CITATION:	*Inquest into the deaths of Ted Ptjara and Tim Ptjara* [2025] NTLC 21
TITLE OF COURT:	Coroners Court
JURISDICTION:	Alice Springs
FILE NO(s):	A00352023 A00422023
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FINDING OF:	Judge Elisabeth Armitage
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REPRESENTATION:

Counsel Assisting:	Fiona Kepert
Counsel for NT Health:	Tom Hutton
Counsel for Corrections:	Ian Read SC
Counsel for Family:	Sarah Love
Counsel for Public Guardian and Public Trustee:	Tina Tomaszewski

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

No. A00352023
A00422023

In the matter of an Inquest into the death of

TED PTJARA

ON:19 JULY 2023

AT: Alice Springs Hospital

In the matter of an Inquest into the death of

TIM PTJARA

ON:12 SEPTEMBER 2023

AT: Alice Springs Hospital

FINDINGS

Judge Elisabeth Armitage

1. These findings address two inquests into the deaths of two brothers who died in July and September 2023 in Alice Springs. The family of these two men have indicated that they should be referred to as Little Brother and Big Brother respectively.
2. According to hospital records Little Brother was born on 27 March 1959 and Big Brother was born on 6 October 1957.
3. Little Brother and Big Brother were raised at MacDonald Downs outstation where their father worked as a stockman. The family also moved around, and the brothers grew up in various remote communities.
4. As younger men the brothers worked on cattle stations and Big Brother was known for his impressive work ethic. Family members described the men as hard-working,

introverted and quiet men of culture. Those close to them enjoyed their great sense of humour.

5. Little and Big Brother were part of a large extended family in Alice Springs and across the central region. Both men were cultural role models for younger family members. They were proud Eastern Arrernte and Alyawarr speakers and taught many nephews how to hunt and how to prepare kangaroo.

6. Although they could communicate to some degree in English, these men were not English speakers. Growing up they probably had little formal western education[1] and instead received an education in their Arrernte and Alyawarr culture and station work. This background indicates a cultural divide between their lives and the western systems attempting, but largely failing, to support them in later life.

7. I offer my condolences to their family and those who knew Big Brother and Little Brother.

Introduction – Little Brother

8. For many years Little Brother lived in Alice Springs but did not have his own residence. There is some information of him living with family earlier on, but most of the more recent information held by service providers indicates he was generally sleeping rough around Alice Springs.

9. In 2016 Little Brother went into mandatory alcohol treatment. Staff at the program were concerned about his capacity to make decisions and commenced the process of applying for an adult guardianship order in the Northern Territory Civil and Administrative Tribunal (**NTCAT**).

10. At the same time referrals were made for assistance through aged care. An aged care assessment was commenced on 27 July 2016, and it was completed on 8 August 2016. Housing was identified as a need, and a recommendation was made for referral to Assistance with Care and Housing for the Aged for housing support.[2]

11. On 4 November 2016 NTCAT made orders appointing the Public Guardian as Little Brother's guardian for personal and financial matters. [3] Authority included:

    a. decisions regarding where and with whom he is to reside;

    b. decisions regarding health care action within the meaning of the *Guardianship of Adults Act*; and

[1] Family told police that there was no school near to the cattle station where they grew up, see 1.1 and 8.1.
[2] 6.3 - Allied Health statement at [124].
[3] 10.11A - Beth Walker 3rd affidavit, Annexure BW-1, p 16.

c. decisions regarding his day to day care, including facilitating access to support services.

12. A neuropsychology report informed the making of orders.[4] The neuropsychologist found that while Little Brother was able to understand, with the assistance of an Alyawarr interpreter, questions about his finances and accommodation and wishes, he needed and expressed an interest in having support in those areas. The neuropsychologist found that Little Brother had a "significant memory impairment that appears to be related to his history of chronic alcohol misuse".[5] The neuropsychologist concluded:

"On balance, I regard Mr Clements as having mental capacity to make some decisions in relation to his accommodation, money and access to support services. However, he lacks the mental ability and capacity to organise these for himself or be able to take the initiative to have someone arrange these for him, or have the money management skills to realise these for himself."

