

CITATION: *Inquests into the deaths of Karen Bading, Ms Dick and David Hardy*
[2025] NTLC 015

TITLE OF COURT: Coroners Court

JURISDICTION: Darwin

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Meliodosis; Comorbidities; Health/Risk
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quarantine.

Coroners Act 1993 (NT), ss 34, 39.

APPEARANCES:

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Instructed by the Coroner's Office of the Northern Territory

For the family of Ms Dick Ms F Keppert
Instructed by NAAJA

For the Department of Health: Mr L Peattie
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Introduction

1. On 11 March 2020, the World Health Organisation declared Covid-19 to be a global pandemic. Eight days later, the Chief Health Officer of the Northern Territory (**CHO**) declared a public health emergency. The next day, the Chief Minister closed the Northern Territory's borders to the rest of Australia. By the end of the week, five of Australia's States and Territories had followed suit.
2. These inquests examine the causes and relevant circumstances of the deaths of three people who died during the Northern Territory's response to this unprecedented public health emergency: Karen Bading, David Hardy and Ms Dick.¹ Although in many respects the lives of these three individuals were lived worlds apart, a common link is that they each died in late 2021 or early 2022 while, or shortly after, residing at the Centre for National Resilience (**CNR**), the quarantine facility established jointly by the Australian and Northern Territory governments, and ultimately managed by the Northern Territory government, in Howard Springs.
3. While the purpose of the inquest is to be reflective and analytical with a view to identifying any issues, it is important to note at the outset that the Northern Territory was, and has been seen by many as, a great success story of the Australian COVID experience. It was most fortunate that COVID levels remained low for much of the pandemic. It was highly fortunate that those in the Northern Territory, especially the medically vulnerable, were spared the experiences that the rest of mainland Australia endured.
4. In no small part, this uniquely Territorian experience of Covid-19 was due to the commitment of staff at the Department of Health, Police Fire and Emergency Services and others involved in the Northern Territory's Covid-19 response. I wish to recognise the tireless, and selfless, efforts of these individuals, in particular, staff at the CNR and members of the Rapid Assessment Team (**RAT**) who deployed to remote communities, like Robinson River, which were experiencing Covid-19 outbreaks.

¹ This name is used at the request of Ms Dick's family.

Ms Dick

5. Ms Dick was born on 2 October 1971 in Mount Isa, Queensland. She grew up in Doomagee, just across the border from Borroloola and Robinson River. It was in Robinson River that she became a much-respected member of her community. She was in a relationship with Freddie Jackson, her husband, for 36 years. They had three children together, Nicole, Farron and Shandell.

Responding to an outbreak of Covid-19 in a remote community

The ‘Contain and Test’ strategy

6. For those living in the Northern Territory during the ‘Covid years’, and particularly those in government and the public health sector, the period was one of great anxiety. The Northern Territory is home to many hundreds of Aboriginal communities—some in urban centres such as Bagot Community or Minmarama in Darwin or the Town Camps of Alice Springs; others in regional centres, like Katherine or Tennant Creek; and yet others in much more remote parts of the country, in places like Robinson River in the Barkly Region of the Gulf of Carpentaria.
7. Early modelling by the Commonwealth and Northern Territory Governments, as well as NGO and academic researchers, predicted that a COVID-19 outbreak in a remote Indigenous community, if not controlled, would be devastating. Some of that modelling suggested that rates of mortality in an unvaccinated community during an uncontrolled outbreak could be as high as 30 percent.
8. As a result, the Northern Territory and Commonwealth Governments and NGOs began developing strategies to manage Covid outbreaks in remote communities. One of these strategies, developed jointly by the Commonwealth and the Northern Territory, with significant input from Aboriginal controlled health organisations, became known as the ‘Contain and Test’ strategy.
9. The Contain and Test strategy recognised that indigenous communities, and in particular remote indigenous communities, presented with very specific risks. One risk factor was the high rates of chronic illness and co-morbidities for Covid-19, that

predisposed many Aboriginal persons to a much higher risk of severe, or even fatal, Covid-19 infection. Another was the geographic distance and associated isolation from specialised healthcare of many such communities. Yet another was the inadequate and overcrowded living conditions in communities of highly interconnected households, which meant that an uncontrolled outbreak in a remote community was likely to spread rapidly.

10. The Contain and Test strategy recognised that in order to effectively manage an outbreak of Covid in a remote indigenous community, it was necessary to rapidly respond, test, and then isolate positive cases and close contacts. Considering the level of overcrowding in such communities, it was recognised that in many cases the only practicable way of isolating people from each would be to remove them from the community.

The ROMP and the RAT

11. The response to COVID-19 in the Northern Territory was delivered under the Territory Emergency Plan.² While the Plan is primarily used to respond to natural disasters such as cyclones or floods it can also be used to respond to any emergency.³
12. The Territory Emergency Plan establishes an Emergency Management and Coordination Structure, including a chain of command which features Cabinet and the Security and Emergency Management Sub-Committee of Cabinet (**SEMSC**) on the first and second levels of the hierarchy, respectively. On the third level of the hierarchy is the Hazard Management Authority, which changes according to the type of emergency. As a public health emergency, NT Health (the **Department**) was the Hazard Management Authority for the COVID-19 pandemic.⁴

² [RB 3-5] Affidavit of Dr Ruth Derkenne of 17 February 2023, [21].

³ [RB 3-5] Affidavit of Dr Ruth Derkenne of 17 February 2023, [21].

⁴ [RB 3-5] Affidavit of Dr Ruth Derkenne of 17 February 2023, [23].

13. The emergency response was largely coordinated from a central point, known as the Emergency Operations Centre (**EOC**). During the pandemic, the EOC was based at the Berrimah Police Station.⁵
14. To facilitate the Contain and Test strategy, the Department, in consultation with relevant stakeholders, developed policies to guide the response to a remote COVID-19 outbreak. The key policies were:
- (a) the Northern Region COVID-19 Close Contact Evacuation and Transport Guideline (**Close Contact Evacuation Guideline**);
 - (b) the Remote Outbreak Management Plan (**ROMP**); and,
 - (c) the COVID-19 Outbreak Management Plan Remote Community – Health Subplan.⁶
15. Under these policies, and, in particular, the ROMP, a two-stage scaled response to an outbreak in a remote community was contemplated. Those stages, as summarised in the affidavit of Dr Ruth Derkenne, were as follows:

(a) Immediate Deployment of the Rapid Assessment Team

When a positive case of COVID-19 was confirmed to be in a community, a Rapid Assessment Team (**RAT**) was to be immediately deployed. The RAT is a multidisciplinary team comprised of staff from Police, Health and a Logician. A representative from Welfare may also be present, if deemed necessary.

The RAT was designed to provide an initial surge capacity to the local workforce and had to be self-sufficient for the first 72 hours in community. During this initial period, the RAT was required to establish a green zone, engage with the Local Emergency Committee and Local Controller, and assess the immediate needs of the community. This included the provision of food and emergency assistance to holistically support a community quarantine period of 14 days.

(b) Sustained Deployment of the Rapid Response Team

Based on the assessment of the RAT, and taking into consideration the size of the community and likely extent of the outbreak, additional personnel would be deployed as a Rapid Response Team (**RRT**),

⁵ [RB 3-5] Affidavit of Dr Ruth Derkenne of 17 February 2023, [24].

⁶ [RB 3-5] Affidavit of Dr Ruth Derkenne of 17 February 2023, [32].

including members from Police, Health and Welfare groups. Once an RRT was in place, the focus shifted from an immediate surge response, to supporting the ongoing needs of the community for a full a quarantine period.

16. As Dr Derkenne noted, the ROMP stated that positive cases and their close contacts were to be evacuated in line with the Close Contact Evacuation Guideline.⁷ The extent to which these policies did, and were understood to, require the consent of those being evacuated was an issue in the inquest.

A note on the Robinson River response

17. There was no disagreement during this inquest and I am satisfied that, from a public health perspective, the outbreak in Robinson River was managed exceptionally well. In particular, the implementation of the Contain and Test strategy by the RAT, and others at the CDC, quickly stopped the spread of the virus within Robinson River,⁸ where modelling suggested that the virus would spread to 99.9% of the community within two months⁹ and would likely result in a large number of deaths.¹⁰ Indeed, approximately 20% of the close contacts identified in the Robinson River outbreak subsequently showed signs of infection, demonstrating the transmissibility of the virus.¹¹ Despite this, no-one from Robinson River passed away from COVID-19. These results were achieved despite this being the first community outbreak in the Territory.¹² Dr John Boffa, the Public Health Officer at the Congress, who originally proposed the Contain and Test model in the Territory, said:

The Northern Territory Government outbreak response in Robinson River is an exemplar to the nation. They have fully implemented the contain and test strategy. All positive people and their primary contacts flown out to HS. Everyone else tested, vaccinated and supported. WOW.¹³

18. Nevertheless, a number of issues were identified during the inquest of things that could have been done differently, or better. The focus on that small number of

⁷ [RD 3-9] Affidavit of Janine Hawkes of 7 February 2023, [41].

⁸ Transcript of Proceedings on 10 April 2024, 262-263.

⁹ [RB 3-5] Affidavit of Dr Ruth Derkenne of 17 February 2023, [37].

¹⁰ Transcript of Proceedings on 19 April 2024, 713-714.

¹¹ Affidavit of Charles Hawkhurst Pain dated 17 February 2023, [42].

¹² Transcript of Proceedings on 19 April 2024, 716.

¹³ 00000177-Photo-2021-11-18-12-25-06 within WhatsApp Chat – Robbo Rats.

issues in what follows should not be allowed to distract from the success of the response to the outbreak at Robinson River.

The deployment of the RAT from 15 November 2021

19. On 14 November 2021, a man and a woman returned a positive test result in Katherine. The woman had spent time in Robinson River, visiting and staying in several houses, resulting in the first outbreak in a remote community in the Northern Territory.
20. Between around 2:00pm and 5:00pm on the afternoon of 15 November 2021, members of the RAT team were contacted by more senior employees in the Department and informed of a likely deployment. The members of the RAT who deployed that same day were:
 - (a) Ms Janine Hawkes – as the Health Lead, Ms Hawkes was responsible for the health component of the deployment, including coordinating community swabbing and screening, maintaining infection control and liaising with the CDC, who were responsible for contact tracing;¹⁴
 - (b) Sergeant Caragh Hen – as the Police Lead, and Forward Commander, Sgt Hen was primarily responsible for liaising with the local community, and assisting the health team to swab, screen and then evacuate the community;
 - (c) Emily Vintour-Cesar – Health Administration Support;
 - (d) Jebet Kipsaina – Clinical;
 - (e) Kylie Tune – Clinical;
 - (f) Chris Harden – Police;
 - (g) David O’Keefe – Police;
 - (h) Nathan Trevena – Fireperson and logistician; and,

¹⁴ [RD 3-9] Affidavit of Janine Hawkes of 7 February 2023, [2],[24].

(i) Nathan Prasad – Environmental Health Officer.

21. Ms Hawkes, for example, recalled being contacted at around 2:00pm, and informed that she was being stood up as a member of the RAT for deployment to an outbreak of Covid-19 in a remote community.¹⁵ She was asked to meet at the EOC in Berrimah. Ms Hawkes recalled leaving her work desk at the Menzies School of Health and going home to prepare for her deployment.¹⁶
22. From around 3:00pm, members of the RAT began to arrive at the EOC where they were introduced to one-another and received a briefing from the then Health Commander, Josie Curr.¹⁷ It is likely that briefing occurred between 5:00 and 7:00pm that evening, although the precise timing is unclear.
23. The best record of the content of the briefing is contained in a document titled ‘RAT Deployment Robinson River – Briefing #1’.¹⁸ The document described the key ‘Objectives’ of, and ‘Arrangements’ for, the RAT deployment. The relevant part of the document is as follows:

Objectives of RAT

- Assessment of situation on the ground
- Set up of the Green zones
- Evacuation of positive cases and identified close contacts
- Testing of essential workers and community residents
- Increase Vaccinations

Arrangements

Team deployed from Darwin at 1900hrs on Airwing and Careflight planes

9 members as per team members list (Police, Health and Logistician)

¹⁵ [RD 3-9] Affidavit of Janine Hawkes of 7 February 2023, [27].

¹⁶ [RD 3-9] Affidavit of Janine Hawkes of 7 February 2023, [27].

¹⁷ [RD 3-9] Affidavit of Janine Hawkes of 7 February 2023, [28]; [RD 3-14L] Affidavit of Kylie Tune of 20 June 2022, [35]-[36].

¹⁸ [RD 3-9] Affidavit of Janine Hawkes of 7 February 2023, [30] and JH-5. I note that the document describes the briefing ‘as at 2130hrs 15/11/21’. Based on the timing of their deployment to Robinson River from approximately 8:00pm, it is unlikely that this could record the time the briefing was provided. Whether this means the annotation was incorrect, or records the time the minutes of the briefing were settled, or something else, was not interrogated. Notwithstanding that uncertainty, the uncontested evidence of Ms Hawkes was that this document reflected the briefing that was given to the RAT members assembled at the Peter McAuley centre on 15 November 2021.

Community has a good use of English

Green zones identified - School and Police Station

Vehicles for use by RAT being deployed from Borroloola – 2 hire cars, school also has a bus and Troopy that can be used. Borroloola Police will set up the relevant road blocks. FERG member will collect equipment from the airport and transport to the community

Store has been closed by the community but can be opened if required. Store well stocked.

Robinson River School closed.

Good vaccination rates - 87% for first dose and 77% for double dose.

IT and Access

3G service - good telecoms limited data. School on satellite

Health will have 1 laptop and 2 tablets - also taking 2 printers with wireless access

Police 2 laptops - not sure about access...this is limited there is wifi at school and Clinic

McArthur River Mine - Has isolated itself from the community but willing to offer support as required (e.g. use of vehicles) Transport - Planes leaving Darwin on Tuesday 16 November 2021 at 0600hrs and 0800hrs - can - take 5 people each flight

Additional staffing resources - Alice Springs Police RAT members and Darwin Health RAT members placed on Standby

Waste water collection and testing to be conducted¹⁹

24. At around 8:00pm, the RAT deployed to Robinson River in two planes, arriving in the community around midnight.²⁰ The first team to arrive immediately began deep cleaning the school bus that was to be used by the RAT during the period of their deployment.²¹ The bus then returned to airport and collected the RAT members who had arrived on the second plane.²²
25. Upon arriving at the Robinson River School, the RAT established it as the ‘Green Zone’ for their deployment. This involved cleaning and disinfecting classrooms that were used as accommodation, the school library which was used as a centre of

¹⁹ [RD 3-9] Affidavit of Janine Hawkes of 7 February 2023, [30] and JH-5.

²⁰ [RD 3-9] Affidavit of Janine Hawkes of 7 February 2023, [34].

²¹ [RD 3-14L] Affidavit of Kylie Tune of 20 June 2022, [42].

²² [RD 3-14L] Affidavit of Kylie Tune of 20 June 2022, [42].

operations, and a kitchenette for catering. This process continued until around 3:00am on the morning of 16 November 2021.²³ It is unlikely that any member of the RAT slept for more than two hours, if they slept at all.

16 November 2021

26. At 6:00am on the morning of 16 November 2021 Ms Hawkes and Sgt Hen led a briefing of the RAT members, to determine tasks and priorities for that day.²⁴ Sergeant Hen reiterated that the RAT's role was to facilitate and support the community lock down, to test the population and trace the outbreak, and to maintain communication with stakeholders. Sergeant Hen's priority was to establish communication with local stakeholders, while Ms Hawkes' priority was to arrange for the first round of swabbing to occur.²⁵

27. At around that time, the RAT were provided with the details of three community members who it was anticipated might assist them to liaise or communicate with the community. Those community members were Jasmine Campbell, Kevin Liddy and Richard 'Dickie' Dickson.²⁶ Sgt Hen, in particular, insisted that a strong line of communication was necessary with community, and that this communication would be best facilitated by engaging closely with these community leaders. I find that the RAT did engage closely with the community leaders. As Ms Hawkes noted,

we would often ask Mr Dickson and other Elders, "tomorrow, we are going to swab everyone in each house, do you want us to set up in the street or for us to go to each house?" and they would decide what the best approach would be.

28. The majority of the first day was dedicated to swabbing and screening community members, so that this information could be relayed back to the CDC. It is important to recognise the extraordinary human effort that this required from the RAT. On this, and the following days in community, the small team worked very long hours, dressed in full PPE, in the sun, in temperatures of up to 40 degrees.

²³ [RD 3-14L] Affidavit of Kylie Tune of 20 June 2022, [43].

²⁴ [RD 3-14L] Affidavit of Kylie Tune of 20 June 2022, [45].

²⁵ [RD 3-9] Affidavit of Janine Hawkes of 7 February 2023, [35],

²⁶ [RD 3-9] Affidavit of Janine Hawkes of 7 February 2023, [35]; [RD 3-14L] Affidavit of Kylie Tune of 20 June 2022, [45].

