team titled "For action: Compliance and Operations Report due 31 March 2020" dated 5 March 2020, with the attachment titled "CCCFR COR template 19-20".

- the email from Margaret Harrison to DESE - NT CCCF Restricted titled, "Compliance and Operations Reports for Kintore, Mt Liebig, Papunya, Santa Teresa and Titjikala Early Learning Centres" dated 13 April 2020, with only the attachment titled "Kintore CCCFR COR 19-20 org" disclosed.
- the email from Kylie Davenport to Margaret Harrison titled, "MRC CCCF CORs - Feedback/Action Required" dated 1 May 2020.
- the email from Margaret Harrison to Kylie Davenport titled, "Response to Feed back and action required for the Compliance and Operations report" dated 5 May 2020, with the document titled "OCHRE CARD request" attached.
- the email from Kylie Davenport to Margaret Harrison titled, “RE: Completed Assessment: Response to Feed back and action required for the Compliance and Operations report” dated 11 May 2020.
- the document titled, "Deed of Variation in relation to extending for two years the Community Child Care Fund - Restricted (CCCFR) Grant Agreement with MacDonnell Regional Council" executed by the Commonwealth on 19 June 2023.

5 Recipients of information

The information identified in section 4 may be disclosed to:

- the Office of the Coroner (Northern Territory) limited to:
  - the Northern Territory Coroner conducting the Inquest;
  - Counsel Assisting the Northern Territory Coroner conducting the Inquest;
  - such staff of the Officer of the Coroner involved in the conduct of the Inquest;
- interested persons to whom leave has been granted under s 40 of the *Coroners Act 1993* (NT) to appear in the Inquest; and
- any person assisting any interested person referred to above in the conduct of the Inquest.

Australian Government
Department of Education

PIC CC 24-035

A New Tax System (Family Assistance) (Administration) Act 1999

Public Interest Certificate

I, Emma Hill, Assistant Secretary, Access and Inclusion Branch,of the Department of Education (the department), make this instrument under paragraph 168(1)(a) of the *A New Tax System (Family Assistance) (Administration) Act 1999*.

15 July 2024

Disclosure of information in the public interest

1 Commencement

This instrument commences on the day it is signed.

2 Certification

In accordance with:

(a) paragraph 168(1)(a) of the *A New Tax System (Family Assistance) (Administration) Act 1999*; and

(b) section 9 of *the Family Assistance (Public Interest Certificate Guidelines) (Education) Determination 2018* (PIC Guidelines);

I certify that it is necessary in the public interest to disclose the information mentioned in section 4 to the class of persons mentioned in section 5 for the purpose mentioned in section 3 in circumstances where:

- the information is potentially relevant to the inquest into the death of William Jurrah being conducted by the Office of the Coroner (Northern Territory) (the Inquest); and
- disclosure of the information has been sought by the Office of the Coroner (Northern Territory) under correspondence dated 3 July 2024.

3 Purpose for which information may be disclosed

The information mentioned in section 4 is being disclosed for the sole purpose of enforcement related activities - namely only for the preparation for, and the conduct of, the proceedings in the form of the Inquest - set out in section 9 of the PIC Guidelines.

L\354090973.11

Enforcement related activities (s 9 of the PIC Guidelines)

I am satisfied, in accordance with section 9 of the PIC Guidelines, that:

- disclosure of the information mentioned in section 4 would facilitate an enforcement related activity, namely the preparation for, and conduct of, the proceedings in the form of the Inquest; and
- the class of persons mentioned in section 5 is an authority of the Northern Territory.

4 Information able to be disclosed

The information to be disclosed for the purposes described in section 3 are:

- the document titled, "*CCCFR Quality and Safety Review - Aggregate Report*" prepared by PwC and dated July 2021, but not information that identifies services provided by providers other than MacDonnell Regional Council.

5 Recipients of information

The information identified in section 4 may be disclosed to:

- the Office of the Coroner (Northern Territory) limited to:
  - the Northern Territory Coroner conducting the Inquest;
  - Counsel Assisting the Northern Territory Coroner conducting the Inquest;
  - such staff of the Officer of the Coroner involved in the conduct of the Inquest;
- interested persons to whom leave has been granted under s 40 of the *Coroners Act 1993* (NT) to appear in the Inquest; and
- any person assisting any interested person referred to above in the conduct of the Inquest.

Australian Government
Department of Education

PIC CC 24-037

A New Tax System (Family Assistance) (Administration) Act 1999

Public Interest Certificate

I, Emma Hill, Assistant Secretary, Access and Inclusion Branch, of the Department of Education (the department), make this instrument under paragraph 168(1)(a) of the *A New Tax System (Family Assistance) (Administration) Act 1999*.

Dated 29 July 2024

Disclosure of information in the public interest

1 Commencement

This instrument commences on the day it is signed.