13. On about 14 February 2017 the Office of the Public Guardian requested a comprehensive aged care assessment be undertaken to determine Little Brother's eligibility for permanent residential care. However, initial efforts to find Little Brother were unsuccessful and, when he was located on 6 April 2017, Little Brother declined to participate in an assessment (when asked in English).

14. In May 2018 an aged care assessment was completed and a support plan prepared which recommended, "that [Little Brother] be approved for residential respite at a low level as well as permanent residential care."[6] The aged care assessment team reported that Little Brother had continually declined offers of assistance and only agreed to an assessment on the basis that it was a service he could choose to accept at a later time if his situation deteriorated.[7]

15. In mid to late 2018 the Office of the Public Guardian commenced the process of helping Little Brother to apply for NDIS. This process took a very long time. Little Brother was accepted into the scheme on about 31 July 2020 and an approved NDIS plan did not commence until 2 November 2020. The amount of funding available under the plan was also very limited.

16. This unacceptable delay and limited funding outcome arose because it was difficult to obtain the necessary assessments. Barriers included wait times for assessors in Alice Springs, difficulty locating Little Brother and an apparent disinterest from Little Brother.

[4] 10.4.
[5] 10.4, p 6.
[6] 6.3 – Allied Health statement, p 312.
[7] 6.3 – Allied Health statement at [131].

17. A support coordinator was appointed under the NDIS plan in November 2020 and a support worker was appointed in about May 2023.

18. The NDIS plan provided funding for an occupational therapist to complete a functional assessment. If this been done it would likely have produced further evidence as to Little Brother's needs and likely resulted in increased funding. However, an assessment was never completed as Little Brother was difficult to locate or declined to participate when spoken to in English without the assistance of an interpreter. It is highly doubtful that he understood what was being offered and the potential benefits.

19. Despite the existence of the adult guardianship orders, the NDIS plan and his eligibility for residential aged care, Little Brother continued to be homeless and received only very limited supports between 2016 and 2023, when he passed away.[8]

20. On 14 July 2023 Little Brother attended and was admitted into Alice Springs Hospital.

21. On 17 July 2023 Little Brother took his own leave (TOL) from the hospital, that is he left the hospital without speaking to or notifying staff. Given the time of year, it would have been a cold night and Little Brother was not dressed for the elements. He spent the night outdoors without adequate protection from the cold.

22. On 18 July 2023 Little Brother was found by an Aboriginal Community Police Officer who knew him. Little Brother was very unwell, and he was returned by ambulance to the hospital. He was admitted to the intensive care unit and passed away on 19 July 2023.

Introduction – Big Brother

23. Big Brother was also homeless for a long time. Medical records document a prolonged alcohol use disorder and, over the years, a decline in cognitive capacities.[9]

24. In 2017 Big Brother was charged with criminal offences and a referral was made to mental health services. An ‘at court mental health assessment’ identified significant disorientation and potential incapacity. During the assessment he was unable to answer basic questions such as whether it was morning, afternoon or night or his current location. Big Brother was also responding to unseen stimuli and was unable to perform any basic task of cognition.[10]

[8] Little Brother’s whereabouts were often unknown, it’s possible that he sometimes stayed with family, he also had brief periods of time in accommodation such as at Sid Ross Hostel following medical treatment.
[9] See 7.2 - Dr Delima, p 4.
[10] 2.6 - Forensic Mental Health service notes.

25. Posthumously, Dr Lowe diagnosed that from about January 2021 there was evidence that Big Brother was suffering from Korsakoff syndrome, a cognitive impairment usually caused by thiamine deficiency arising in the context of high alcohol consumption.[11]

26. In September 2021, when Big Brother was again in prison, a clinical nurse made referrals to aged care and commenced an adult guardianship application.[12] Evidence to support the application for adult guardianship orders included a Kimberly Indigenous Cognitive Assessment undertaken on 21 October 2021 which recorded a score of 19 out of 39, with deficits in all domains. A score of 33 or less on the Kimberley Indigenous Cognitive Assessment is considered indicative of impairment. Brain scans also indicated pronounced cerebral and cerebellar atrophy.