17 November 2021

29. Although the RAT were responsible for testing, and gathering information to assist contact tracing, it was the CDC, and other staff of the Department outside Robinson River, who were responsible for making decisions about evacuation.
30. On 17 November 2021, ‘a decision was made to evacuate those members of the Robinson River community that had been identified as close contacts, as well as the people who had recently returned positive results’.²⁷ Ms Vintour-Cesar considered it likely that this decision had been communicated before 8:48am, when she received an email from the CDC containing a list of ‘Close contacts currently quarantining at Robinson River’.²⁸ I consider that to be consistent with the emails that followed it.
31. At 10:05am, Ms Vintour-Cesar replied to the CDC’s 8:48am email, with ‘a final list of close contacts for evacuation’.²⁹ The list included each of the close contacts identified in the CDC’s list, and one additional close contact which had been identified overnight by Ms Paxton, the clinic manager. Ms Vintour-Cesar’s email concluded by stating:
- My understanding is that these will all be flown out to CNR, please keep us up to date with the plans there so that we can ensure clear communication to community.
32. At the inquest, Ms Vintour-Cesar confirmed that by this statement she was conveying her understanding that each of the close contacts were being flown out of the community.³⁰ There is no reference in the email to obtaining ‘consent’ from any of the close contacts, nor the possibility that one or more of the close contacts might elect to remain in the community.
33. At some point between 8:30am and 10:52am, Ms Vintour-Cesar, Ms Hawkes and Sgt Hen spoke by phone to Laura Francis at the CDC. The best record of this conversation is contained in an email sent by Ms Francis to the RAT members at

²⁷ [3-16] Affidavit of Emily Vintour-Cesar of 8 June 2022, [38].

²⁸ Transcript of Proceedings on 9 April 2024, 68.

²⁹ [3-16] Affidavit of Emily Vintour-Cesar of 8 June 2022, [41].

³⁰ Transcript of Proceedings on 9 April 2024, 68.

10:52am. The email listed three close contacts from a particular house in the Robinson River Community, before continuing:

Thanks Em, Janinie and Caragh for the phone call;

Action points

- The 3 listed above are first priority for movement to CNR this morning, [Person] 1 [REDACTED] is a child and before we expand the transport list to further household contacts, we should verify who needs to accompany her before adding to the extra seats on the plane other close household contacts. None of these have been contacted as yet by CDC, communication with clients is an issue
- Lulu from the clinic is the best liaison for the case management team at CDC to contact about speaking to the cases. Could we please have her best contact details to pass onto the team. It would best for the cases to be interviewed somehow to a prior to transport via a phone in the house if possible.
- Jordan is happy to have input into what to communicate with cases to expect regarding transfer to CNR.
- They should know at least they need to bring clothes, medications, phones if available etc. I think Caragh your suggestion of a community flyer drop would be excellent
- [REDACTED] is a name that has come up this morning, but is not on the list of close contacts, could we please confirm if she is in the community
- In addition to the 3 listed above if the escort/s of the child can be identified plus additional close contacts from house 19 can be confirmed for the first plane to 8 make up 8 total, with an approximate weight of each please

I don't think there is anything else, once we have the names confirmed asap, I can send through the list to the transport EOC, MGLO, health commander and CNR³¹

34. Few, if any, of the RAT members called at inquest had an independent memory of this conversation. Ms Vintour-Cesar could not recall anything about it that was not summarised in the email,³² though she could recall a conversation in which Ms Paxton was identified as the person who would tell people about going to Howard

³¹ Affidavit of Laura Frances of 5 August 2022, LF-1 at p 16.

³² Transcript of Proceedings on 9 April 2024, 69.

Springs.³³ Ms Vintour-Cesar recalled that ‘we thought it would be best’ for Ms Paxton to have these conversations with community, given what we assumed to be Ms Paxton’s established relationship with the community.³⁴ When asked ‘What was the conversation she was going to have with community members, as you understood it?’, she answered:

As I understood it, the conversation would be around letting them know that they were either positive or a close contact for COVID-19. Letting them know the – that the plan was to evacuate to CNR because of that, and telling them what they would need, and telling them how long it would be for. In that email – in the action points, you can see that there’s somebody else who has been mentioned [who] is happy to have input into what to communicate with cases to expect regarding transfer to CNR. They should at least know to bring clothes, medication, phones if available, et cetera. In my mind, Lulu was also doing some of that.

35. At 10:59am, Ms Francis sent a further email:

Attached is the list we are working off to prioritise the contacts and cases being transferred out of Robinson River today to CNR

First on the list as priority are the 3 names highlighted in the email below and the team on the ground will provide a further 5 names based on who needs to escort the child below, with the balance of the first plane made of other close household contacts from house 19.

Information for transport: patient weight, RAT team to assist Information for CNR: testing regime to be confirmed.

36. Ms Hawkes spoke to Ms Paxton by phone and informed her that she was to start communicating with the community. As Counsel Assisting submitted, it can be inferred from the email at [38] below, that this phone call occurred shortly before 11:07am. Ms Vintour-Cesar agreed that this must have been the sequence.³⁵

37. In her affidavit prepared on 7 February 2023, Ms Hawkes stated that during this conversation she told Ms Paxton that she was required to obtain ‘informed consent’ from each of the community members who was to be evacuated to the CNR. Ms Paxton denied that she was ever told this. Ultimately, while I cannot rule out that Ms Hawkes did ask Ms Paxton to obtain ‘informed consent’ from each community

³³ Transcript of Proceedings on 9 April 2024, 69.

³⁴ Transcript of Proceedings on 9 April 2024, 69.

³⁵ Transcript of Proceedings on 9 April 2024, 70.

member, I consider this to be unlikely. More importantly, I accept Ms Paxton's evidence that she did not understand this to be the effect of what must have been a brief conversation, and that her understanding was reasonable. In my view, her understanding is consistent with:

- (a) the timing and brevity of the telephone call;
- (b) the fact that clinic staff would not have had any prior expectation that they were expected to obtain 'consent' or 'informed consent' from community members;
- (c) the fact that no Departmental policy, including the Borroloola Pandemic Action Plan which is likely to have been available to Ms Paxton in the clinic,³⁶ advised that consent was required before close contacts could be evacuated from community, or that obtaining such consent was a responsibility of clinic staff;
- (d) Ms Hawkes' evidence that the request to obtain informed consent did not reflect her understanding of Departmental policy, legal requirements, and nor was she trained on it;³⁷
- (e) the fact that there is no reference to this request in any of the documentary evidence, including the emails, text and WhatsApp messages and Ms Hawkes' notes (or indeed, to the issue of 'consent' at all);
- (f) Ms Paxton's evidence regarding the generally poor quality of communication between the clinic staff based in community, and at least some members of the RAT based in the green zone;³⁸

³⁶ Affidavit of Louise Paxton of 15 April 2024, [5]. See [4-8] Borroloola Local Pandemic Action Plan as at 30 November 2020.

³⁷ Transcript of Proceedings on 10 April 2024, 67.

³⁸ [RD 3-14E] Statutory Declaration of Louise Paxton of 23 March 2022, [7]-[9]. Ms Paxton noted, in evidence, that the quality of the communication with other members, such as Sgt Hen, was good: Transcript of Proceedings on 9 April 2024, 49.

- (g) the evidence of Ms Alcock that she did not know ‘what the consent process was’;³⁹ and,
- (h) the evidence of Ms Paxton and Ms Alcock regarding the conversations they subsequently had with the community, which could not be said to have involved the taking of informed consent.

38. At 11:07am, Ms Vintour-Cesar replied to Ms Francis’ email of 10:59am as follows:

Thanks Laura. We have just spoken to Lulu, clinic manager who has confirmed she will go out to inform the 3 positives.

She will also obtain contact number for house 19, their weights, and will confirm who the extra 5 will be who will travel.

39. At 11:08am, Sgt Hen emailed the Robinson River Clinic Manager email address, copying Ms Hawkes, with the subject line ‘Positives – Request for Assistance’ attaching a list of close-contacts and their house numbers.⁴⁰

40. By 12:07pm, Ms Paxton replied, from the Robinson River Clinic Manager email address, stating:

Sorry, the weights below. Off PCIS as can't weight them today:-)

The plane is going to be here at 1330 hours

I have been there to tell them they are all going. Confirmed by the RFDS

41. It is evident from these emails that between 11:08am and 12:07pm Ms Paxton attended at House 19 and told the residents that they were going to Howard Springs (CNR). Ms Paxton and Ms Alcock were to repeat this process, over the course of 17 and 18 November, for a number of other houses in the community. The email correspondence, and the evidence of Ms Paxton and Alcock was consistent: the process did not involve providing recommendations or options to community members and asking them to make a choice. Rather, they understood that they were being directed to inform community members that they were required to be evacuated, and the reasons for their evacuation. It is evident that Ms Paxton and Ms

³⁹ [RD 3-1] Statutory declaration of Suezanne Alcock of 25 March 2023, [7].

⁴⁰ [RD 4-3] Statutory declaration of Caragh Hen of 22 February 2022, CH012.

Alcock were under considerable time pressure, and that the need to check medical records, check weights, collect medication and drive community members to the airport would have left little time for conversation with community members when they were informed they were leaving.

42. As Ms Paxton noted:

We were given a list of people that were going to be evacuated. Right? And then we had to take that list, go to the community members, and tell them, “Sorry, you’re going to Howard Springs for your own safety, to prevent COVID spreading in the community,” and all the rest. And then we would say, “We’ll be back to pick you up at – you know, in half an hour. Can you pack your things? Can you be ready? We’ll come and we’ll pick you up.” So then we would come back to the clinic, and (inaudible) myself, we’d get the medications ready to go to the patients. So we were running the (inaudible) their medications, drive them to the airport, and then we’d come back to the clinic.

43. As best she was able, Ms Paxton said that she answered community members questions about ‘what was going to happen’.⁴¹ She told them ‘that they would go to Howard Springs ... by plane, and that they would be looked after when they get to Howard Springs’.⁴² But beyond these matters, Ms Paxton said that the clinic staff ‘didn’t know what the conditions were like at Howard Springs’.⁴³ If asked about duration, she said, ‘You’re probably going there for two weeks, and maybe more’.⁴⁴ This was an assumption she made because, at that time in the rest of the country, quarantine duration was ordinarily 14 days.⁴⁵

44. Ultimately, Ms Paxton was asked:

And you understood effectively that [the RAT] were giving you a direction to go and tell family members that they were going to be evacuated?---Yes.

Along with some information about why they were being evacuated?---Of course. We explained to everybody why they were being evacuated.

⁴¹ Transcript of Proceedings on 9 April 2024, 38.

⁴² Transcript of Proceedings on 9 April 2024, 38.

⁴³ Transcript of Proceedings on 9 April 2024, 38.

⁴⁴ Transcript of Proceedings on 9 April 2024, 38.

⁴⁵ Transcript of Proceedings on 9 April 2024, 38.

In your statement you note that there was – you know, no one resisted being taken to the airport?---No.

Is it fair to say though, that this was not the kind of process for obtaining informed consent that one might use - - -?---This is not (inaudible) consent. They agreed. So consent is not the right word for me to have used in my statement. Agreed to go to the airport and agreed to go to Howard Springs.

And when you say “agreed” you mean they understood they were being told to go and they agreed to go without resistance?---Correct.

Okay?---They understood that this is what they needed from you to keep (inaudible).

Okay. It wasn't as if you were being asked to go to each house and say, “Hey, there are a bunch of options here and it's up to everyone to make a decision for themselves.”?---(No audible response).

THE CORONER: Are you there, Lulu?

MR COLERIDGE: Lulu, we lost you for a second. I might just ask the question again?---Okay. It was never an option if you don't want to go, this is what we can do. We were not given that option to go to them with.⁴⁶

45. Similarly, when asked whether the RAT told Ms Paxton that community members ‘had a choice’, Ms Paxton answered;

No. Choice never came up. We were told to ask people to go to quarantine. So we were instructed to tell them this is required and to keep yourself safe. So the choice – but there wasn't – we weren't given the choice to say, “You have a choice. You can stay here or you can go.” So we don't give them a choice to stay. They had to go. So – nobody got the choice.⁴⁷

46. And later:

... Did you understand when you were having those conversations and when you were told these are the people to be evacuated, did you understand that to be basically a direction that these people were to be evacuated and you were to explain to them why they were to be evacuated?---Yes.

All right?---Was a direction.

⁴⁶ Transcript of Proceedings on 9 April 2024, 40-41.

⁴⁷ Transcript of Proceedings on 9 April 2024, 45.

It was a direction. You understood it to be a direction?---Yes.

And you were trying to deliver the direction in a persuasive way that would explain the benefits of evacuation?---Yes. Exactly.

You certainly weren't given any information that there was an opportunity for people to isolate or quarantine within the community?---No.

These ones that you were told to be evacuated? ---Yes.⁴⁸

47. Ms Alcock's account was to similar effect. She said that the RAT 'arranged for who would be transferred to the CNR and let us [Ms Paxton and Ms Alcock] know'.⁴⁹ Like Ms Paxton, she did not understand that the clinic staff were being asked to obtain the 'consent' of the evacuees, but effectively saw herself as a driver:

6. [...] Louise would receive a manifest from the RAT team every day about who was leaving, what time and what house number.

7. As our clinic drivers were in isolation, I was basically a driver during this period. I would attend the houses in the community and the clients were already packed to go. I drove them out to the airstrip. As far as consent, I know that the RAT team were going house to house daily swabbing people and had all of the contact with the clients. I don't know what the consent process was.

48. Ms Alcock agreed at inquest that she was not trying to obtain consent from the residents of the houses when she spoke to them. Of these conversations, she said that many residents were 'very apprehensive about going, because they didn't know what to expect in Howard Springs', although some 'were excited about going'.⁵⁰ Like Ms Paxton, Ms Alcock had some 'basic information which I relayed to them', although this was more about accommodation and meals and that their medication would be provided.⁵¹ Some residents asked 'why they had to go', and she answered as best she could. She said that 'everyone seemed accepting of that and accepting that they needed to be transferred for their own health's sake'.⁵²

⁴⁸ Transcript of Proceedings on 9 April 2024.

⁴⁹ [RD 3-1] Statutory declaration of Suezanne Alcock of 25 March 2023, [5].

⁵⁰ Transcript of Proceedings on 10 April 2024, 12.

⁵¹ Transcript of Proceedings on 10 April 2024, 12.

⁵² Transcript of Proceedings on 10 April 2024, 12.

49. In summary, I find that Ms Alcock's evidence was to the same effect of Ms Paxton's: the clinic staff did not offer community members a 'choice', but told them they were being evacuated and provided, as best they were able, information about the evacuation and, in some cases, the public health justifications for it.
50. One of the houses at which such a conversation occurred was House 43, where Ms Dick resided with her family. In her statutory declaration to the inquest, Ms Paxton recalled that she was the clinic member who informed the household of the need to travel to Howard Springs:

I recall going to House 43 on 17 November 2021 (the date given to me by NT Police) and speaking to residents Freddie Jackson, Raylene Dick and family (8 or more clients) regarding their evacuation. I discussed that they had been exposed to Covid-19 and the need to transfer them so we could limit the spread of Covid-19 in the community. That transfer, and isolation, was to protect them all due to the close living arrangements they experience with community living, that they would be looked after at Howard Springs. They all verbally consented and discussed amongst themselves. Everyone appeared happy to be going to isolation. No resistance from any client was experienced. If anyone had resisted, they simply would not have got on the plane.

51. At inquest, Ms Paxton was asked about the timing, and content, of this conversation:

[...] Can you tell me how long before they got on the plane did that conversation with them about going to Howard Springs occur? ---Okay. I think from what I can remember, Suezanne and I were about to go to lunch when we got a call to say that House 43 was to be flown out. So I went to go tell House 43, and Suezanne packed up medicines. And then because Suezanne (inaudible) to go to the airport, so she then packed up the medicines and bum bag. She picked them up and went to the airport. It all happened in an hour. It couldn't have been much longer than that. It was very, very quick. If you look at the email that I (inaudible) been told was 12:07 something and the plane was direct at (inaudible), so we had to be there at, you know, 1:15 (inaudible) ten past 1:00. So I presumably picked them up at 1:00. So you can see the time (inaudible) very little.

So it all happened, going to the house, having the conversations, getting the medications, getting them in the car, driving them to the airport, taking off, between 12:07 and whenever it was the plane took off?---Yes, from about 12 o'clock until the plane taking off, yeah. It all happened in that time. So in less than an hour and a half all that happened.

And who specifically, do you recall, talking to at House 43? ---I specifically remember Freddie, because he was the driver in the clinic.

Staff are pretty special when they work in the clinic, they're special. And I can remember him introducing me to his wife who was standing next to him. And there were a couple of other people standing there. And – so his (inaudible) were really good introducing me to the wife, because I do remember that. And then Freddie and I spoke and he (inaudible) language, that was standing there. And whatever questions they threw at him, he's conveyed to me and I've answered back. So we had a chat. And I probably spent about ten minutes with her.

And can you recall any specifics of that conversation?---No. I just (inaudible) what I can remember.

Okay. Do you have any reason to think that what you've told us about the conversation you recall having generally with everyone – do you have any reason to think that that wouldn't have been the conversation you had with House 43?---I would have had the same conversation with everyone that I spoke to (inaudible).

52. Freddie Jackson gave evidence regarding this conversation. Although Mr Jackson considered that 'everyone in my house had no choice', it is far from clear that Mr Jackson was saying that he felt that he was being compelled to go by the clinic staff, or the Department, rather than compelled by the circumstances. His oral evidence was that when he found out that Covid-19 was in the community, he was scared and 'wanted to get out of there'.⁵³ When asked whether he was 'happy to go to Howard Springs?' he answered, 'Yeah, we're happy. Because we're going to go there to a safe place. Where it's safe'.⁵⁴ He added, 'We was happy to go. We're going to go to a safe place'.⁵⁵ When asked 'what did you think would happen if you didn't want to go?', he answered 'I would have stayed at home, mate.' When asked whether he thought he would be allowed to stay at home?' he answered, 'Yeah...'⁵⁶
53. To be clear, there was a very significant degree of variance between Mr Jackson's account of this conversation, and the accounts of other community members regarding similar conversations with clinic staff on 17 and 18 November 2021. But Mr Jackson's is the clearest account of the conversation between Ms Paxton and the residents of House 43, which included Ms Dick. While I cannot impute Mr Jackson's sentiments to Ms Dick, I am satisfied that he was frightened of Covid-

⁵³ Transcript of Proceedings on 8 April 2024, 69-70.