2 Certification

In accordance with:

(a) paragraph 168(1)(a) of the *A New Tax System (Family Assistance) (Administration) Act 1999*; and

(b) section 9 of *the Family Assistance (Public Interest Certificate Guidelines) (Education) Determination 2018* (PIC Guidelines);

I certify that it is necessary in the public interest to disclose the information mentioned in section 4 to the class of persons mentioned in section 5 for the purpose mentioned in section 3 in circumstances where:

- the information is potentially relevant to the inquest into the death of William Jurrah being conducted by the Office of the Coroner (Northern Territory) (the Inquest); and
- disclosure of the information has been sought by the Office of the Coroner (Northern Territory) under correspondence dated 22 July 2024.

3 Purpose for which information may be disclosed

The information mentioned in section 4 is being disclosed for the sole purpose of enforcement related activities - namely only for the preparation for, and the conduct of, the proceedings in the form of the Inquest - set out in section 9 of the PIC Guidelines.

L\354262858.11

Enforcement related activities (s 9 of the PIC Guidelines)

I am satisfied, in accordance with section 9 of the PIC Guidelines, that:

- disclosure of the information mentioned in section 4 would facilitate an enforcement related activity, namely the preparation for, and conduct of, the proceedings in the form of the Inquest by the Coroner and the Coroner's counsel-assisting; and
- the class of persons mentioned in section 5 is an authority of the Northern Territory.

4 Information able to be disclosed

The information to be disclosed for the purposes described in section 3 are:

- the affidavit of Anne Twyman; and
- the exhibit to that affidavit marked "AT".

5 Recipients of information

The information identified in section 4 may be disclosed to:

- the Office of the Coroner (Northern Territory) limited to:
  - the Northern Territory Coroner conducting the Inquest;
  - Counsel Assisting the Northern Territory Coroner conducting the Inquest;
  - such staff of the Officer of the Coroner involved in the conduct of the Inquest;
- interested persons to whom leave has been granted under s 40 of the *Coroners Act 1993* (NT) to appear in the Inquest; and
- any person assisting any interested person referred to above in the conduct of the Inquest.

Australian Government
Department of Education

PIC CC 24-043

A New Tax System (Family Assistance) (Administration) Act 1999

Public Interest Certificate

I, Anne Twyman, First Assistant Secretary, Early Learning Programs and Youth Division, of the Department of Education (the department), make this instrument under paragraph 168(1)(a) of the *A New Tax System (Family Assistance) (Administration) Act 1999*.

Dated 23 August 2024

A Twyman.

Disclosure of information in the public interest

1 Commencement

This instrument commences on the day it is signed.

2 Certification

In accordance with:

(a) paragraph 168(1)(a) of the *A New Tax System (Family Assistance) (Administration) Act 1999*; and

(b) section 9 of *the Family Assistance (Public Interest Certificate Guidelines) (Education) Determination 2018* (PIC Guidelines);

I certify that it is necessary in the public interest to disclose the information mentioned in section 4 to the class of persons mentioned in section 5 for the purpose mentioned in section 3 in circumstances where:

- the information is relevant to the inquest into the death of Kumanjayi Jurrah being conducted by the Office of the Coroner (Northern Territory) (the Inquest); and
- disclosure of the information has been sought by the Coroner under correspondence from Mr Paul Morgan, Counsel-assisting the Coroner, of 7 August 2024.

3 Purpose for which information may be disclosed

The information mentioned in section 4 is being disclosed for the sole purpose of enforcement related activities - namely only for the preparation

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for, and the conduct of, the proceedings in the form of the Inquest - set out in section 9 of the PIC Guidelines.

Enforcement related activities (s 9 of the PIC Guidelines)

I am satisfied, in accordance with section 9 of the PIC Guidelines, that:

- disclosure of the information mentioned in section 4 would facilitate an enforcement related activity, namely the conduct of the proceedings in the form of the Inquest by the Coroner and the Coroner's counsel-assisting; and
- the class of persons mentioned in section 5 is an authority of the Northern Territory.

4 Information able to be disclosed

The information to be disclosed for the purposes described in section 3 are:

- the Commonwealth's closing submissions dated 26 August 2024 to the extent they contain protected information.

5 Recipients of information

The information identified in section 4 may be disclosed to:

- the Office of the Coroner (Northern Territory) limited to:
    - the Northern Territory Coroner conducting the Inquest;
    - Counsel Assisting the Northern Territory Coroner conducting the Inquest;
    - such staff of the Officer of the Coroner involved in the conduct of the Inquest;
- interested persons to whom leave has been granted under s 40 of the *Coroners Act 1993* (NT) to appear in the Inquest; and
- any person assisting any interested person referred to above in the conduct of the Inquest.