27. On 25 October 2021, NTCAT appointed the Public Guardian as Big Brother's guardian for personal and financial matters. [13] Authority included decision making powers concerning:

    a. where and with whom he is to reside;

    b. health care action within the meaning of the *Guardianship of Adults Act*; and

    c. day to day care, including facilitating access to support services.

28. On 25 August 2021 Big Brother was released from prison and admitted to Alice Springs Hospital as a 'social admission' pending the allocation of appropriate accommodation. Keeping Big Brother at hospital was often challenging. As well as taking his own leave (TOL) there were incidents of aggressive behaviour and medication was used to manage his behaviour.

29. Initial attempts to complete an aged care assessment were unsuccessful with Big Brother either taking his own leave from the hospital or presenting in an agitated state so that the assessment could not be completed. The aged care assessment was eventually completed on 7 December 2021 and Big Brother was recommended for permanent residential care and high-level residential respite care.

30. The Aged Care support plan documented that:

    a. [Big Brother] cannot care for himself;

    b. [Big Brother] would like to have somewhere safe to live where he has other men to talk to and his care needs are met.[14]

31. Despite indicating a willingness to enter aged care, this did not eventuate. Initially the aged care facilities were at full capacity (in light of the covid-19 restrictions).

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[11] 4.13 – Dr Lowe.
[12] 5.16 – Beth Walker at [10] and 6.3 – Allied Health statement at [99].
[13] 5.1 – NTCAT orders.
[14] 6.3 – Allied Health statement, p 300.

However, there were also concerns that the existing aged care facilities would not be able to manage Big Brother's behaviour and/or that they would decline to take him because of his behaviour.

32. Big Brother's application for NDIS was approved on 26 November 2021 and a support plan commenced on 19 January 2022. The support coordinator commenced in March 2022.

33. Similarly to Little Brother's situation, despite the various assessments and orders, Big Brother continued to be homeless. On 23 May 2023 it is alleged that Big Brother committed a criminal offence. He was arrested and remanded in custody.

34. On 9 June 2023 an application for Territory Housing was completed.[15]

35. Following Big Brother's remand, significant work was undertaken by various organisations to obtain updated assessments of Big Brother's disability needs and to apply for an increased NDIS plan to cover supported independent living. Although NDIS does not provide accommodation per se, if assessments show an individual's needs due to their disability are sufficiently high to warrant supported independent living, the NDIS packages provide sufficient funding to cover housing as well as disability supports. The updated NDIS plan commenced on 22 August 2023 and Big Brother was granted bail on 28 August 2023 to reside in supported accommodation.

36. There was no real preparation or transition plan in place and, perhaps unsurprisingly, within a short period following his arrival at a supported residence Big Brother became upset, is said to have threatened staff and damaged property. Big Brother left the residence and was arrested by police the same day. Big Brother then remained in custody until his death.

37. On 8 September 2023 Big Brother complained of chest pains and was taken to the clinic at the Alice Springs Correctional Centre, and then by ambulance to the Alice Springs Hospital.

38. Big Brother was admitted to the hospital but remained in the custody of two Corrections officers.

39. While at Alice Springs Hospital, there were incidents in which Big Brother's health and behaviour deteriorated, and he appeared combative. Shortly before his passing, on two occasions on 9 and 10 September, Big Brother spat on a Corrections officer, following which the officers used a spit hood on Big Brother.

40. Big Brother was transferred to palliative care on 11 September 2023. He passed away at the hospital on 12 September 2023.

[15] 5.23 – Meghan Forsyth at [17].