⁵⁴ Transcript of Proceedings on 8 April 2024, 71, 72 and 77.

⁵⁵ Transcript of Proceedings on 8 April 2024, 71, 72 and 77.

⁵⁶ Transcript of Proceedings on 8 April 2024, 73.

19, that he thought that leaving the community was a good idea, and that whatever his understanding of the legal force of the ‘direction’ to leave, he did not just comply but wanted to go.

The issue of ‘consent’

Legal principles

54. There was no material difference between the submissions of Counsel Assisting, the Dick Family and the Department regarding the principles.

55. Counsel Assisting submitted:

27. The word ‘consent’ has variable meanings. In this context, and for the purpose of determining the status of the Robinson River evacuees’ ‘residence’ at the CNR, the word ‘consent’ should be taken to mean ‘voluntary agreement’ or ‘willingness’. In that sense, ‘consent’ for these purposes is:

- (1) considerably less than ‘informed consent’, as that expression might be used in a clinical setting (ie, permission granted in full knowledge of the possible consequences); or,
- (2) something more than ‘compliance’, as that word might be used to describe a mere lack of resistance (for example, cooperation by a person who believes that they are under arrest).

28. The authorities recognise that ‘a fine line’ divides valid consent, in the sense of true willingness, from compliance. When determining whether an apparent ‘consent’ involves true willingness, the Court must have regard to the whole of the evidence, bearing in mind that:

- (1) it is not a legal precondition of a valid consent that the party whose consent is in issue ‘accurately understood the[ir] rights’;
- (2) ‘what a person does or does not know may’, however, ‘be relevant, as an evidentiary fact, to the question whether the person’s will has been overborne’; and,
- (3) when ‘deciding whether the willingness was uncoerced, it is proper to remember the apparent authority of a patrolman and the situation of the motorist who has been ‘taken’ to the police station’.

29. Similar principles have been developed in the context of allegations of unlawful, or ‘de facto’, detention. Hence, in the context of their interactions with police, a person ‘may, voluntarily and without constraint, accede to a police officer’s [request] to accompany him and, if he does so, there is of course no interference with his liberty.’ This is so ‘even if he goes reluctantly out of respect for authority or fear that a refusal will be construed as an indication of guilt or some other similar motive.’ If, however, ‘the circumstances are such as to convey, notwithstanding the words of invitation or request, that the suspect has no real choice, his freedom is under restraint and he cannot be regarded as accompanying the police officer voluntarily.’

56. The Department largely agreed with these principles.⁵⁷

Analysis

57. Ultimately, I have found that the Robinson River health clinic staff told community members that they were being evacuated, and, in some cases, provided information about, or a justification for, that evacuation. They did not offer community members a ‘choice’ and were not seeking their ‘consent’. While I accept that no community member resisted being evacuated, the real issue is whether this lack of resistance is evidence of agreement, or voluntariness, on the one hand, or mere compliance, on the other.

58. I accept Counsel Assisting’s submission⁵⁸ that each of the evacuees will have received the instruction from clinic staff differently. To some, like Freddie Jackson, it is likely that statements that the evacuees ‘had to’, or ‘needed to’, go meant no more than that there were compelling public, or personal, health reasons why they *should* go. Some community members are likely to have been thankful, or even excited, at the prospect of their evacuation. But I also consider it to be likely that there were, at least some evacuees who understood, reasonably, that they were being given a binding legal direction to go, noncompliance with which could have consequences such as arrest. If that is correct, there would be a real question as to

⁵⁷ Submissions of the Department dated 27 September 2024, [16].

⁵⁸ Counsel Assisting’s closing submissions dated 19 July 2024, [24(5)].

whether these individuals were evacuated with their ‘consent’, as that expression is used in the authorities.

59. Notwithstanding those concerns, I remind myself that this is an inquest into the death of a single individual, Ms Dick. In Ms Dick’s case, although I have real doubts about the quality of any ‘consent’ she provided and find positively that it did not amount to ‘informed consent’, there is insufficient evidence to conclude that she went under compulsion. I cannot ignore the evidence of Freddie Jackson, who stood next to Ms Dick as Ms Paxton spoke to the residents of House 43. While I cannot impute Mr Jackson’s state of mind to Ms Dick and am cautious not to place too much weight on statements he made that purport to describe the collective sentiments of his household, there is simply no reliable evidence of Ms Dick’s state of mind that would permit me to find that she felt differently.
60. In those circumstances, it is neither necessary, nor appropriate, for me to consider whether any other member of the community may not have consented to their evacuation.

Improving consent processes

61. In their closing submissions, the Dick Family largely put technical, or legal, arguments about ‘consent’, ‘lawfulness’ and ‘detention’ to one side. Instead, the Dick Family submitted that there was ‘value in interrogating whether she consented as that word is understood either in everyday language or in the medical context of informed consent’.⁵⁹ I agree.
62. Whatever the lawfulness of the evacuation of the members of the Robinson River community, it is clear that the consent process could be improved in the future.
63. Firstly, whatever the intent of those who drafted them, the better view of the Department’s policies is that they conveyed to a reader that consent was *not* required for close contacts of a positive case. The most specific policy dealing with the evacuation of close contacts—the Close Contact Evacuation Guideline—stated expressly that ‘close contacts will require mandatory quarantine for 14 days’ and

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that ‘close contacts will be evacuated to a regional quarantine facility as soon as possible’. I also accept Counsel Assisting’s submission that the ROMP ‘said nothing whatsoever about a requirement that close contacts provide consent’ and, in December 2021, ‘was updated to confirm that consent was required for *medically vulnerable people*, with no such amendment for close contacts’.⁶⁰

64. Although the Department urged a different, and more ‘flexible’, interpretation of these policies, it agreed, at the very least, that a lack of clarity regarding the requirement for, and concerning the process for obtaining, consent was a significant deficiency in them that could and should be rectified. It submitted that ‘it would have been preferable for its policies to deal expressly with whether consent was or was not required and to provide guidance on how that consent should be obtained’.⁶¹ The Department supported recommendations to that effect.
65. Secondly, it is clearly unsatisfactory that no member of the RAT was provided any training regarding the requirement for, and process for obtaining, consent from close contacts in the communities to which they were deployed. Save for Kylie Tune, no member of the RAT recalled receiving any training about these matters. Nor do the detailed training records provided by the Department suggest that any such training occurred. I consider this must be rectified, alongside amendments to the relevant policies.
66. Thirdly, while it may be impractical to obtain the kind of ‘informed consent’ that would be required in a clinical setting, it is strongly desirable that the residents of communities like Robinson River be provided with as much information as is possible to assist them to understand the decision they are being asked to make. At a minimum, this information should convey to community that they have a choice to stay or leave and of the general nature of ‘quarantine’. While I commend the RAT for involving community leaders like Mr Dickson, Ms Campbell and Mr Liddy in the emergency response, it is concerning that Ms Campbell ‘wasn’t aware it was

⁶⁰ This may well suggest, as Counsel Assisting submitted, that ‘even in the period immediately following the evacuation, the understanding within the Department was that consent *was not* required for close contacts.’ That is, however, a controversial submission and is not something I need to determine.

⁶¹ Submissions of the Department of Health dated 27 September 2024, [66].

a choice’ and did not ‘think that people understood that once we got to the facility we would not be able to leave’.

Events at the CNR

Arrival and extension of stay

67. Ms Dick arrived at the CNR on 17 November 2021, after being flown in from Robinson River on a Charter flight. She was allocated to room M3 5A in Zone 12B (Orange Zone), along with other members of the Robinson River community.⁶² On 28 November 2021, the CNR identified that a number of residents in the Orange Zone had testing positive to Covid-19.⁶³ This necessitated the extension of the quarantine period of positive cases, as well as their close contacts, like Ms Dick.⁶⁴
68. Although the inquest received a significant body of evidence regarding the period between 17 November and 7 December 2021, in light of the findings I make below regarding the cause and circumstances of Ms Dick’s death, it is unnecessary to recount those events in any detail.

Events on 6 and 7 December 2021

69. As I consider further below, the cause of Ms Dick’s death was acute disseminated melioidosis, in the context of a number of chronic health conditions. The primary records, and expert evidence of the infectious diseases’ expert, Professor Bart Currie, satisfies me that this infection progressed unusually swiftly, and even six hours prior to Ms Dick’s collapse, her observations were normal.
70. Ms Dick’s clinical observations on 6 and 7 December 2021 were as follows:
- (a) At 12:37am on 6 December 2021, Ms Dick was administered Panadol in response to a complaint of lower back pain. The PCIS note was, ‘stated this is not a new issue for her and suffers with lower back pain every now and again and a headache, Temp 36.5, Resps: 19, Pulse 84, BP 132/68.’

⁶² [RD 3-3] Affidavit of Gabrielle Brown of 16 February 2023, [102].

⁶³ [RD 3-3] Affidavit of Gabrielle Brown of 16 February 2023, [103]-[108].

⁶⁴ [RD 3-3] Affidavit of Gabrielle Brown of 16 February 2023, [110].

- (b) At 1:46pm on 6 December 2021, a COVID-19 daily assessment was completed for Ms Dick. No COVID-19 symptoms or other concerns were noted.
- (c) On the evening of 6 December 2021, Ms Dick complained of a central headache. At 10:20pm, the clinical team attended to administer Panadol. Ms Dick was asleep when the team arrived but woke for the Panadol and a medical assessment, which recorded 'Temp 36.6, resps 19. Bp 132/72, Sats 97% RA, Pulse 88'.
- (d) At 12:32pm on 7 December 2021, a COVID-19 daily assessment was completed for Ms Dick. No COVID-19 symptoms were noted. The PCIS notes state 'Nil other health concerns voiced'.

71. At 8:11pm on 7 December 2021, call logs record a call indicating that Ms Dick was 'feeling sick' and was 'heavily breathing.' Although there was some evidence of a number of earlier calls from Ms Dick, between 5:30pm and 6:30pm, little is known of the content of these calls.

72. Upon receiving the call, Mr John Mangahas instructed two nurses to attend on Ms Dick and they immediately made their way to the zone.⁶⁵ Upon locating Ms Dick and making observations of her, staff left the zone to call in the emergency and call an ambulance. While I accept that it was highly undesirable that Ms Dick was left alone while this occurred and it was distressing to her family, I also accept that no criticism should be made of any individual staff member at the CNR. The staff felt they needed to leave the zone because they were dressed in full PPE, and could not practicably call 000 from that location, and there was a policy that prohibited a single staff member from remaining in the Orange Zone alone.

73. It was most unfortunate that, upon arrival at the CNR, the St John Ambulance crew experienced 'significant delay in accessing' Ms Dick. This delay occurred because security staff at the CNR directed the ambulance to the wrong zone. Although this was regrettable, I am again satisfied that no adverse findings should be made in

⁶⁵ Statement of Statement of Raj Karmacharva dated 10 December 2021, 21-22.

relation to any individual staff member at the CNR. Indeed, the confusion arose in very unusual circumstances where there was another incident occurring on-site in a different zone for which an ambulance had already been called.⁶⁶

74. Paramedics arrived at Ms Dick's location at approximately 9:21pm and commenced CPR. After gaining intra-osseous and intra-venous access, they administered adrenaline and a bolus of sodium bicarbonate and of normal saline in an attempt to treat what paramedics believed might have been severe diabetic keto acidosis. Efforts to resuscitate Ms Dick continued until 9:58pm, when all present agreed that further efforts were futile and she was pronounced deceased.

Cause of death

75. An autopsy was conducted by Dr Marianne Tiemensma, specialist forensic pathologist. On the basis of Ms Tiemensma's evidence, I am satisfied that the direct cause of Ms Bading's death was acute disseminated melioidosis (with suppurative necrotizing pneumonia and sepsis), in the context of poorly controlled type 2 diabetes mellitus, chronic kidney disease, and ischaemic heart disease.
76. Ms Tiemensma's evidence was supported by that of infectious diseases expert Professor Bart Currie. Professor Currie is a professor in medicine at RDH and the head of the Tropical and Emerging Infectious Diseases team at Menzies School of Health Research. In those capacities, Professor Currie leads the Darwin Prospective Melioidosis Study, which he commenced at RDH and Menzies 34 years ago.⁶⁷ I am satisfied that he is a pre-eminent world expert on melioidosis infection.
77. Professor Currie was contacted by Dr Tiemensma for an opinion regarding Ms Dick's cause of death and he was provided with bacteria cultured from specimens taken at autopsy. On the basis of his examination of that culture, he expressed the following opinions:
- (a) It is very likely that Ms Dick was infected with *B. pseudomallei* while at CNR rather than in Robinson River.

⁶⁶ Statement of Samuel Keatch dated 21 December 2021, [5]-[11].

⁶⁷ [RD 5-7] Report of Professor Bart Currie of 25 March 2024, 1.

- (b) From the autopsy findings and the rapid onset of disease that was described, the most likely scenario for her infection was ‘inhalational’ melioidosis rather than through a skin infection or ingestion.
- (c) Data supports the shift to inhalational melioidosis during periods of heavy rainfall and winds and the resultant melioidosis is more severe, usually with pneumonia and not uncommonly progressing to septic shock which can be rapidly fatal.
- (d) Mortality for melioidosis in Darwin is now overall 10%, but with inhalational melioidosis in those with underlying medical conditions such as diabetes, the mortality is higher and death can occur very rapidly.
- (e) The records of Ms Dick indicate that she had diabetes, the most important risk factor for melioidosis, and chronic kidney disease, another well recognised risk factor. Together these make more severe disease more likely.

78. Professor Currie examined the clinical observations for Ms Dick taken on 6 and 7 December 2021. On the basis of those observations, Professor Currie concluded that Ms Dick’s ‘severe infection and its progression after onset was very rapid and that on the day prior to her collapse there were no evident features to suspect melioidosis’.⁶⁸ The clinical observations, including those as late as 12:30pm on 7 December, were ‘completely normal set of observations’⁶⁹ and there ‘were unfortunately no suggestions of a melioidosis illness prior to her collapse that would have triggered investigation for melioidosis’.⁷⁰ Accordingly, it is unlikely that more prompt medical attention, even within a tertiary hospital, would have altered the outcome of the very rapid onset of Ms Dick’s illness.

Formal findings as to time, place and cause of death

79. Pursuant to s 34(1)(a)(i)-(iv) I find that:

- (a) Ms Dick was born on 2 October 1971 in Mount Isa, Queensland.

⁶⁸ [RD 5-7] Report of Professor Bart Currie of 25 March 2024, 2.

⁶⁹ Transcript of Proceedings on 18 April 2024, 80.

⁷⁰ [RD 5-7] Report of Professor Bart Currie of 25 March 2024, 2.

- (b) Ms Dick passed away at the CNR, at Darwin, on 7 December 2021, at 9:58pm; and,
- (c) the direct cause of Ms Dick’s death was acute disseminated melioidosis (with suppurative necrotizing pneumonia and sepsis), in the context of poorly controlled type 2 diabetes mellitus, chronic kidney disease, and ischaemic heart disease.

Issues arising

80. Despite my conclusion that there was no failure to promptly identify, or treat, Ms Dick’s melioidosis infection, a number of issues were identified at inquest regarding processes at the CNR, or under the ROMP, that could be improved. As there was little disagreement about these, it is sufficient to deal with them briefly.

Lack of risk assessment

81. The Department accepted in its evidence, and in submissions, that its policies were not clear about who was responsible for making the assessment of suitability for quarantine. This issue arose most clearly during the inquest into the death of Ms Bading but was also apparent in the inquest into the death of Ms Dick.

82. In Ms Dick’s case, the evidence demonstrated that there was no system in place for communicating information about clinical risk between the community clinic and the CNR. Ms Alcock said that she and Ms Paxton ‘went through and prioritised who was more vulnerable in the community’, but she was not aware of that information being passed on to CNR staff.⁷¹ Similarly, Ms Paxton made a list of key health conditions or needs of individuals at Robinson River, and provided this to the RAT, but there was no evidence that this list was passed on to the CNR. There did not seem to be any process for alerting the CNR about residents who were medically vulnerable.

83. In addition, and as I note further during my findings concerning Ms Bading’s death, there was no meaningful assessment at the CNR of the clinical risk of incoming

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residents. Indeed, there appears to have been an assumption at the CNR that no such assessment was required because incoming residents had already been assessed or deemed to be independent and capable of caring for themselves. That assumption proved to be false.

84. Ultimately, the Dick Family and the Department were largely agreed regarding the solution to this problem. While the CNR was not a primary health service, the Department and Dick Family were agreed that a triage system could and should be adopted that identified those at higher risk of deterioration, whether from Covid-19, from chronic illness or otherwise. Personalised care plans could then be developed for those at higher risk. The Department conceded that, ‘had such a system been in place during the relevant period, Ms Dick would have been within the class of person for whom a personalised care plan would have been prepared’.⁷² Accordingly, the Department supported recommendations that, in any future pandemics:

- (a) residents at quarantine facilities be triaged into groups, identifying those people with a higher general health risk;
- (b) for persons who are identified as being at higher health risk, there be pro forma documentation prepared and completed which identifies (in short form) the person’s relevant medical details;
- (c) for those persons identified as being at higher risk, there be an individualised care plan, which includes (if practicable) an in-person review by a medical practitioner shortly after admission and specifies (amongst other matters) when the person should be reviewed in person thereafter;
- (d) that the care plan prompts proactive questions about the person’s condition by staff and the taking of any observations relevant to that condition; and
- (e) that the care plan identifies what medications the person is taking, the quantity of medication the person has, when the person is likely to run out of their medication, and when a review should occur to ensure that (in the event of an extension in the person’s quarantine) the person has sufficient medication for their stay.