Office of the Public Guardian and NDIS

41. Despite both brothers having adult guardianship orders, aged care assessments and NDIS packages, they remained homeless and lived rough, lifestyles that are known to contribute to poor health outcomes and increased mortality risk. This raised the question as to whether services suitable to meeting the needs of these brothers (and others in similar circumstances) were available in Alice Springs. Was homelessness really the best or only option for them?

42. While I heard evidence of efforts from a variety of services and individuals, objectively little was achieved in terms of the goals of those respective services, "the day to day lifestyle [Little Brother] lived prior to the guardianship appointment remained generally unchanged."[16] Up until Big Brother went into custody in May 2023, the same could be said for his situation.

43. This inquest identified some opportunities for improvement, and significant service gaps.

44. Following the deaths of Little and Big Brother the Office of the Public Guardian (the **OPG)** arranged for a review of each case, and several recommendations were made (**the OPG review**). The Public Guardian gave evidence that she agreed with all the recommendations.[17] Full implementation would require additional funding, the OPG is currently looking at priorities and capacity at current resourcing levels to determine which of the recommendations can be carried out.[18]

Communication with Little and Big Brother

45. Two primary explanations were proffered as to why Big Brother and Little Brother remained homeless. Firstly, that it was their wish, and second, that there was no suitable accommodation available.

46. I heard evidence that offers of assistance were often turned down, with both brothers expressing a desire to continue living as they were and that they valued the freedom and autonomy that their lifestyle afforded them.

47. In contrast to that evidence, there was also evidence that from time to time both brothers indicated a willingness to accept accommodation.

    a. In 2014 Big Brother stated he would like to live in a house, but not in a hostel.[19]

    b. In 2016 during a neuropsychological assessment, "When asked if [Little Brother] would like to have his own place to live, he perked up and replied

[16] 10.11G Public Guardian file review p 2 and 4, see also Transcript p 270.
[17] Transcript p 306.
[18] Transcript p 314.
[19] 6.3 – Allied Health statement, p 20 [117].

that would be good." [20] An Alyawarra interpreter was used for this assessment.

c. On 27 July 2016 Little Brother expressed to Allied Health staff an interest in finding accommodation.[21]

d. The August 2016 support plan generated from the aged care assessment stated that Little Brother requested accommodation.[22]

e. In 2019 and again in late 2022 Little Brother stayed at Sid Ross Hostel for as long as it was available to him. He left only when he was no longer eligible. [23]

f. In late 2021 Big Brother expressed a preference to stay at Old Timers Village.[24]

48. The decision to remain homeless had such a substantial impact on the lives and health of Little and Big Brother, that it warranted a thorough examination by those charged with providing support, before it was accepted. Such an examination should have included:

a. an understanding of why accommodation assistance was being declined;

b. ensuring the men truly understood what was on offer (with the use of an interpreter and visits to the accommodation); and

c. an appreciation that returning to their known lifestyle was, "a habitual response to return to a familiar environment that requires no new cognitive skill to navigate."[25]

49. Some of the resistance of the brothers was not incompatible with accepting accommodation. Instead, it appeared they did not understand what was being offered. For example, concerns expressed by the brothers that it would be too expensive or wanting to live alone[26] were not inconsistent with accepting accommodation but indicated a lack of understanding about what was available.

50. Understanding Little and Big Brothers' true wishes required the frequent use of an interpreter, more than one conversation, and probably visits to the proposed accommodation facilities with the brother(s).

51. Without an interpreter, workers had very limited capacity to communicate with both men. NDIS support workers and Corrections officers gave evidence of the use of hand gestures and body language to facilitate basic communication of day to day

[20] 10.4, p 6.
[21] 6.3 – Allied Health statement at [122].
[22] 10.11A Beth Walker at [22].
[23] 4.15 – Dr Holwell at [42(g)] and [115(h)]; 8.2 – Coronial memorandum, p 3.
[24] 1.2 – Coronial memorandum, p 10 and statement of Annie Farthing, 6.3 [107].
[25] 7.2 – Dr Delima, p 9.
[26] 6.3 – Allied Health statement at [118]; 1.8 and 8.1 being the Police Coronial memorandums.

needs.[27] For English only speakers it was easy to assume that communication barriers were due to cognitive impairment rather than English proficiency.

52. This was in stark contrast to the description I heard from another witness who communicated with the brothers in language. [28] Aboriginal Community Police Officer Alice (**ACPO** Alice), who knew and had spoken to both brothers, gave evidence at the inquest. ACPO Alice spoke in Arrernte and Alywarr and told me that the men spoke back to him in those languages. ACPO Alice found both men easy to understand and had no difficulties communicating when speaking in language.[29]

53. There is no evidence of the OPG, the NDIS support workers or NDIS support co-ordinations services using an interpreter when discussing accommodation options with the brothers. One of the Adult Guardianship officers gave evidence that in her single meeting with Little Brother she relied on the support worker to assist with communication. [30] Given that the support worker did not speak Little Brother's language and was using hand gestures to communicate,[31] I cannot be satisfied that anything much was understood by Little Brother. Gratuitous concurrence is a well-known phenomenon when communicating with Aboriginal people and this seems to me to be a heightened risk in the scenario described.

54. While efforts to communicate using simple words and hand signs might have been barely sufficient when trying to establish rapport, or communicate basic concepts, this limited form of communication was entirely ineffective, when it came to discussing in any meaningful way, the potential advantages of supported independent living, or aged care facility options, or when it came to trying to understand the brothers' true wishes.

55. While I am left with the impression that both brothers were reluctant to try the accommodation services that were available and may have refused, on the evidence before me I cannot be satisfied that the two brothers understood their options, that all options had been properly explored, or that they were genuinely declining what was offered.

[27] 10.4 – the neuropsychological assessment of Little Brother noted his "English was limited to a few basic words and short sentences" but the assessment was able to be completed and a background taken with the assistance of an Alyawarr interpreter; transcript pp 12 and 233; 5.11 – prison visit notes; I note also Officer Alice's experience of attending the prison where a correctional officer said "good luck talking to him".
[28] 5.12 re Big Brother, 10.21, p 38 re little brother.
[29] Transcript p 275-8.
[30] Transcript p 271-2.
[31] Transcript p 223.

56. While there were challenges in obtaining an interpreter, particularly when meetings were opportunistic, the OPG review acknowledged there were also missed opportunities. Prison and/or hospital visits are obvious examples.[32]

Decision making processes and homelessness

57. In its most confined arrangement, the role of the OPG in respect of a person under guardianship was described in the following manner:

    a. another service will advise the office of a decision that needs to be made for the person under guardianship;

    b. more than one option must be presented;

    c. the service presenting the options must set out the pros and cons of each course;

    d. the Public Guardian will weigh up those matters, take the person under guardianship views into account, and then decide based on the options.[33]

58. While this process makes sense in a lot of situations, it simply did not work for Big and Little Brother because no option for accommodation was ever proposed and, according to the OPG witnesses, no decision was ever made. [34] The effect of making no decision was, in practice, a decision to accept the status quo. It was, in its effect, a de facto decision that the brothers would continue to remain homeless.

59. A robust decision making process around homelessness should have warranted further investigation about:

    a. the very real and substantial impact that homelessness was having on the health and wellbeing of Little Brother and Big Brother;

    b. the limited weight that could be placed on the statements of wishes of the two men given their cognitive impairments, their limited language and the likelihood for misunderstanding when interpreters were not used; and

    c. why no accommodation options were being offered.

60. The Public Guardian explained that forcing someone into accommodation that they are opposed to, such as aged care, is problematic. Fundamentally, guardianship principles recognise the importance of an individual's views and wishes and require decision makers to exercise their authority in the least restrictive way practicable. Additionally, studies indicate early placement in aged care is associated with a higher risk of mortality and, when it is done against an individual's wishes, it may

[32] 5.12 prison visit notes from Tom Langcake.
[33] 5.17 – Alleman at p 5; Alleman at transcript pp 252-4; Walker at transcript p 318.
[34] Alleman at transcript p 259, Public Guardian at transcript p 312.

negatively impact their social and emotional wellbeing.[35] It is unclear if those studies compared the impacts of aged care against homelessness and the brothers' homelessness was negatively and increasingly impacting their health and creating a higher risk of mortality.