⁷² Submissions of the Department of Health, [78].

Suitability of primary health care model for residents of remote community

85. I accept the submission of the Dick family that, in some significant respects, the model of care at the CNR did not meet the needs of the cohort of residents who arrived from Robinson River. The family highlighted the following issues:

- (a) First, the information booklet for residents was not in an accessible format and resources in Aboriginal languages or utilising visuals were not produced.
- (b) Second, the envisaged model of health care, as set out at p 18 of the booklet, was that residents could call a HSQ phone number for urgent assistance, but otherwise were directed to contact external services to make a telehealth appointment for any non-urgent illness. Residents were also directed to arrange delivery of medication via online orders with Chemist Warehouse or Palmerston Superclinic. Given the Robinson River clinic was dealing with the covid lock down in the community, it is not realistic that telehealth appointments would have been available, even if that had been a suitable model, for the Robinson River residents in HSQ.
- (c) Third, the evidence suggested that residents from Robinson River would have been used to and expected a proactive model of health care. As the family noted, '[a]n underlying assumption about the type of health care needed was that only people who could manage their health on their own in the community would undergo quarantine at HSQ. If that model was to be applied to evacuees from remote communities, it needed to take into account the reality of how self-management in community was likely occurring, that is, with the support of family and an Aboriginal health service.'⁷³
- (d) Fourth, for some Aboriginal people, decision making in health care is done jointly with family rather than as an individual.

⁷³ Submissions of the Dick Family at [21]

(e) Fifth, a number of practices that are important for culturally safe health care (relationship building, allowing patients additional time, working alongside an Aboriginal worker) were necessarily much harder to implement in HSQ.

86. In accepting these submissions, I recognise that there are limits to what can be achieved in a facility such as the CNR, which is not, and cannot be expected to be, a primary health care service like a clinic in a remote community. Nevertheless, the Department should consider how any model it adopts for the provision of quarantine services in the future, can better accommodate persons with different expectations surrounding health care.

Post death engagement with family members

87. The Dick Family submitted that I should make recommendations that the Department engage with Ms Dick's family in a process of open disclosure, and otherwise. In circumstances where the Department has now offered to undertake open disclosure with Ms Dick's family, it is unnecessary for me to make any recommendation about this.

Recovery activities

88. Counsel Assisting submitted that I should find that, notwithstanding clear provision in the ROMP for 'recovery activities' following an evacuation from a remote community, no such activities had occurred.

89. In that regard, the ROMP provided in some detail for the 'recovery activities' that were to follow a declaration that an outbreak was over. It advised that a Recovery Action Plan would be developed specific to the recovery needs of the community, and that the content of this plan would be reliant on an impact/needs assessment of the community. The ROMP stated that recovery at the local level would be coordinated through a Local Recovery Coordinator, supported by officials in Darwin.

90. I reject the Department's submission that it is not open to me to make this finding. The ROMP clearly contemplated that such recovery activities were a critical part of the response to Covid-19 outbreaks in remote communities. While the failure to

undertake these activities may not be a circumstance of Ms Dick's death within the meaning of s 34(1)(v), I am satisfied that the failure to undertake the recovery activities contemplated by the ROMP is a matter, including public health or safety, connected with the death being investigated within the meaning of s 34(2). Accordingly, while I have not extensively investigated the issue and am unable to say why these activities were not undertaken, I make the comment that it is highly undesirable that these recovery activities were not undertaken at Robinson River.

David Hardy

91. David Hardy was born in Manchester, United Kingdom, on 15 December 1943. He was the youngest of 2 boys, to parents Leslie and Bridget Hardy (now deceased).⁷⁴ He is survived by his brother, Colin, and son, Robert Hardy, who he adopted in 1974 after marrying his wife, and Robert’s mother, Pauline Hardy (now deceased).⁷⁵
92. After Robert emigrated to Australia in 2009, David visited the country most years.⁷⁶ After the death of his wife in 2019, he decided to remain in the country, to be close to Robert, and applied for an aged parents visa.⁷⁷ In March 2020, he travelled to the UK to sell his house and belongings, intending to return to Australia shortly thereafter. When borders closed, he was unable to do so because he was not yet a permanent resident of Australia.⁷⁸ Despite his best efforts and those of his son, Mr Hardy was unable to return to Australia until November 2021, when parents were recognised as members of immediate family and, therefore, became eligible for an exemption to travel restrictions.⁷⁹
93. On 18 November 2021, Mr Hardy departed Manchester, UK, and arrived at Darwin International Airport on 20 November 2021.⁸⁰ Statements taken from other passengers suggest that Mr Hardy was likely to have been in good spirits, and excited to return. Nickolas Hollinsworth, for example, stated that the ‘mood on the plane was jolly – many, most or all of us had been stuck in some sense and [were] happy to be on our way’.⁸¹ He said that most passengers were celebrating and that, if he was ‘thinking of the right guy [he] would describe [Mr Hardy] at this time as ebullient’.⁸² They shared ‘[s]ome jokes on the p[lane and “where are you from” and “where are you going” type stuff’.⁸³

⁷⁴ [DH 2-1] Statement of Robert Hardy (undated).

⁷⁵ [DH 2-1] Statement of Robert Hardy (undated).

⁷⁶ [DH 2-1] Statement of Robert Hardy (undated).

⁷⁷ [DH 2-1] Statement of Robert Hardy (undated).

⁷⁸ [DH 2-1] Statement of Robert Hardy (undated).

⁷⁹ [DH 2-1] Statement of Robert Hardy (undated).

⁸⁰ [DH 2-2] Statutory declaration of Nikolas Hollinsworth dated 29 February 2024, [2].

⁸¹ [DH 2-2] Statutory declaration of Nikolas Hollinsworth dated 29 February 2024, [2].

⁸² [DH 2-2] Statutory declaration of Nikolas Hollinsworth dated 29 February 2024, [2].

⁸³ [DH 2-2] Statutory declaration of Nikolas Hollinsworth dated 29 February 2024, [4].

94. After clearing immigration and customs, Mr Hardy was transported to the Centre for National Resilience, Howard Springs, arriving in the early evening where he was processed and placed in the International arrival area (B3 10A, Zone 4).⁸⁴
95. There was nothing remarkable regarding his admission to the CNR and he was reportedly talking to other residents in adjoining rooms at the location from time to time and was in good spirits. At one point, Mr Hardy and a number of other residents sat at a picnic table in front of the row of rooms.⁸⁵ One of these men, Shane Sinclair, recalled that Mr Hardy was drinking vodka from a ‘1 litre bottle’. He said that ‘it was a full bottle and [Mr Hardy] drank the entire bottle that night’.⁸⁶ He didn’t know where he had gotten it.⁸⁷ Another resident, Ethan Zoetelief, also described seeing Mr Hardy at the picnic table. Like Mr Sinclair, he described the bottle as ‘a full sized bottle that [Mr Hardy] brought from duty free’.⁸⁸ Although Mr Hollinsworth did not observe Mr Hardy drinking at the table, he recalled being told by one of his neighbours ‘later that night or the next day’, and most likely prior to Mr Hardy’s death, that Mr Hardy had been ‘hitting it hard drinking with no mixer and that he needed help getting back to his room’.⁸⁹
96. At approximately 11:30pm, Lisa Vermeulen, Director of Nursing, was assisting another resident in Zone 4 when she observed Mr Hardy sitting at the picnic table with three other men. Ms Vermeulen described the three men ‘sitting there having a chat and having a drink, like any normal people would’.⁹⁰ While they were not being disruptive, Ms Vermeulen reminded the three men that, under the then Chief Health Officers directions, they were required to remain on their balconies when outside their rooms.⁹¹ She explained that as it was the first night for each of these men in the facility, it was appropriate just to provide a reminder of the rules but take no further action.⁹² The group dispersed at approximately midnight.

⁸⁴ [DH 3-2] Statutory declaration of Cameron Tyers dated 18 January 2022, [6],

⁸⁵ [DH 2-2] Statutory declaration of Nikolas Hollinsworth dated 29 February 2024, [5].

⁸⁶ [DH 2-3] Statutory declaration of Shane Sinclair dated 6 February 2024, [5].

⁸⁷ [DH 2-3] Statutory declaration of Shane Sinclair dated 6 February 2024, [5].

⁸⁸ [DH-2-4] Statutory declaration of Ethan Zoetliff dated 15 February 2024, [4].

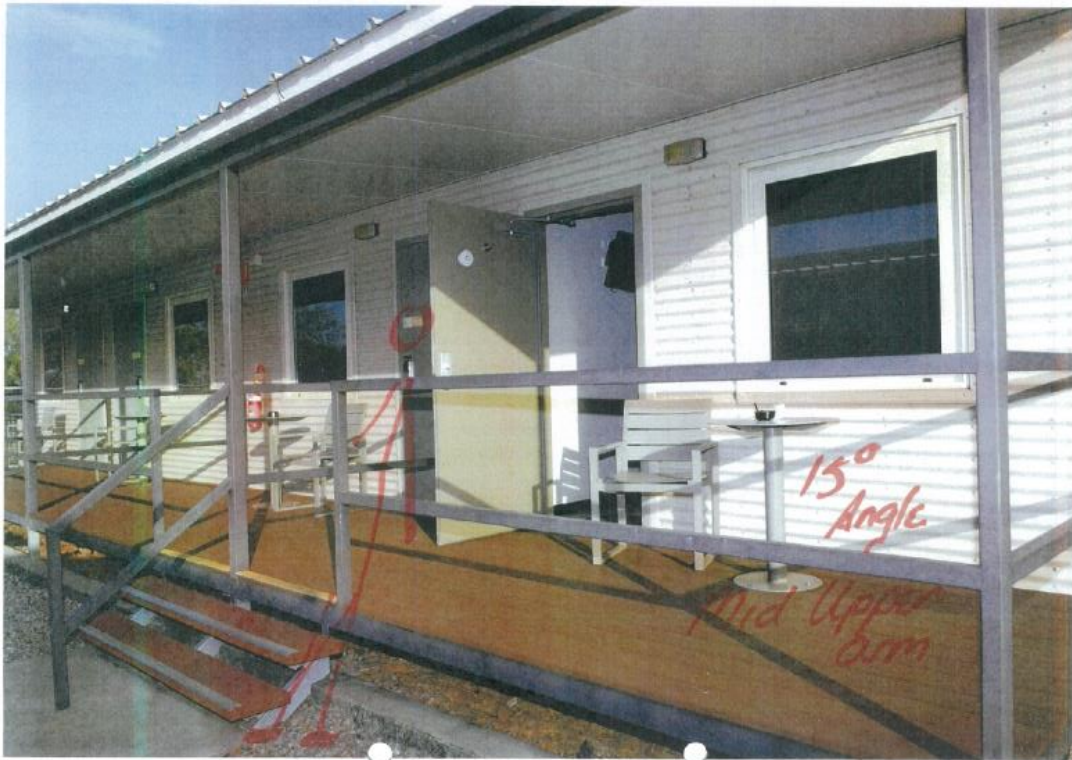
⁸⁹ [DH 2-2] Statutory declaration of Nikolas Hollinsworth dated 29 February 2024, [5].

⁹⁰ Transcript of Proceedings on 18 April 2024, 28.

⁹¹ [DH 3-2.1] Transcript of audio-recorded statutory declaration of Lisa Vermeulen dated 31 December 2021, 4.

⁹² [DH 3-2.1] Transcript of audio-recorded statutory declaration of Lisa Vermeulen dated 31 December 2021, 4.

97. While Mr Hardy was walking to his room, Ms Vermeulen and other staff were focussing on another resident. When they turned back to Mr Hardy, Ms Vermeulen noticed that he was leaning against his balcony rail. She said that it was ‘like he’d lost his footing’. Ms Vermeulen provided coronial investigators with this diagram, superimposed on a photograph of Mr Hardy’s room:⁹³



98. At inquest, Ms Vermeulen explained that diagram depicted Mr Hardy leaning against the railing of the balcony in front of his room. He was standing in ‘the rocks’ to the immediate right of the two stairs up to the balcony. The right side of Mr Hardy’s body was leaning against the railing, specifically the ‘area between the shoulder and the elbow’ of the right arm,⁹⁴ which I take to be consistent with the annotation on her diagram of ‘mid upper arm’.

⁹³

[DH 3-2.1] Transcript of audio-recorded statutory declaration of Lisa Vermeulen dated 31 December 2021, 4.

⁹⁴

Transcript of Proceedings on 18 April 2024, 30.

99. Ms Vermeulen and other staff approached Mr Hardy and asked if he was ok. He answered, ‘yeah, I just can’t stand up’.⁹⁵ Ms Vermeulen assisted him to stand. Ms Vermeulen said that Mr Hardy looked embarrassed but did not appear to be in pain. Ms Vermeulen did not observe obvious signs of intoxication, like slurring, but conceded that she would not have been able to smell anything because she was wearing a mask and face shield.⁹⁶
100. Mr Hardy then walked unaided up the two or three steps to the chair on his balcony.⁹⁷ Ms Vermeulen described Mr Hardy’s gait as ‘quite fine’. Once in his chair, she again asked Mr Hardy if he was ok, and he said that he was fine and started stuffing his pipe.⁹⁸ The staff left Zone 4 at around 11:45pm.
101. At approximately 1:20am, Ms Vermeulen returned to Zone 4 to take a swab from another resident. She saw Mr Hardy sitting smoking his pipe and stopped to talk to him. She recalled ‘having a bit of a laugh’ and telling Mr Hardy that he reminded her of her father, who had also smoked a pipe.⁹⁹ Mr Hardy laughed and said, ‘how do you know that I’m that old, I’m very young’.¹⁰⁰ Mr Hardy appeared in good and Ms Vermeulen described him as a gentleman.¹⁰¹
102. On the morning of 21 November 2021, it is likely that CNR staff spoke to Mr Hardy between 7:30am and 9:00am to conduct a daily symptom and temperature check. In addition, because the 21st was to be Mr Hardy’s first full day in the facility, he received a Covid-19 test. That is confirmed by Mr Hardy’s Covid-19 test results for 21 November 2021, which suggest that he attended at his door and performed a nose and throat swab at 9:00am.¹⁰² While speaking to staff, he requested a sim card for his telephone.¹⁰³ There is no record that he reported any discomfort.
103. At 1:45pm on 21 November 2021, senior registered nurse Mr Cameron Tyers commenced a shift as team leader with responsibility for Zone 4. During handover,

⁹⁵ [DH 3-2.1] Transcript of audio-recorded statutory declaration of Lisa Vermeulen dated 31 December 2021, 5.

⁹⁶ Transcript of Proceedings on 18 April 2024, 31.

⁹⁷ Transcript of Proceedings on 18 April 2024, 30.

⁹⁸ [DH 3-2.1] Transcript of audio-recorded statutory declaration of Lisa Vermeulen dated 31 December 2021, 5.

⁹⁹ [DH 3-2.1] Transcript of audio-recorded statutory declaration of Lisa Vermeulen dated 31 December 2021, 5.

¹⁰⁰ [DH 3-2.1] Transcript of audio-recorded statutory declaration of Lisa Vermeulen dated 31 December 2021, 5.

¹⁰¹ [DH 3-2.1] Transcript of audio-recorded statutory declaration of Lisa Vermeulen dated 31 December 2021, 5.

¹⁰² [DH 6-2] 6-2 Pathology results - Covid Results on 22.11.21.

¹⁰³ [DH 3-2] Statutory declaration of Cameron Tyers dated 18 January 2022, [6].

outgoing staff advised that they had attempted to deliver the sim card to Mr Hardy's room earlier that afternoon but, when they knocked, there was no answer. They left the sim card on the table outside the room. Although there was, at that time, no cause for concern, they asked Mr Tyers to conduct a welfare check of Mr Hardy during his shift.¹⁰⁴

104. At approximately 3:35pm, Mr Tyers and another nurse, knocked on the door to Mr Hardy's room while conducting rounds of Zone 4. There was no answer and Mr Tyers noticed that the sim card Mr Hardy had requested was still on the table on the veranda outside the room.¹⁰⁵ While he was standing outside the room, another resident told Mr Tyers that he had seen Mr Hardy drinking a bottle of vodka the night before.¹⁰⁶
105. At approximately 3:40pm Mr Tyers knocked again. When there was no answer, he called out that he would be opening the door with the master key. On doing so, he observed Mr Hardy lying on the bed. He entered the room and conducted a response check on Mr Hardy and observed no signs of life. While attempting to take a saturation reading from Mr Hardy's index finger, Mr Tyers noted that Mr Hardy was cold to the touch and in full rigour mortis.¹⁰⁷ Mr Tyers alerted the other nurse in Zone 4, and together they alerted the emergency quarantine facility number and the on-call doctor.¹⁰⁸
106. A crime scene was established and subsequently processed by CSEU member, S/C Korbin Fomin with investigators attending the scene. There were no signs of any disturbance and no suspicious circumstances were established.
107. Upon searching his room, police located a receipt from 'World Duty Free' at Darwin airport. The receipt was for a bottle of 'Smirnoff Red 37.5% 100CL', or, in other words, a 1 litre bottle of vodka.¹⁰⁹

¹⁰⁴ [DH 3-2] Statutory declaration of Cameron Tyers dated 18 January 2022, [6].