61. Dr Lowe, a geriatrician with extensive experience in the Northern Territory, reviewed the medical records for both brothers. Concerning Big Brother, Dr Lowe formed the view that there was evidence in 2017 of mild cerebral and cerebellar atrophy and brain degeneration because of alcohol consumption. By 2021 there was evidence of worsening generalised atrophy and Wernicke-Korsakoff syndrome from January 2021.[36]

62. Wernicke encephalopathy is a brain injury caused by a lack of thiamine. High alcohol consumption and malnourishment are strongly associated with thiamine deficiency. Hence, homelessness and related food insecurity likely contributed to the development of Big Brother's Wernicke encephalopathy. While Wernicke encephalopathy can be a degenerative condition,[37] early treatment can reverse symptoms. If left untreated, Korsakoff psychosis can develop resulting in permanent cognitive impairment.[38]

63. I acknowledge that in January 2021 there were no adult guardianship orders in place and Dr Lowe's opinion is one that is being given posthumously. However, the potential that even a portion of Big Brother's cognitive impairment could have been reversed at an early stage and further deterioration prevented through improved diet, thiamine medication and reduction in alcohol, is a stark reminder of the impact Big Brother's homelessness was having on him and the need for proper consideration (and implementation) of alternatives to homelessness.

64. To avoid this happening in the future, the Public Guardian has indicated that there will be an alert which identifies clients who have been homeless for a period of 3 months. Continued homelessness past that point will be treated as a 'decision' to ensure relevant decision making processes and considerations are applied.

65. In respect of these two brothers, it is not clear what the outcome of such a decision making process would have been. Having weighed all the factors it may have been determined that continued homelessness was the accepted outcome. However, if the negative health impacts associated with homelessness were properly considered, this might have led to acceptable accommodation options being identified, explained and offered.

[35] Evidence of Public Guardian, Transcript p 313.
[36] 4.13 – Dr Lowe, p 5.
[37] Dr Paltridge, Transcript p 129 and 7.2 – Dr Delima at [9.3].
[38] 4.16 – Dr Wilson at [89]; 7.2 – Dr Delima, [9.3] – [9.6].

66. Whether Big Brother should have gone into residential aged care is another decision which was not properly considered by the Public Guardian. It was proposed in December 2021 that Big Brother enter residential aged care. This did not immediately progress because of Covid-19.[39] There is no evidence that this was revisited in the 18 months that followed.

67. There was some evidence that aged care facilities may have been unable to manage Big Brother's behaviour and may have declined to accept him. But this was not a reason not to explore this option and, if necessary, other housing alternatives if aged care was not available.

Annual reviews

68. The OPG review recommended annual file reviews or audits of clients.[40] The recommendations did not specify what such reviews/audits might entail, but in her evidence the Public Guardian said that it would be an opportunity to "do some deeper thinking" about the key issues affecting each client and agreed it would provide an opportunity to look for alternative options if the client's goals were not being achieved.[41]

69. The OPG will need to identify their capacity to undertake annual file reviews, how to prioritise matters for review and develop guidelines. While not being exhaustive, reviews/audits should:

    a. assess whether the support co-ordination agency is meeting expectations;

    b. assess the efficacy of existing supports;

    c. identify any unmet needs, and develop a plan for how the needs are to be met;

    d. consider what, if anything, further needs to be done to find and engage family members in the decision making and care of the person subject to the adult guardianship order.

Culturally appropriate services

70. The OPG review identified issues concerning the provision of culturally appropriate services. Police and health staff have pointed to significant improvements in communication and service delivery when they work alongside Aboriginal Liaison Officers (**ALOs**). The Public Guardian is not using ALOs and the OPG is still in the process of determining priorities and how best to utilise limited resources to achieve improvements cultural safety.

[39] Transcript p 248.
[40] 5.19 – Public Guardian review, p 1.
[41] Transcript p 307-8.

71. I encourage the Public Guardian to review the submissions of the Anti-Discrimination Commissioner, in particular whether the positive duty obligations under the *Anti-Discrimination Act* apply to the OPG and how it engages with the needs of Aboriginal clients.

72. Possible strategies, referred to either in the OPG review or in the evidence at inquest, for improving cultural competency in the OPG include:

    a. funding a specific role within the organisation that focuses on improving culturally appropriate practices;[42]

    b. mandating the engagement of cultural brokers under NDIS plans;[43]

    c. updating practice guidelines to support staff to identify and take into account cultural considerations when decision making.

73. I will recommend that the OPG develops a strategy for improving culturally appropriate practices to meet the needs of Aboriginal and Torres Strait Islander people who are under adult guardianship orders.

NT Health

Take own leave (TOL)

74. When Little Brother left the hospital on 17 July 2023, he was very sick. The ICU consultant reviewed his medical records and considered that Little Brother was at risk of passing away even if he had remained in hospital. However, the fact that Little Brother spent the night outdoors in only a hospital gown likely contributed to his health deteriorating. It likely changed the timeline of his demise, if not the outcome.[44]

75. His family wanted to know whether enough was done to prevent him leaving the hospital, and then, whether enough was done to try and find him quickly.

76. Where the hospital believes a patient is at risk of causing harm to themselves or others, for example, if they are a high risk of falling or they are disoriented and at risk of wandering, an additional staff member can be allocated to provide close observation. This person is referred to as a 'special'. A special is not generally allocated to prevent a patient taking their own leave because one of the principles underpinning health care is that patients have the right to choose whether and what health care they will accept.

[42] The Public Guardian at transcript p 310-311.
[43] 10.11G – Public Guardian review, p 5.
[44] Transcript p 297.

77. The hospital reviewed Little Brother's case and concluded that there was not a proper basis to allocate a special. Although Little Brother had previously left hospital before completing treatment, that was not so frequent as to justify classifying him as a 'high risk of leaving'.[45]

78. However, on the morning of 17 July 2023 Little Brother was found away from his room and disoriented and in those circumstances, NT Health agreed that a special should have been actively considered at that time. That is not to say that a special would have been allocated. Whether a special might have been allocated includes consideration of factors that are difficult to assess in hindsight from medical records alone. For example, Little Brother's demeanor and the number of other high needs patients on the ward at the time would have been relevant factors.

79. Once staff realised that Little Brother was neither on the ward nor at the radiology department, policies set out the procedures that are to be followed for:

    a. searching for Little Brother;

    b. assessing the level of risk to Little Brother;

    c. notifying police; and

    d. notifying family or support workers about his absence from hospital.

80. Little Brother was correctly assessed as being at high risk and appropriate steps were taken to try and locate him. As well as searching the hospital grounds, staff notified the OPG that Little Brother had left. Little Brother's NDIS support worker was notified, and he indicated he would search for Little Brother in the community. In addition, Police were notified. Police placed Little Brother on the Muster Briefing Report on both 17 and 18 July 2023. This recorded Little Brother as a missing person from the hospital and directed police to proactively look for him.[46]

81. NT Health provided evidence about the steps taken by the hospital to address 'incomplete care', which includes patients taking their own leave (TOL). The focus is on improving patient-centered and culturally safe care to reduce the frequency of TOL while also respecting the rights of patients to determine their own care. For example, the hospital undertook a study into rates of TOL for orthopaedic patients in 2020 and 2021. The study demonstrated that TOL incidents reduced when ALOs were used. This is further evidence of the benefits of culturally appropriate care and the importance of ALOs.

82. Unfortunately, Little and Big Brother were admitted on weekends and ALOs were only rostered to work during Monday – Friday regular business hours. I was told that there is currently a trial of ALOs working in the emergency department after hours.

[45] Transcript p 205.
[46] 8.6 – PROMIS records.