¹⁰⁵ [DH 3-2] Statutory declaration of Cameron Tyers dated 18 January 2022, [6].

¹⁰⁶ [DH 3-2] Statutory declaration of Cameron Tyers dated 18 January 2022, [9].

¹⁰⁷ [DH 3-2] Statutory declaration of Cameron Tyers dated 18 January 2022, [11]-[14].

¹⁰⁸ [DH 3-2] Statutory declaration of Cameron Tyers dated 18 January 2022, [15].

¹⁰⁹ [DH 9-2] Photographs of items in David Hardy's room.

Cause of death

108. On 22 November 2021, Dr Marianne Tiemensma, specialist forensic pathologist, conducted a post-mortem examination of Mr Hardy for the Coroner's Office.¹¹⁰
109. Dr Tiemensma found that Mr Hardy 'showed features of acute respiratory failure, underlying natural disease (advanced pulmonary emphysema and ischaemic heart disease in the context of aortic stenosis and coronary artery disease) and evidence of minor recent trauma.' The minor recent trauma consisted of a torn right long biceps muscle tendon and an undisplaced fracture of the right 8th lateral rib, with associated surrounding intercostal haemorrhage. Toxicology revealed a blood alcohol content of 0.013%.
110. Dr Tiemensma concluded that the cause of death was advanced chronic obstructive pulmonary disease, in the context of ischaemic heart disease. She concluded that although the minor injury to the biceps, and rib, were not considered life threatening, 'they may have caused severe pain, which in the context of [Mr Hardy's] underlying conditions, could have precipitated the acute respiratory failure'. It was not possible to identify a precise mechanism, or cause of these injuries, or to say with certainty whether they contributed to death.
111. Based on the pathological, and toxicological, results, I find that the cause of death was acute respiratory failure secondary to chronic obstructive pulmonary disease and ischaemic heart disease.
112. In relation to the minor trauma to Mr Hardy's biceps and ribs, Counsel Assisting did not seek any finding as to their timing or cause, and submitted that it was not, on the evidence, possible to say whether they were 'caused during Mr Hardy's "fall" or at some earlier or later time'. The Department, on the other hand, submitted that I should positively find that the injury occurred 'sometime *after* Mr Hardy's (sic) lost his balance'.
113. I am unable to accept the Department's submission. On the evening before his death, Mr Hardy suffered some kind of event that resulted in him being observed

¹¹⁰ [DH 5-2] Report of post-mortem examination by Dr Marianne Tiemensma of 23.12.21

by Ms Vermeulen leaning against the railing of his balcony. That event may or may not have been a ‘fall’ into his balcony railing, possibly from the steps leading up to it. The part of Mr Hardy’s body she observed against the railing was the very part of his body that was later found to be injured – the right upper biceps. He said he was unable to stand and required assistance. A ‘fall’ is, in my view, at least plausible as a mechanism of injury.

114. The Department submitted that I could exclude a ‘fall’ as a mechanism of injury because the injuries would have been painful,¹¹¹ and because Mr Hardy did not complain of any injury or pain at that or any other time. It noted that Mr Hardy had been able to walk up the stairs to his chair unaided and appeared to be walking ‘fine’.

115. Each of these facts and observations reduces the likelihood of a fall as a mechanism of injury to some degree. But they do not permit me to exclude it. While he did not report being in pain, I am satisfied on the evidence of Mr Sinclair and Mr Zoetelief that Mr Hardy was intoxicated, possibly significantly so.¹¹² There are many reasons why Mr Hardy may not have reported pain, including that intoxication and what Ms Vermeulen described as his embarrassment at having fallen in the first place. Accordingly, although I do not go so far as to say that a ‘fall’ into the balcony railing on the evening of 20 November 2021 caused the injuries, nor am I prepared to find that it did not.

116. Ultimately, I am unable to make any finding as to the timing or mechanism of the injuries to Mr Hardy’s biceps and ribs.

Other comments

117. Notwithstanding those findings, I accept Counsel Assisting’s submission that no issues arise as to the adequacy of Ms Hardy’s care and supervision. While in a hospital setting his ‘fall’ might have prompted a clinical assessment, that was not the context in which Ms Vermeulen spoke to Mr Hardy. Ms Vermeulen observed

¹¹¹ Transcript of Proceedings on 18 April 2024, 71.

¹¹² Indeed, in light of the positive, albeit very low, blood alcohol reading at post-mortem, it is likely that he was still intoxicated when he spoke to CNR staff on the morning of 21 November 2021.

Mr Hardy leaning against the railing to the balcony outside his unit, satisfied herself that there was no issue requiring further assessment and, as matters transpired, later interacted with Mr Hardy and observed him to be well. Ms Vermeulen's interactions with Mr Hardy, in the context in which they occurred, were reasonable, professional and compassionate. She took the time to speak to this elderly gentleman twice, at midnight and shortly after 1:20am, despite the fact that she was nearing the end of a busy shift and was dressed in full PPE. It was apparent from her evidence to the inquest that she enjoyed her short interactions with Mr Hardy, and was and remains genuinely affected by his death.

118. I also accept Counsel Assisting's submission that the CNR's policies as to alcohol possession and consumption were adequate. The policies were well developed, fit for purpose, and communicated clearly to incoming residents. The fact that some residents may have disregarded them does not suggest that the policies were inadequate. In addition to the legal complexity that would have attended a requirement that incoming residents undergo a search, there were compelling reasons not to impose such an invasive requirement, including, as Ms Brown noted, because it would have undermined rapport between CNR staff and the incoming cohort.

Formal findings as to time, place and cause of death

119. Pursuant to s 34(1)(a)(i)-(iv) I find that:

- (a) at the time of his death, Mr Hardy was 77-year-old man and national of the United Kingdom (born on 15 December 1943);
- (b) Mr Hardy died at the CNR, at Darwin, on 21 November 2021, between 9:00am and 3:50pm; and,
- (c) the direct cause of Mr Hardy's death was acute respiratory failure in the context of advanced chronic obstructive pulmonary disease, ischaemic heart disease and minor trauma (acute haemorrhage and laceration of the right long biceps muscle tendon).

Karen Bading

120. At the time of her death, Karen Bading was a 46-year-old aboriginal woman who was admitted to the CNR on 1 January 2022 after testing positive for Covid-19. On 3 January 2022, she was transferred to the RDH, after staff at the CNR recognised that she was acutely unwell. She died ten days later on 14 January 2022.
121. At the time of her referral and admission to the CNR, Ms Bading suffered from a number of serious underlying health conditions and had recently spent a significant period in hospital. These conditions, and recent health treatment included:
- (a) Liver cirrhosis secondary to alcohol consumption or auto-immune disease which was Child Pugh A in 2018 but had progressed to Child Pugh C (the most severe) in 2021. Imaging showed prominent gastric, duodenal veins/varices and splenic veins;
 - (b) A seizure disorder since 2011 following a traumatic brain injury and cryptococcal fungaemia, for which she took Keppra (levetiracetam);
 - (c) An autoimmune disorder consisting of arthropathy and rash. To that end, she had: a positive ANA (anti-nuclear antibodies—homogenous with a peak titre of 1/2560); a positive DAT (direct antiglobulin test) and also had anti C and anti M antibodies; elevated rheumatoid factor (38.9); a positive ANCA (antineutrophilic cytoplasmic antibody) with a nuclear pattern; anti DS (double stranded) DNA antibodies; anti CCP pos (13, N<5); low complement levels.
 - (d) A likely diagnosis of SLE (systemic lupus erythematosus) with predominantly haemolytic manifestations; and,
 - (e) A recent admission as an inpatient at the Royal Darwin Hospital between 11 October 2021 and 9 November 2021, during which she spent 22 days in the intensive care unit (ICU) and became very weak and severely deconditioned.¹¹³

¹¹³ [KB 5-1] Report of Professor Carlos Scheinkestel dated 2 October 2023, 4.

122. On any view, these were serious, chronic, health conditions that, taken together with her recent and significant hospitalisation, rendered Ms Bading extremely vulnerable to severe Covid-19 infection. In other words, I accept Professor Carlos Scheinkestel's opinion that when Ms Bading contracted Covid-19 in December 2021, she was 'weak and had not yet recovered from a life-threatening illness. This would have predisposed her to a more severe infection with Covid 19 and Covid 19 infection was more likely to cause her more serious problems in view of her underlying co-morbidities'.¹¹⁴

Covid-19 Emergency Response in Bagot Community

123. Because Covid-19 was a reportable disease, the CDC's Surveillance Team was notified, by a pathology lab or clinician, when there was a positive Covid-19 test. After this occurred, an epidemiologist in the Surveillance Team imported the available relevant information about the case into 'Redcap', a tool used by the Covid-19 Response Unit to record data about Covid-19 cases and close contacts. A new case file for the person was then generated to be worked on by the Case Management Team.¹¹⁵

124. The CDC Case Management Team was responsible for case managing people in the Northern Territory who were required to isolate.¹¹⁶ The Case Management Team was largely comprised of nurses and allied health staff. It worked seven days a week, over overlapping morning and afternoon shifts, from 8:30am to 9:00pm. I find that it was an extremely hardworking team which worked under very difficult circumstances.

125. Although the composition of the team changed over time, in November and December 2021, Thalia Hewitt was the ad hoc Case Management Coordinator, having chosen to return from a period of leave to assist with the very significant

¹¹⁴ [KB 5-1] Report of Professor Carlos Scheinkestel dated 2 October 2023, 4.

¹¹⁵ [KB 3-3] Affidavit of Thalia Hewitt dated 26 March 2024, [38].

¹¹⁶ [KB 3-3] Affidavit of Thalia Hewitt dated 26 March 2024, [28].

demands on the Territory's emergency response towards the end of 2021.¹¹⁷ She reported to the Covid-19 Case and Contact Tracing Manager, Rebecca Slade.¹¹⁸

126. At the beginning of each shift, Ms Hewitt would allocate cases to a Case Manager, or team of Case Managers, who were then responsible for contacting each positive case and providing them with information concerning the requirement that they isolate. Guidance as to how to conduct these calls, or 'Case Interviews', was provided to Case Managers by a Case Interview **Call Script**.¹¹⁹
127. If a Case Manager was unable to contact a person, the person was referred to the 'Stop-and-Stay' team of NT Police, which went into the community to locate people.¹²⁰ If police located the person, they provided 'Stop and stay' advice, namely, that the person had tested positive to Covid-19, that they were required to isolate, that they should do so immediately, and that the CDC would contact them soon. The police also facilitated contact between the Case Management Team and the positive case, so that the Case Interview could occur.¹²¹
128. One significant aspect of the Case Interview was to determine where the person would be required to complete their period of isolation. When Ms Bading contracted Covid-19, the Case Manager could make three types of referrals, to:
- (a) self-isolate at home (or other suitable place) under a then pilot program for self-isolation, if a person could do so safely, and effectively, with support;
 - (b) isolate at a designated quarantine facility, such as the CNR or the Alice Springs Quarantine Facility;
 - (c) isolate at a designated health facility, such as the Royal Darwin Hospital (**RDH**).

¹¹⁷ [KB 3-3] Affidavit of Thalia Hewitt dated 26 March 2024, [21].

¹¹⁸ [KB 3-3] Affidavit of Thalia Hewitt dated 26 March 2024, [33].

¹¹⁹ [KB 3-3] Affidavit of Thalia Hewitt dated 26 March 2024, [

¹²⁰ [KB 3-3] Affidavit of Thalia Hewitt dated 26 March 2024, [52].

¹²¹ [KB 3-3] Affidavit of Thalia Hewitt dated 26 March 2024, [52].

129. In light of her chronic ill health,¹²² there is no suggestion that Ms Bading would have been eligible, or could safely, self-isolate at home. Rather, the real issue at inquest was why, in light of her level of chronic illness, Ms Bading was not immediately referred to a designated health facility.

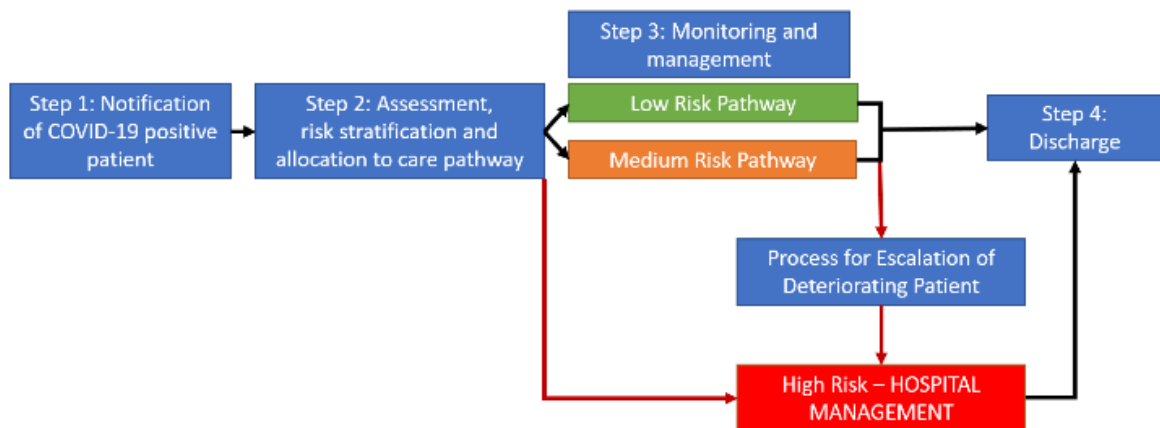
130. At the time Ms Bading was contacted by the CDC, a Covid-19 Clinical Flowchart had been created in draft at the CNR. That document had not been developed for the CDC—and contained matters like oxygen saturation that could not be assessed over the phone—but nevertheless set out the various pathways for the management of a Covid-19 positive case. The first page of the Flowchart was as follows:

COVID-19 Clinical Flowchart for CNR

Purpose

The purpose of this document is to outline the clinical patient flow pathways for COVID positive patients residing in the centre for national resilience, the 29th December, 2021.

Overview of Clinical Flowchart of COVID positive patients



131. However, in practice the Case Management Team was not designating the positive cases to a risk pathway.¹²³ Instead, the Case Management Team’s role, as it understood it, was simply to conduct ‘an initial screening, based on the case’s self-report of their symptoms and risk factors’. The Case Manager did not conduct a

¹²² In particular her liver disease and asthma: [KB 3-3] Affidavit of Thalia Hewitt dated 26 March 2024, [123](d).
¹²³ Transcript of Proceedings on 15 April 2024, 52.

detailed health assessment of a positive case.¹²⁴ Because many Case Managers were not clinically trained, Ms Hewitt explained that their ability to ‘screen’ was equivalent to that of a non-clinical employee with some training in first aid.¹²⁵ Accordingly, they were unlikely to flag a person as requiring transfer to a hospital unless they were ‘acutely unwell in that very moment’.¹²⁶ They were unlikely to flag someone as requiring transfer to a hospital who had underlying conditions of real concern (which clinical staff might have identified as high risk).¹²⁷

132. Consistent with that approach, Case Managers did not usually have regard to health records and other information about a person (case) that might have been available on Northern Territory health databases, like PCIS. Although these records contained a ‘wealth of health information about the case in question’, ‘because the composition of the case management team included non-clinical staff’, and because of the assumption that an assessment would occur at a later point in time, staff within the Case Management Team were discouraged from delving into these records, which were used to obtain contact information only.¹²⁸
133. The lack of real risk assessment by the Case Management Team was deemed appropriate on the assumption that, when people arrived at a designated quarantine facility like the CNR, they would then undergo a much more detailed health assessment by a person with appropriate clinical qualifications.¹²⁹ Indeed, Ms Hewitt explained that ‘all the work that we undertook’ in the Case Management Team was undertaken in the belief that this would occur:¹³⁰ that the risk assessment described by the clinical flowchart would be undertaken by clinicians on arrival at the CNR.
134. As Ms Bading’s case demonstrates, however, that assumption proved to be false. Not only did the CNR not conduct such an assessment, it did not do so because it

¹²⁴ [KB 3-3] Affidavit of Thalia Hewitt dated 26 March 2024, [71].

¹²⁵ Transcript of Proceedings on 15 April 2024, 53.

¹²⁶ Transcript of Proceedings on 15 April 2024, 53.

¹²⁷ Transcript of Proceedings on 15 April 2024, 53.

¹²⁸ Transcript of Proceedings on 15 April 2024, 48.

¹²⁹ [KB 3-3] Affidavit of Thalia Hewitt dated 26 March 2024, [74]; Transcript of Proceedings on 15 April 2024, 54.

¹³⁰ Transcript of Proceedings on 15 April 2024, 54.

assumed that this assessment had *already* been conducted by the Case Management Team.¹³¹

Ms Bading's referral to the CNR

135. At around 9:30pm on 30 December 2021, Dr Peter Markey emailed Thalia Hewitt, Rebecca Slade, and others at the Centre for Disease Control, to notify them that Karen Bading had tested positive for Covid-19.
136. By 11:26am on 31 December 2021, the Case Management Team, with the assistance of local police, had located Ms Bading and a Case Manager, Rarrtjiwuy (Melanie) Herdman, was speaking to her.¹³²
137. Ms Herdman is a Yolngu woman and Chair of the Miwatj Health Aboriginal Corporation. Although she was not clinically trained, she had long experience in indigenous primary health care and was often assigned as Case Manager to support vulnerable indigenous positive cases.¹³³ It is likely for that reason that Ms Hewitt assigned Ms Herdman to Ms Bading's case.¹³⁴
138. Ms Herdman recalled that she followed the Call Script and also had a general conversation with Ms Bading. She recalled that Ms Bading was calm and asked lots of questions. She recalled that Ms Bading's husband, Damien Jentian, was in the room with her during the interview.¹³⁵ Ms Herdman did not consider Ms Bading to be 'acutely unwell', although it is not clear whether this assessment was based solely on her impression that she was not 'audibly short of breath'.¹³⁶ When Ms Herdman advised Ms Bading that she would not be eligible to self-isolate, and would be required to isolate at the CNR, Ms Bading expressed some concerns regarding duration and whether her carer, Mr Jentian, would be able to isolate with her. Ms Herdman confirmed that Mr Jentian would be able to travel to the CNR and isolate with her.¹³⁷

131

[KB 3-3] Affidavit of Thalia Hewitt dated 26 March 2024, [33].

132

Affidavit of Melanie Herdman dated 12 April 2024, [47].

133

Affidavit of Melanie Herdman dated 12 April 2024, [47].

134

Affidavit of Melanie Herdman dated 12 April 2024, [51].

135

Affidavit of Melanie Herdman dated 12 April 2024, [51](f).

136

Affidavit of Melanie Herdman dated 12 April 2024, [52].

137

139. During her interview with Ms Bading, Ms Herdman identified that Ms Bading was Indigenous,¹³⁸ identified that Ms Bading had recently been in hospital (although it is not clear if any questions were asked about the nature of that admission),¹³⁹ that Ms Bading was fully vaccinated,¹⁴⁰ that Ms Bading had Covid-19 symptoms (sore throat, cough, shortness of breath, runny nose and fatigue/malaise),¹⁴¹ that Ms Bading had risk factors (liver disease and asthma),¹⁴² and that she had been to see Danila Dilba that day because she felt unwell.¹⁴³
140. At 12:16pm, Ms Herdman completed a CVDR-620 Form for Ms Bading on Jira,¹⁴⁴ logging a request for her transport to the CNR.¹⁴⁵ Despite the answers given during her Case Interview, the CVDR-620 form stated that Ms Bading had ‘No symptoms’.¹⁴⁶
141. At 12:26pm, Ms Herdman put a note on Redcap stating that she had spoken to Ms Bading,¹⁴⁷ and, at 1:38pm, noted that she had completed her Case Interview.¹⁴⁸ Ms Herdman referred Ms Bading to the CNR.
142. At 4:07pm, Ms Herdman emailed a number of group email addresses at the Emergency Operations Centre and the CNR to advise them to expect Ms Bading’s arrival at the CNR.¹⁴⁹ The email did not flag any elevated risk or seek a medical review upon Ms Bading’s arrival.
143. On 1 January 2022, at 10:55am, a Jennifer Malone, of the Transport team at the Emergency Operations Centre, sent an email to St John Ambulance with a request that a number of people, including Ms Bading, be transported to the CNR as soon as possible.

¹³⁸ Affidavit of Melanie Herdman dated 12 April 2024, RMH-2, pg 43.

¹³⁹ Affidavit of Melanie Herdman dated 12 April 2024, RMH-2, pg 53.

¹⁴⁰ Affidavit of Melanie Herdman dated 12 April 2024, RMH-2, pg 59-69 and RMH-3, pg 97.

¹⁴¹ Affidavit of Melanie Herdman dated 12 April 2024, RMH-2, pg 71.

¹⁴² Affidavit of Melanie Herdman dated 12 April 2024, RMH-2, pg 71.

¹⁴³ Affidavit of Melanie Herdman dated 12 April 2024, RMH-2, pg 69.

¹⁴⁴ A digital ticketing system for transport.

¹⁴⁵ Affidavit of Melanie Herdman dated 12 April 2024, [54].

¹⁴⁶ Affidavit of Melanie Herdman dated 12 April 2024, RMH-4, pg 99.

¹⁴⁷ [KB 3-3] Affidavit of Thalia Hewitt dated 26 March 2024, [124].

¹⁴⁸ [KB 3-3] Affidavit of Thalia Hewitt dated 26 March 2024, [125].

¹⁴⁹ Affidavit of Melanie Herdman dated 12 April 2024, RMH-7, pg 105.

144. At 12:59pm, Ms Malone provided a ‘modified form for Karen Bading which now include[d] her carer’, her husband, Mr Jentien. At 1:21pm, she added a comment to the CVDR-620 Form for Ms Bading, noting that:

Upon call to confirm St John pickup, Damien and Karen requested that Damien go to CNR to as Karen's carer. He also said he was positive too! Medical have advised that Husband Damien Jentian could also travel to CNR with her. St John and CNR have been advised.¹⁵⁰

145. As matters transpired, these notes were not communicated to the team who collected Ms Bading from her home and Mr Jentian was not permitted to travel with her.

Arrival at the CNR on 1 January 2022

146. Intake to the CNR was undertaken at the entrance to the CNR complex, immediately after the incoming residents alighted from a bus.¹⁵¹ Mr Paul Dimond, a senior registered nurse, explained that this was a ‘very quick’ triage process, with incoming residents waiting, often standing and in the sun, to speak to CNR staff donned in full PPE. At the time of Ms Bading’s arrival to the CNR, registration was documented on a very simple registration form (see [149], below). Basic clinical observations were taken to provide a baseline.

147. When asked about the CNR’s clinical risk flowchart document (at [130] above), Mr Paul Dimond explained that he had no actual recollection of ever having seen the document.¹⁵² He said that staff simply didn’t have the time to ask the kinds of questions they might have needed to ask to assess comorbidities, social risk factors and things of that nature, that they would have needed to understand to make the risk assessment in the document.¹⁵³ There was no review of medical records at the time of intake.

148. Mr Dimond’s understanding was that a detailed risk assessment was not necessary, because the CDC had already ‘told us *by action*’ that these people were suitable for CNR.¹⁵⁴ Mr Dimond frankly accepted that this was an ‘assumption’ and that it was

¹⁵⁰ KB 6-25 Email from Jillian Farquhar with CVDR-620 attachment for Karen Bading.

¹⁵¹ Transcript of Proceedings on 16 April 2024, 41.

¹⁵² Transcript of Proceedings on 16 April 2024, 41.

¹⁵³ Transcript of Proceedings on 16 April 2024, 41.

¹⁵⁴ Transcript of Proceedings on 16 April 2024, 42.

based on little more than the fact that they ‘were at CNR – that they were there’.¹⁵⁵ He described being ‘taken aback’ when he learned that no such assessment had been undertaken by the CDC, and that decisions as to where a person was to isolate were made by persons without clinical training.¹⁵⁶

149. Ms Bading arrived at the CNR on 1 January 2022. Her intake was managed by registered nurse Jennette Reynante and nursing student Puja Rasaili. Her intake form was as follows:

¹⁵⁵ Transcript of Proceedings on 16 April 2024, 42.

¹⁵⁶ Transcript of Proceedings on 16 April 2024, 43.

160
**CNR Cluster Registration
 Form v1**

**Coronavirus
 (COVID-19)**

Version number 1

Date of Arrival: 11/01/22 Intake by: Jennette | Paja

Name: <u>Karen Bading</u>	Male <input type="checkbox"/>
DOB: <u>14/2/75</u>	Female <input checked="" type="checkbox"/>
Address (Where you usually live): <u>Bading's community</u>	Community Clinic Name: <u>Pagol Clinic</u>
Mobile Number: <u>0475112453</u>	<u>M8 2A</u>

Travelling With: alone

Allergies: <u>N/A</u>	Dietary Needs: <u>Normal</u>
--------------------------	------------------------------

On any medications: <u>Wellsfor Park</u>	Smoker <input type="checkbox"/>
Did you bring the medicine with you?	Non-Smoker <input checked="" type="checkbox"/>
	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

Vaccination for COVID-19?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
If yes - Dose 1 <input checked="" type="checkbox"/> Dose 2 <input checked="" type="checkbox"/>	

Arrival Temperature: 39.3 Room Number: M8 2A



150. I am satisfied, on the basis of the general evidence regarding the nature of intake to the CNR, and Ms Bading's intake form, that no risk assessment was undertaken upon her arrival to the facility. It is unlikely that any questions were asked

regarding her comorbidities, and significant recent medical history, or that the public and hurried setting would have been appropriate for a discussion of those matters.

151. The clinical observations—temp 37.3; blood pressure 80/49; resp rate 23; heart rate 110; oxygen saturation 96%—were very concerning. As Professor Carlos Scheinkestel noted in his expert report, if these observations were taken in a hospital that would have required a ‘MET’ or a medical emergency team call.¹⁵⁷ The Department and its witnesses agreed with this assessment.¹⁵⁸ As Professor Christine Connors noted, Ms Bading ‘had an extremely low blood pressure and elevated heartrate which is saying something is happening here and we need to figure out what’, which ‘should have been escalated by the intake team.’¹⁵⁹ Mr Dimond stated that it was ‘highly irregular’ that the blood pressure wasn’t brought to anyone’s attention.¹⁶⁰
152. It is not clear why no action was taken in relation to these very concerning clinical observations. Certainly, it strongly corroborates the notion that no meaningful health assessment was undertaken by the CNR at the time of intake. Further, the baseline observations were not uploaded to PCIS, or another record system, that was readily accessible to other health staff at the CNR. This meant that the desktop review of Ms Bading’s case by Dr Buchholz at around 3:00pm the next day was based on incomplete information.
153. On 2 January 2022, at 11:01am, a nursing student and a registered nurse conducted a Covid-19 check. They observed that Ms Bading’s heart rate was 94 beats per minute, her temperature was 36.3 and her oxygen saturation was 98%.¹⁶¹ No blood pressure was taken, because blood pressure was not part of the standard Covid-19 symptom checks at the CNR.

¹⁵⁷ [KB 5-1] Report of Professor Carlos Scheinkestel dated 2 October 2023, 4.

¹⁵⁸ Submissions of the Department of Health dated 27 September 2024,

¹⁵⁹ Transcript of Proceedings on 19 April 2024, 39.

¹⁶⁰ Transcript of Proceedings on 16 April 2024, 40.

¹⁶¹ [KB 6-14] PCIS Records for Karen Bading between 2 January 2022 and 3 January 2022, 1.

154. At around 3:00pm that afternoon, Dr Buchholz reviewed Ms Bading's records. This was not prompted by a request or referral, or even CNR policy,¹⁶² but was consistent with Dr Buchholz' practice, at least in the early stages of the pandemic, to review the medical records on PCIS for residents accommodated within the Red Zone.¹⁶³ It is commendable that Dr Buchholz developed this practice, on her own initiative. That the review would not have occurred but for this proactive young doctor tends to highlight the gap in CNR policy.
155. In reviewing her medical records, Dr Buchholz noted that Ms Bading's medical history included liver cirrhosis with encephalopathy three months prior, seizure disorder (though it appeared she had not experienced a seizure for approximately six years), systemic lupus erythematosus, and haemoptysis three months prior, which required embolization of a bronchial artery. She also noted the circumstances of her transfer to the CNR, following the COVID-19 swab at her GP clinic.¹⁶⁴
156. Significantly, the PCIS records did not reflect, and Dr Buchholz was not otherwise aware of, the very concerning observations that had been taken upon Ms Bading's arrival at the CNR the day prior. As Dr Buchholz noted, had she known about these observations she might have conducted an 'urgent clinical review *face to face*',¹⁶⁵ called an infectious diseases expert, or made the decision to transfer to the RDH immediately.¹⁶⁶
157. Dr Buchholz notes recorded that she had 'Phoned Karen to review today given significant comorbidities / moderate risk of severe COVID'.¹⁶⁷ Ms Bading told Dr Buchholz that she had vomited the previous evening and that morning (but not that afternoon).¹⁶⁸ Dr Buchholz asked whether she had had bowel movements, which she had.¹⁶⁹ Dr Buchholz noted that 'Obs have been WNL [within normal limits] with

¹⁶² As the Department noted, 'nothing obliged Dr Buccholz to proactively review Ms Bading's medical history: Submissions of the Department of Health dated 27 September 2024, [136].

¹⁶³ Affidavit of Elizabeth Buccholz dated 15 March 2024, [40], [51].

¹⁶⁴ Affidavit of Elizabeth Buccholz dated 15 March 2024, [40], [52].

¹⁶⁵ Transcript of Proceedings on 16 April 2024, 32.

¹⁶⁶ Transcript of Proceedings on 16 April 2024, 18.

¹⁶⁷ [KB 6-14] PCIS Records for Karen Bading between 2 January 2022 and 3 January 2022, 2.

¹⁶⁸ Affidavit of Elizabeth Buccholz dated 15 March 2024, [54].

¹⁶⁹ Affidavit of Elizabeth Buccholz dated 15 March 2024, [54].

nursing staff’,¹⁷⁰ tending to confirm that Dr Buchholz was not aware of the very concerning observations upon arrival at the CNR the day prior.

158. At 3:27pm, Dr Buchholz emailed the nursing staff who were overseeing Ms Bading’s zone to inform them of Ms Bading’s ‘serious underlying health issues’, which she then listed.¹⁷¹ The email asked that Ms Bading be provided 2 x 4mg of ondansetron wafers for her nausea. It concluded by stating, ‘Double vaccinated but super low threshold to transfer to RDH if any resp symptoms, abdo pain or confusion’ and that Dr Buchholz would review Ms Bading the next day.¹⁷²

159. At this point, it is necessary to say something about contact between Ms Bading and a family member in community, Ms Natalie Harwood. That afternoon, Ms Bading had called Ms Harwood and told her that she had been vomiting and was feeling very sick. Ms Harwood, evidently very concerned, spent much of 1 and 2 January ‘calling everyone I could to try and get some medical attention for her’. She explained,

I tried calling the numbers for the Howard Springs facility, when I eventually got through my call was cut off. I called the Police, friends and family who I thought may have information but was unsuccessful in obtaining help for her. I even contacted the Minister for Health's office. I then called RDH asking if someone could contact a doctor at Howard Springs to see my sister however no one went to see her. This was despite her being COVID positive and having a poor health history.¹⁷³

160. At 5:14pm, an employee in the Minister for Health’s office, Luke Ablett, who had evidently spoken to Ms Harwood, emailed the Top End Health Service Ministerial Liaison Team and the Department Liaison Officer for the Department of Health, regarding Ms Bading. He said:

Can I please request an urgent welfare check on Karen Bading, 0475 111 453 who is a COVID positive resident at CNR. I’ve just spoken to her sister and they’re concerned for Karen wellbeing. She has asthma, diabetes, liver cirrhosis and apparently was vomiting yesterday. She has apparently had limited welfare checks since arriving.

¹⁷⁰ [KB 6-14] PCIS Records for Karen Bading between 2 January 2022 and 3 January 2022, 2.

¹⁷¹ Affidavit of Elizabeth Buccholz dated 15 March 2024, EB-2.

¹⁷² Affidavit of Elizabeth Buccholz dated 15 March 2024, EB-2.

¹⁷³ [KB 2-1] Email from Natalie Harwood on 19 January 2022.

Given her co-morbidities, maybe she could be considered for Lorraine Brennan?

Outcomes to MO please.¹⁷⁴

161. At 6:35pm, this email was forwarded to the Executive Director of the CNR, Ms Gabrielle Brown.¹⁷⁵ Ms Brown responded to the email at 9:55pm, as follows:

So people are aware - all Red zone are checked in twice a day by nursing staff in person. We are aware of co-morbidities. Described can be normal symptoms of covid.

The decision on LB is a medical one and does not rest on co-morbidities. We manage on site more than listed below.

162. One difficulty with this email is that it suggested that the twice daily routine Covid-19 checks would be adequate for a clinical assessment to occur. As Dr Buchholz clarified, 'those check-ups were really not designed ... to allow a clinical or risk assessment to be made' of a resident.¹⁷⁶ Dr Buchholz considered that the standard questions that might be asked during these twice daily checks were not probing enough to pick up symptoms of concern for a resident like Ms Bading.¹⁷⁷

163. Precisely what action Ms Brown took after sending this email is unclear, given her limited memory by the time of inquest.¹⁷⁸ All that can be said with confidence is that she understood that Mr Ablett was asking for an assessment, by a clinician, of whether Ms Bading needed to be transferred to the Lorraine Brennan wing of the RDH, and that she notified the clinical team of this request some 12 hours later, at approximately 9:30am on 3 January 2022.¹⁷⁹ Ms Brown was not sure why she did not do so sooner.¹⁸⁰

164. An hour and a half earlier, at 8:00pm, Ms Bading was seen by registered nurse Melanie Brewer and was given 8mg of Ondansetron as charted by Dr Buchholz.¹⁸¹

¹⁷⁴ Affidavit of Gabrielle Brown dated 4 April 2024, [76], GB-17.

¹⁷⁵

¹⁷⁶ Transcript of Proceedings on 16 April 2024, 19.

¹⁷⁷ Transcript of Proceedings on 16 April 2024, 19.

¹⁷⁸ Transcript of Proceedings on 17 April 2024, 595-596.

¹⁷⁹ Transcript of Proceedings on 17 April 2024, 597.

¹⁸⁰ Transcript of Proceedings on 17 April 2024, 597.

¹⁸¹ [KB 3-1] Affidavit of Paul Dimond dated 26 March 2024, [54](a); [KB 6-14] PCIS Records for Karen Bading between 2 January 2022 and 3 January 2022, 2.

No observations were taken, although the notes record that Ms Bading was ‘complaining of nausea and vomiting’.¹⁸²

165. At 8:05pm, Ms Bading complained to another staff member of continuing nausea and vomiting, although it is unclear who this staff member was.¹⁸³ It appears that staff did not return to the Red Zone to speak with Ms Bading, because they had just left the zone after a long shift.¹⁸⁴ Instead, Ms Brewer called Ms Bading and attempted to reassure her that the medication had not yet had a chance to work. Ms Bading told Ms Brewer that she was ‘feeling hot in myself’. Ms Brewer recommended that Ms Bading ‘turn the aircon on, have a shower’ and consume ‘fluids as tolerated’.¹⁸⁵
166. At approximately 9:30pm on 2 January 2022, Ms Tammy-Allen Fernandes commenced the night shift as on-call nurse.¹⁸⁶ Rostered on with Ms Fernandes was Ms Sandy Brown, an administrative officer who was training to become an Aboriginal and Torres Strait Islander Health Practitioner (or ATSIHP).¹⁸⁷
167. Sometime prior to commencing her shift at 9:30pm, Ms Fernandes recalled that another staff member raised Ms Bading’s case with her and said that a Medical Officer had reviewed the case and said she should be monitored closely.¹⁸⁸ Although Ms Fernandes could not recall the content of the staff handover between 9:30 and 10:15pm, she also considered it to be likely that there was some discussion of Ms Bading’s case during the handover period.¹⁸⁹
168. At around 10:30pm that evening, Ms Harwood, who had become increasingly concerned about Ms Bading, decided to drive to the CNR with another family member, Sarah Perris, ‘to make some noise on why my sister still hadn’t been [seen] by a medic and to try to get answers’.¹⁹⁰ They were approached by either police, or

¹⁸² [KB 6-14] PCIS Records for Karen Bading between 2 January 2022 and 3 January 2022, 2.

¹⁸³ [KB 3-1] Affidavit of Paul Dimond dated 26 March 2024, [54](b); [KB 6-14] PCIS Records for Karen Bading between 2 January 2022 and 3 January 2022, 2.

¹⁸⁴ [KB 6-14] PCIS Records for Karen Bading between 2 January 2022 and 3 January 2022, 2.

¹⁸⁵ [KB 6-14] PCIS Records for Karen Bading between 2 January 2022 and 3 January 2022, 2.

¹⁸⁶ [KB 3-2] Affidavit of Tammy-Allen Fernandes dated 2 April 2024, [43].

¹⁸⁷ [KB 3-2] Affidavit of Tammy-Allen Fernandes dated 2 April 2024, [43].

¹⁸⁸ [KB 3-2] Affidavit of Tammy-Allen Fernandes dated 2 April 2024, [44].

¹⁸⁹ [KB 3-2] Affidavit of Tammy-Allen Fernandes dated 2 April 2024, [46].

¹⁹⁰ [KB 2-1] Email from Natalie Harwood on 19 January 2022, 2.

security, and told the officials that they would ‘not be leaving here until my sister is seen by someone’. One of the officials said that they would see what they could do.¹⁹¹

169. At some point before midnight, Ms Fernandes received a telephone call from one of the night shift staff requesting that she attend on Ms Bading, who was feeling unwell.¹⁹² She notified Ms Brown, and together they attended the Red Zone staff pod to don PPE.¹⁹³

170. Upon arrival at the Red Zone, Ms Fernandes spoke to Paul Dimond, a registered nurse who had worked the day shift as team leader, and who had stayed back to finish some paperwork.¹⁹⁴ Mr Dimond provided Ms Fernandes with some information regarding Ms Bading.¹⁹⁵ At inquest, Ms Fernandes explained that she was made aware that Ms Bading ‘had been given something to help her nausea, but nothing else was really flagged that I can remember’.¹⁹⁶ Ms Fernandes was not sure whether she was told by Mr Dimond that Ms Bading had a low threshold for transfer to the RDH, and may have only seen this in writing at some later point in time, for instance when she came to prepare her statement.¹⁹⁷ Although Ms Fernandes was aware that Ms Bading’s case had been ‘reviewed’ by a doctor, she did ‘not have a lot of information about the review’. She could not recall being told about any specific symptoms that the doctor wished staff to look out for.¹⁹⁸ She did not think she would have looked at Ms Bading’s notes on PCIS prior to entering the Red Zone but may have had a ‘quick look’ when writing up her own notes after leaving the Red Zone.

¹⁹¹ [KB 2-1] Email from Natalie Harwood on 19 January 2022, 2.

¹⁹² [KB 3-2] Affidavit of Tammy-Allen Fernandes dated 2 April 2024, [47].

¹⁹³ [KB 3-2] Affidavit of Tammy-Allen Fernandes dated 2 April 2024, [48].

¹⁹⁴ [KB 3-2] Affidavit of Tammy-Allen Fernandes dated 2 April 2024, [50].

¹⁹⁵ [KB 3-2] Affidavit of Tammy-Allen Fernandes dated 2 April 2024, [52].

¹⁹⁶ Transcript of Proceedings on 16 April 2024, 55. I prefer Ms Fernandes’ oral account of this conversation to the account given in her affidavit. The affidavit was not prepared at a meaningfully earlier point in time and was prepared with the assistance of her legal representatives.

¹⁹⁷ Transcript of Proceedings on 16 April 2024, 54-55.

¹⁹⁸ Transcript of Proceedings on 16 April 2024, 56.

171. It is likely that Ms Fernandes arrived with Ms Brown at Ms Bading's room at approximately 11:30pm on 2 January 2024.¹⁹⁹ Ms Bading was sitting at the table on her veranda.²⁰⁰ She was on the phone to a female family member.²⁰¹ Although Ms Fernandes could not recall the name of this person, I am satisfied that it was Ms Harwood.
172. Ms Fernandes spent approximately 30-40 minutes with Ms Bading. She stated, in her notes and her evidence to the inquest, that Ms Bading complained of 'vomiting and feels nauseated' and that 'she fe[lt] sick after taking her medications'. Ms Bading stated that although she was 'given 8mg Ondansetron ... she did not feel any better'. Ms Fernandes noted that Ms Bading was coughing or '[s]pitting up flem' while speaking.²⁰²
173. Ms Fernandes took observations, being a blood pressure of 100/60, oxygen saturation of 98%, pulse rate of 90 and resp rate of 17.²⁰³ Although she did not record a temperature, she stated in her affidavit that she did take a temperature and found Ms Bading to be afebrile (she did not have a fever).²⁰⁴ Ms Fernandes considered these observations to be 'within normal limits' and concluded that the 'observations *alone* did not indicate any risk'. This again tended to confirm that clinical staff at the CNR were not aware of the concerning observations upon Ms Bading's arrival at the facility.
174. Ms Fernandes' notes suggest that, at some point during her consultation, she called Dr Buchholz. Dr Buchholz prescribed Ms Bading another 4mg of Ondansetron.
175. During her consultation, Ms Fernandes agreed to speak to Ms Bading's family member, who was on speaker-phone.²⁰⁵ Although Ms Fernandes could not recall exactly what was said, the general effect of the conversation was that the family member was concerned about Ms Bading's health because of her underlying health

¹⁹⁹ That is consistent with the notes taken by Natalie Harwood, and with the time Ms Fernandes commenced writing her clinical notes (at 12:40am).

²⁰⁰ [KB 3-2] Affidavit of Tammy-Allen Fernandes dated 2 April 2024, [54].

²⁰¹ [KB 3-2] Affidavit of Tammy-Allen Fernandes dated 2 April 2024, [54].

²⁰² [KB 3-2] Affidavit of Tammy-Allen Fernandes dated 2 April 2024, [56](g).

²⁰⁴ [KB 3-2] Affidavit of Tammy-Allen Fernandes dated 2 April 2024, [56](e).

²⁰⁵ Transcript of Proceedings on 16 April 2024, 56.

conditions.²⁰⁶ She explained that she had attempted to enter the facility to see Ms Bading but had been refused by security, and that she was now parked outside the facility.²⁰⁷

176. Ms Sarah Perris, who was outside the facility with Ms Harwood, thought there was ‘a lot of information going back and forwards’ and took these notes on her phone as the conversations were happening:²⁰⁸

11:30pm nurse outside room
Confirmed via call.
Checking blood pressure
Dizzy
Shirt wind
Dr in a rush

Obs
Temp 36.8
Blood pressure
Feeling hot
Saturation 98 oxygen in blood good
Carer maybe allowed in the morning who? Suggested
Tammy nurse doing the check
Tenay social worker
ALO engagement team to support tomorrow
Hot throat a medicine in Webster pack
Feels cold

177. Ms Perris explained that the note ‘11:30pm nurse outside room’ recorded Ms Bading telling Ms Harwood and Ms Perris that a nurse was outside her room, and was about to consult with her.²⁰⁹ Ms Perris said that the note ‘shirt wind’ should have read ‘short wind’, and that Ms Bading was ‘out of breath when she was talking’ and that ‘she sounded really sick over the phone’.²¹⁰ She was saying to Ms Harwood, ‘Bub, I’m short wind, I’m dizzy’.²¹¹

178. Ms Harwood also gave evidence that Ms Bading was feeling dizzy. She explained that Ms Bading was saying that she was dizzy and ‘finding it difficult to breathe’

²⁰⁶ [KB 3-2] Affidavit of Tammy-Allen Fernandes dated 2 April 2024, [57].

²⁰⁷ [KB 3-2] Affidavit of Tammy-Allen Fernandes dated 2 April 2024, [57].

²⁰⁸ Transcript of Proceedings on 15 April 2024, 41.

²⁰⁹ Transcript of Proceedings on 15 April 2024, 41.

²¹⁰ Transcript of Proceedings on 15 April 2024, 42.

²¹¹ Transcript of Proceedings on 15 April 2024, 42.

and that she ‘can’t breathe properly’.²¹² I am satisfied, on the basis of the contemporaneous notes, and Ms Harwood’s and Ms Perris’ evidence, that Ms Bading *did* say these things, and that she *was* dizzy and finding it difficult to breathe.

179. It is not clear whether Ms Bading said each of the things recorded in the notes in front of Ms Fernandes. For her part, Ms Fernandes said that Ms Bading didn’t seem to be short of wind or dizzy, although she did not think she would have asked her if she was.²¹³ She agreed that it would have been significant to her from a clinical perspective if she had been dizzy or short of breath.²¹⁴ Dr Buchholz agreed that these symptoms would have been concerning, and explained that dizziness, in particular, might have suggested worsening underlying liver disease.²¹⁵ I am unable to say why these symptoms, which I find to have been present, were not identified.
180. Neither Ms Perris nor Ms Harwood could recall the meaning of the note ‘Dr in a rush’.²¹⁶ The temperature of 36.8 confirms Ms Fernandes’ account that she did, in fact, take a temperature and that it was within normal limits.
181. During her conversation with Ms Fernandes, Ms Harwood asked that Ms Bading be moved closer to her other family members in the CNR. Ms Fernandes explained that Ms Bading ‘genuinely did not feel happy or safe where she was’ and ‘wanted to move closer near her family’. Ms Fernandes left the zone for around 15 or 20 minutes to check whether that request could be accommodated and identified a room that was directly across from one of Ms Bading’s family members.²¹⁷ Ms Fernandes assisted Ms Bading to move to this room, before leaving the Red Zone.²¹⁸
182. Both during the initial consultation, and the move to the second room, Ms Fernandes recalled that Ms Bading was able to ambulate with the assistance of a 4-wheeled walker. When asked by counsel for the Department whether Ms Bading was ‘wobbly on her feet’, Ms Fernandes said ‘she may have been wobbly on her feet’, although

²¹² Transcript of Proceedings on 16 April 2024, 34.

²¹³ Transcript of Proceedings on 16 April 2024, 57-58.

²¹⁴ Transcript of Proceedings on 16 April 2024, 60.

²¹⁵ Transcript of Proceedings on 16 April 2024, 20.

²¹⁶ Transcript of Proceedings on 15 April 2024, 34.

²¹⁷ Transcript of Proceedings on 16 April 2024, 58.

²¹⁸ Transcript of Proceedings on 16 April 2024, 59.

it is unclear whether she had an independent memory of this.²¹⁹ When asked whether she was ‘steady’, she said she appeared steady holding a railing or her walker, but clarified that she did not think that she saw Ms Bading stand ‘on her own without her wheelie walker’.²²⁰ When asked by counsel for the Department whether she knew what ‘ataxia’ was, she said she did not.²²¹

183. At approximately 12:20am, Mr Dimond sent a handover email to a large number of CNR staff. He noted that it had been an ‘extraordinarily busy shift’. In relation to Ms Bading, the email noted:

M8 2A – Karen Bading – Vomiting and nausea – anti emetic given. At 2300 asked to see resident sill c/o nausea. On call Team advised and will visit resident. Her family attended CNR wanting access to her, same refused by Security. Family also phoned Police stating she required medical assistance. MO reviewed today, whilst we have a low tolerance as far as her underlying medical issues are concerned we have been speaking with her throughout the PM shift and delivered an Rx antiemetic. The night staff have moved her to M3 3B pro tem to be closer to her sister in m3 3B. Her sisters would like a room change tomorrow morning to M3 3C and D.²²²

184. As I have noted, at 9:23am on 3 January 2022, Ms Brown emailed a number of group medical email addresses at the CNR, in effect passing on the concerns raised in the email sent by Mr Ablett at around 5:00pm the day before:

For the radar and follow up as required. Karen Bading, positive from Bagot is reported to have the following health conditions –

- Asthma
- Diabetes
- Liver cirrhosis and
- was reported to be vomiting on Sunday

I have been requested to consider if a transfer to LBC is required, I have initially responded that the underlying health conditions are common and that any transfer to LBC is a medical decision in this context.

²¹⁹ Transcript of Proceedings on 16 April 2024, 61.

²²⁰ Transcript of Proceedings on 16 April 2024, 62.

²²¹ Transcript of Proceedings on 16 April 2024, 61.

²²² [KB 3-1] Affidavit of Paul Dimon dated 26 March 2024, PAD-3, 34.

Can I please confirm we are aware of the above conditions and that the site is able to monitor health and wellbeing through our twice day contacts.²²³

185. Almost immediately, at 9:26am, Dr Buchholz replied:

Have been aware for 24 hours – about to go in and assess.

I have a low threshold to transfer – she was in hospital 3 months ago unwell.

Will let you know in an hour.²²⁴

186. Upon her review of Ms Bading, Dr Buchholz found her to be very unwell. She appeared jaundiced, had been experiencing intermittent vomiting and nausea for the past three days, demonstrated an ataxic gait, was a bit ‘unsteady and a bit wobbly on her feet’,²²⁵ had an elevated respiratory rate of 24 breaths per minute, had a loud heart murmur and said that she felt short of breath.²²⁶ Dr Buchholz was concerned that Ms Bading was experiencing a deterioration of her liver cirrhosis, secondary to Covid-19 infection.²²⁷ Dr Buchholz confirmed that a significant part of her concern was based on her physical observations—the jaundice and ataxia—matters that would not previously have been apparent to her, if they were present, during a telephone consultation.²²⁸

187. At 10:50am, Dr Buchholz sent a further email that said, ‘Going to 4B for assessment – she’s very unwell in Red Zone.’²²⁹ ‘4B’ was a reference to Ward 4B of the RDH.²³⁰

188. At 12:19pm, she updated Ms Bading’s clinical notes on PCIS as follows:

Serious underlying health issues – really should have been taken straight to RDH when diagnosed.

Vomiting for 3 days, jaundice, nausea

...

²²³ Affidavit of Gabrielle Brown dated 4 April 2024, [76], GB-20.

²²⁴ Affidavit of Gabrielle Brown dated 4 April 2024, [76], GB-21.

²²⁵ Transcript of Proceedings on 16 April 2024, 22.

²²⁶ Affidavit of Elizabeth Buchholz dated 15 March 2024, [72]-[75].

²²⁷ Affidavit of Elizabeth Buchholz dated 15 March 2024, [72].

²²⁸ Transcript of Proceedings on 16 April 2024, 23.

²²⁹ Affidavit of Gabrielle Brown dated 4 April 2024, [76], GB-21.

²³⁰ Affidavit of Elizabeth Buchholz dated 15 March 2024, [78].

Needs t/f to RDH – accepted by Dr Sze Tay, COVID resource nurse aware, 000 called.²³¹

189. Dr Buchholz explained that, in part, these notes reflected a degree of frustration. At the time, just two, or three, general practitioners were rostered on for the entire CNR facility each day. While that level of staffing had previously been adequate, things were ‘escalating’ in the community and Dr Buchholz felt those staffing levels were no longer adequate. Dr Buchholz explained that she was,

...frustrated that we were being expected to manage people who were probably a bit higher-risk without any oversight about who came to the CNR, and with very minimal information a lot of the time, about their comorbidities. I just felt the expectation was too great. And I was also frustrated for Ms Bading, on her behalf, that she had ended up unwell and requiring transfer.

Is it fair to say that you thought more robust systems were needed to ensure that people were well enough to be at the CNR? --- Yes.²³²

Transfer to RDH.

190. Ms Bading was transferred to the RDH. Following initial resuscitation for hypotension (low blood pressure), at 4:30pm, she required the activation of a code blue, again for hypotension.²³³ With additional investigation, and additional intravenous fluid, her hypotension resolved.²³⁴ Nevertheless, within 24 hours she became disoriented, and, by 5 January 2022, her level of consciousness was dropping, and she was difficult to rouse. She was transferred to the ICU where doctors attempted to treat her, unsuccessfully, until her death on 14 January 2022.

191. Ultimately, I am satisfied, on the basis of the primary medical records and the independent expert opinion of Professor Scheinkestel, that no concerns arise from Ms Bading’s treatment at the RDH between 3 and 14 January 2022.

Time, place and cause of death

²³¹ [KB 6-14] PCIS Records for Karen Bading between 2 January 2022 and 3 January 2022, 6.

²³² Transcript of Proceedings on 16 April 2024, 18-19.

²³³ [KB 5-1] Report of Professor Carlos Scheinkestel dated 2 October 2023, 9.

²³⁴ [KB 5-1] Report of Professor Carlos Scheinkestel dated 2 October 2023, 9.

192. There was broad agreement, and I find, that the time, place and cause of Ms Bading's death was as follows:

- (a) at the time of her death, Ms Bading was a 46-year-old aboriginal woman (born on 14 February 1976);
- (b) Ms Bading died on 14 January 2022 at the Royal Darwin Hospital, having been transferred to that location from the CNR on 3 January 2024; and,
- (c) the direct cause of Ms Bading's death was hepatic encephalopathy due to decompensated Child Pugh C Cirrhosis and meningitis in the context of Covid-19 infection and an unclassified autoimmune disease.

193. I also accept Counsel Assisting's submission, which I do not understand to have been controversial, that the underlying health concerns identified at [121], and the recency of the illness that had seen her admitted to the RDH in October and November 2021, were each major contributors to Ms Bading's death.

Two issues emerging from Ms Bading's care at the CNR

194. At inquest, the parties broadly agreed that two issues emerged from Ms Bading's time at the CNR. The first of these concerned the underestimation of the severity of Ms Bading's Covid-19 infection in the context of her serious underlying health issues. The second concerned the involvement of Ms Bading's family.

Underestimation of the seriousness of Ms Bading's condition

195. The Coroner's Office obtained an independent expert report from a Professor Carlos Scheinkestel. Professor Scheinkestel is the Executive Director of Quality and Safety at Monash Health. Prior to that, he was the Director of the Department of Intensive Care and Hyperbaric Medicine at the Alfred Hospital, one of the largest tertiary hospitals in Australia. He holds the title of Adjunct Clinical Professor in the School of Public Health and Preventative Medicine at Monash University.

196. Professor Scheinkestel was, initially, scheduled to be called as a witness at the inquest. After some consideration, the Department informed Counsel Assisting that it did not require Professor Scheinkestel for cross-examination because it did not

seek to challenge his evidence. When Counsel Assisting placed on the record that Professor Scheinkestel would not be called because there would be little controversy about his evidence, I qualified that, if this important witness was not to be required by the Department, I would assume that ‘nothing was controversial’. Counsel Assisting confirmed that this assumption was correct, in the presence of the Department’s counsel, who did not seek to correct it.

197. In the face of Professor Scheinkestel’s unchallenged evidence, and in light of the evidence I have summarised regarding Ms Bading’s referral to, and care at, the CNR, I am satisfied as follows.

198. First, Ms Bading should not have been admitted to the CNR. The combination of her severe chronic ill-health, and recent medical history, meant that she should have been transferred directly to the RDH and quarantined there. As the Department frankly conceded, the ‘major point’ was that a person in Ms Bading’s condition should not have been transferred to the CNR ‘in the first place’.²³⁵ On the limited information available to Ms Herdman, a medical referral should have occurred.²³⁶ In saying that, I make no criticism of Ms Herdman personally, who was not clinically trained, was not directed by any policy to make such a referral and, in light of Ms Hewitt’s evidence, would have assumed that a medical assessment *would* have occurred at the CNR.

199. Second, Ms Bading’s observations upon admission to the CNR—in particular, her blood-pressure of 80/49—ought to have prompted her transfer to RDH. Indeed, in the hospital setting those observations would have required the activation of a MET (medical emergency team) call. The Department frankly conceded in its submissions that these observations ‘should have been acted on immediately’ but were not.²³⁷ This was consistent with the position the Department took in its opening submissions at the inquest, which was that ‘once Ms Bading arrived at the Centre

²³⁵ Submissions of the Department of Health dated 27 September 2024, [134].

²³⁶ Submissions of the Department of Health dated 27 September 2024, [127].

²³⁷ Submissions of the Department of Health dated 27 September 2024, [131].

for National Resilience, her observations should have alerted staff to her condition and she should have been transferred to the RDH at that point'.²³⁸

200. Third, no action was taken in relation to the initial observations, which were not made known to the clinical team who interacted with Ms Bading between 1 and 3 January 2022. The initial low blood-pressure was not followed up with further measurement later that day, or on the following day. Ultimately, observations were either not done as the 'checks' were over the telephone, or were incomplete: for example, missing a blood-pressure.

201. Fourth, Ms Bading's state of chronic ill health, and the potential impact Covid-19 would have on her were 'seriously underestimated', as was the severity of her Covid-19 infection. As Professor Scheinkestel opined, the approach of the staff at the CNR was to 'wait for something to go wrong and then transfer her' when it ought to have been to transfer her in a 'preventative manner, because she was at high risk'.²³⁹

202. In accepting this submission, I have taken into account that Ms Bading's observations on 2 January 2022 were largely within normal limits and that they were a marked improvement on the very concerning observations at intake.²⁴⁰ I am, however, unable to accept the Department's submission²⁴¹ that these more positive clinical observations undercut Professor Scheinkestel's opinion that the CNR adopted a 'wait-and-see' approach to the detriment of Ms Bading.

203. The difficulty with the Department's submission is that these observations did not, and could not, alter the severity of Ms Bading's chronic illness, her recent and 'significant past medical history', and the potential impact Covid-19 could therefore have on her. It was this chronic illness, medical history and resulting potential for serious illness that, in Professor Scheinkestel's opinion, required her immediate transfer to the RDH. So much was recognised by Dr Buchholz when she

²³⁸ Transcript of Proceedings on 8 April 2024, 19.

²³⁹ [KB 5-1] Report of Professor Carlos Scheinkestel dated 2 October 2023, 9.

²⁴⁰ Submissions of the Department of Health dated 27 September 2024, [134]-[141].

²⁴¹ Submissions of the Department of Health dated 27 September 2024, [131]-[141].

created the note: ‘serious underlying health issues – *really should have been taken straight to RDH when diagnosed positive*’.²⁴²

204. In that context, and without making any criticism of Dr Buchholz or any other clinician personally, it is not to the point that Ms Bading’s observations were within normal limits on 2 January 2024. Professor Scheinkestel’s opinion, which I accept, was that Ms Bading was too unwell to ‘wait and see’ whether her observations worsened, rather than to transfer her preventatively.²⁴³

205. Sixth, I find that as a result of the failure to transfer Ms Bading directly to the RDH, Ms Bading ‘missed out on what would routinely accompany any hospital admission’. For example:

- (a) she would have been commenced on anti-virals;
- (b) the severity of her symptoms could have been closely monitored, and documented. Symptoms such as her dizziness and shortness of breath on the night of 2 January 2022 may not have been missed;
- (c) the risks associated with ‘checks’ over the telephone (including missed or incomplete observations of concerning symptoms, like ataxia or jaundice²⁴⁴) would have been avoided;
- (d) her blood-pressure would have been more closely monitored and acted upon if low;
- (e) it is unlikely that she would have been hypotensive as a result of probable dehydration on 3 January 2024 (the date of her admission); and,

²⁴² It was also recognised elsewhere in the Department’s submissions, when it noted that ‘the major point is that *a person in Ms Bading’s condition ought not to have been transferred* [to the CNR, rather than the RDH] *in the first place*’: Submissions of the Department of Health dated 27 September 2024, [134].

²⁴³ It was not clear, in the end, that Dr Buchholz herself disagreed with this opinion: Transcript of Proceedings on 16 April 2024, 33.

²⁴⁴ As to which, see Dr Buchholz’s evidence: Transcript of Proceedings on 16 April 2024, 22-23.

- (f) she would have had blood tests and, as a result, her hyponatraemia (sodium of 114) would have been identified (when, as matters transpired, it was missed and not picked up until severe and neurological signs had developed).

206. Seventh, had Ms Bading been transferred immediately to the RDH, rather than belatedly on 3 January 2022, ‘the chain of events triggered by her late presentation to hospital with advanced disease may have been avoided and resulted in possibly a different outcome’.²⁴⁵ It is, however, also possible, and perhaps likely,²⁴⁶ that ‘[s]evere infection in someone with [Ms Bading]’s underlying problems may well have been fatal, even if everything had been done perfectly’.²⁴⁷ Ultimately, like Professors Scheinkestel and Connors, I am unable to say whether Ms Bading’s death *would*, rather than *could*, have been avoided if she had been transferred immediately to the RDH.

207. I agree with Counsel Assisting’s submissions that three systems failures contributed to the underestimation of the severity of Ms Bading’s condition, and the failure to promptly transfer her to the RDH.

208. First, neither the CDC nor the CNR conducted any meaningful assessment of Ms Bading’s suitability for quarantine at the CNR. On any view of the evidence, such an assessment was critical to ensure the safety of a resident’s period of quarantine, particularly for those who were Covid-19 positive, because the CNR was not, and did not hold itself out to be, equipped to manage the seriously unwell. The CNR clearly operated on an assumption that such a risk assessment *had* occurred. There was, however, no policy, MOU or even an informal agreement between the CDC and CNR that allocated the responsibility for making that risk assessment. I accept Counsel Assisting’s submission that this led to an intolerable situation in which:

- (a) the CDC did not conduct such an assessment, on the basis of an assumption that the assessment would be undertaken on arrival at the CNR; and,

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²⁴⁶

²⁴⁷

See Affidavit of Christine Connors dated 3 April 2024, [206].

- (b) the CNR did not conduct such an assessment, on the basis of an assumption that the assessment had already been undertaken by the CDC (and that the incoming resident had been deemed appropriate for quarantine at the CNR).

209. Second, systems for assessing and recording the clinical conditions of its residents were inadequate. In Ms Bading's case, the evidence demonstrated that:

- (a) more robust intake assessments were required, at least for a Covid-19 positive resident.²⁴⁸ On the evidence, two ways in which the intake assessments might have been improved were, firstly, by having more experienced clinical staff perform the intake assessments for Covid-19 positive cases (and medically vulnerable persons); and, second, by having training and systems in place to ensure that observations of concern were identified and flagged as requiring action. One such system might be a 'Between the Flags' document for recording patient observations, designed to indicate to even inexperienced clinicians' observations of potential concern. Such a 'between the flags' document would likely have 'picked up' Ms Bading's very low blood pressure upon arrival;
- (b) more robust systems for recording, and sharing, clinical and other data within the CNR were required. Precisely why Ms Bading's intake observations were not recorded in her PCIS file, and therefore not known to Dr Buchholz, remains unclear. Certainly, had they been known to Dr Buchholz, her evidence was that they would have prompted her to contact an infectious disease specialist and, in all likelihood, she would have arranged for Ms Bading's immediate transfer to the RDH.

210. Third, there was a high degree of reliance on telephone 'checks', or the basic in person Covid-19 checks, even for medically vulnerable residents. As Professor Scheinkestel's report conveys, a simple but significant advantage of quarantine at a tertiary hospital for the medically vulnerable is regular observation. In light of her underlying health conditions, I am satisfied that it was highly desirable, if not

²⁴⁸ I accept that more robust intake assessments may not have been practically possible for all residents, in light of resourcing constraints.

necessary, that each of the ‘checks’ on Ms Bading between 1 and 3 January 2024 was in person. In addition, it was necessary that each ‘check’ involved more than the basic Covid-19 questions, that were, in Dr Buchholz’ opinion, unlikely to identify the kinds symptoms of concern in Ms Bading’s case. If this level of care and supervision was not possible from a resourcing perspective (and I accept, on the evidence of Dr Buchholz and others that it is unlikely to have been) this should have been a clear indication that Ms Bading was not suitable for admission to the CNR.

Involvement of family

211. I also accept that systems within the CNR should have been more inclusive of Ms Bading’s family during her period of quarantine. Although there will, of course, be limits to the extent that a facility like the CNR can include family, this inclusion was necessary in Ms Bading’s case.

212. It was necessary for Ms Bading and her family’s emotional well-being, in significant part due to her vulnerability. It was also necessary because a condition of the suitability of persons for quarantine at the CNR was that they were capable of living independently in the community. In Ms Bading’s case, her independence was heavily qualified by her reliance on her family—and in particular her husband, Damien Jentian—for assistance with day-to-day living. Without the assistance of her family, it is doubtful that Ms Bading met the CNR’s own policies regarding suitability for admission. Finally, the level of concern of Ms Bading’s family, and the observations they made over the phone on the evening of 2 January 2022, were well-founded. Had that concern, and those observations, been acted upon by staff at the CNR, it is possible that she would have been transferred to the RDH more promptly (even if a more-timely transfer would not have changed the outcome).

213. In making these findings, I recognise that:

- (a) the CNR was not a tertiary health facility and, even at the best of times, could not have been expected to engage, communicate, or actively facilitate communication with the family of each (or even a significant proportion) of its residents;

- (b) the exponential increase in rates of admission to the CNR toward the end of 2021, and the significant limitations on the CNRs resources (including staff) at that time, made engaging, communicating, or actively facilitating communication with the family of even its most vulnerable residents very difficult; and,
- (c) there were, as Ms Gabrielle Brown explained, compelling public health reasons (including infection control) why the CNR had to discourage family from attending the CNR.

214. Nevertheless, I am satisfied that I should recommend that a policy be developed to ensure that in any future pandemic scenario, or other less emergent scenarios in which quarantine is necessary:

- (a) there be at least a basic assessment of a resident's reliance on third parties for assistance with day-to-day living before they are deemed suitable for residence at a facility that assumes an ability to live 'independently' in the community; and,
- (b) at least in the case of the most medical vulnerable residents, or those most reliant on third parties for assistance with day-to-day living, there be a system to facilitate communication between the third parties and residents and, where desirable and subject to issues such as consent, direct communication between the third party and the quarantine facility.

RECOMMENDATIONS

215. Although I have grouped my recommendations according to the deceased to whom they are most relevant, many are relevant to more than one, or each, of the deceased.

216. For the reasons given in these findings, I make the following recommendations under s 35(2) of the *Coroners Act*:

Ms Bading

1. The Department reviews its policies to ensure that, in any future pandemics, there be a more detailed assessment undertaken of a person's reliance on third parties before they are determined to be suitable for quarantine in a facility that assumes an ability to live 'independently' in the community.
2. The Department reviews its policies to ensure that, in any future pandemics, persons identified as carers and who are approved to quarantine with an infected person are recorded in travel documentation.
3. The Department reviews its policies to provide that, in any future pandemics, there be an appropriate health screening process for quarantine, with the entity or person responsible for conducting that health screening clearly identified. That health screening should ideally occur before a person has arrived at the quarantine facility.
 - 3.1 The health screening process triages individuals by reference to risk, and potential residents with elevated risk factors have their cases reviewed by an appropriate medical officer before a recommendation to transfer is made.
 - 3.2 Staff conducting the health screening be prompted to ask whether the person has had a recent period of hospitalisation.
4. The Department reviews its policies to provide that, in any future pandemics, for persons at a quarantine facility who are identified as being at risk, there be pro forma records prepared and completed which identify (in short form) the person's relevant medical details.
5. The Department reviews its policies to provide that, in any future pandemics, for those persons at a quarantine facility identified as being at higher risk, there be an individualised care plan, which includes (if practicable) an in-person review by a medical practitioner shortly after admission and specifies (amongst other matters) when the person should be reviewed in person thereafter.

6. The Department reviews its policies to provide that, in any future pandemics, staff at the quarantine facility have access to the records created by staff conducting the screening.
7. The Department reviews its policies to provide that, in any future pandemics, health staff at quarantine facilities be provided with ‘between the flags’ observation forms which will visually indicate abnormal observations.
8. The Department reviews its policies to provide that, in any future pandemics, health staff at quarantine facilities be given tablets (or similar electronic devices), rather than paper forms.
9. The Department reviews its policies to provide that, in any future pandemics, for medically vulnerable residents, or those reliant on third parties for day to day living, there be a system to facilitate communication between family and welfare officers at the quarantine facility, including a position for a liaison officer.

Ms Dick

10. The Department reviews its policies to ensure that, in any future pandemics, planning documents deal expressly with whether consent is required for evacuations and, if consent is required, that guidance be given on how and by whom that consent should be obtained.
11. The Department reviews its policies to ensure that, in any future pandemics where consent is required, as much information is provided to those from whom consent is sought as is practicable in the circumstances.
12. The Department reviews its policies to make explicit that, where practicable, an appropriate health officer in remote outbreak groups be responsible for ensuring that a list of relevant medical details be prepared for prospective evacuees and that this be transmitted to the quarantine facility.
13. I refer to and repeat recommendations 3-5.
 - 13.1 The care plan to which I refer in recommendation 5 prompts proactive questions about the person’s condition by staff and the taking of any observations relevant to that condition.
 - 13.2 The care plan to which I refer in recommendation 5 identifies what medications the person is taking, the quantity of medication the person has, when the person is likely to run out of their medication, and when a review should occur to ensure that (in the event of an extension in the person’s quarantine) the person has sufficient medication for their stay.

14. The Department reviews its policies to ensure that health staff in quarantine facilities are given radios or other devices which enable them to communicate with staff elsewhere in the facility without having to leave those areas.
15. The Department reviews its policies and training to ensure that staff in quarantine facilities are aware of procedures for responding to emergencies, including by preparing a brief pictorial guide about what to do in such situations or scenario training.
 - 15.1 Those policies and that training make clear who is responsible for ensuring that security officers are notified that an ambulance will be arriving and where it is needed.
 - 15.2 Those policies and that training provide guidance to staff about the information which they should relay to ambulance services about the resident.