Anecdotally, and consistent with other evidence of the benefits of culturally aware care, I am told that the trial is considered a success.[47]

83. If there is capacity to expand the hours that ALOs are available, while maintaining the quality of the service provided, then I am confident that would be beneficial to patients and health outcomes. As part of any recruitment and retention policy for ALOs, improvements to remuneration and career progression should be proactively considered by NT Health.[48]

84. I am satisfied that Little Brother received appropriate care at the hospital and that NT Health is working to reduce incidents of incomplete care.

Police

Identification of the deceased

85. When police are investigating a death, they are required to identify the deceased. The Crime (Homicide and Serious Investigation) Police General Order[49] states that positive identification is to be undertaken "as soon as possible" and visual identification is preferred. Other methods, such as fingerprinting, can be used if the person cannot be visually identified. Formal identification is a time sensitive requirement, not only because of the importance to the investigation, but as the office in charge (OIC) stated, notifying family promptly is the right thing to do.[50] However, the general order does not provide guidance on who should undertake a visual identification.

86. Big Brother was identified by a young relative, Leroy Petrick. The family expressed concern about the impact on Mr Petrick, and were disappointed that police did not take a more culturally appropriate approach. They said that a senior Aboriginal person from Big Brother's family was the culturally correct person to make the identification.

87. The OIC explained that he had very limited information as to who was next of kin and where he might find family members. When he did locate Mr Petherick he did his best to check whether he was an appropriate person to conduct the identification.[51] The OIC said that he did not consult with an ALO or an Aboriginal Community Police Officer (ACPO) because he was unaware of their availability to be involved in this work. Later in the investigation, the OIC did work with an Aboriginal officer when speaking with family and his practice has changed.[52] The

[47] Transcript p 211.
[48] Transcript p 211.
[49] 1.6 – Ship Affidavit, p 40.
[50] Transcript p 289.
[51] Transcript pp 285-286.
[52] Transcript p 286.

OIC said that when speaking with family in coronial matters the involvement of ALOs or ACPOs is "invaluable", "the results speak for themselves. [using ALOs] - it's completely changed how we were talking to the families and the information we're getting back."[53]

88. The OIC commented that there has been an increase in the frequency of police engaging and working with ALOs generally in Alice Springs. This may well be because of the commendable work of the NT Police Cultural Reform Command lead by Leanne Liddle, progressing the recruitment and retention of Aboriginal staff, as well as other commendable reforms.

89. In this instance I am satisfied that the OIC's approach was reasonable in the circumstances. Appropriate efforts were made to locate family rather than rely on fingerprinting and the OIC is currently using ALOs when talking with families about coronial matters. The evidence that there has been an increase in the number of ALOs employed, and a current push to have staff increasingly available, indicates to me that senior management recognise the importance and value of cultural awareness in Alice Springs and the particular value of ALOs.

90. Even so, on behalf of family, Maurice Petrick has requested that NT Police have a rule requiring an elder be contacted prior to visual identification of Aboriginal people who have passed. While that might often be appropriate, the diversity of families, Aboriginal groups and individual preferences may mean a single rule is not realistic.[54] Working together with ALOs who know local families may be a more effective way to accommodate the breadth of circumstances that will arise for police while ensuring an incorporation of cultural considerations.

91. In any event, whether there should be additional guidance and whether the involvement of ALOs in identification and inquest investigations is something that should be specifically encapsulated in training or general orders is a matter appropriate for the consideration of NT Police, and in particular the Cultural Reform Command, and I will make a recommendation to that effect.

Communication about the inquest

92. In addition to identification, police also play a role in communicating with family about coronial investigations and the holding of an inquest. The family raised concerns about how, who and when they were informed of the inquests and that no interpreter was used.[55]

93. I acknowledge that experience, there will be many circumstances in which family feel shocked when informed of the death of a loved one. I am sorry that was the

[53] Transcript p 287.
[54] Transcript p 292.
[55] Maurice Petrick at [36] and [74]; Transcript p 287.

impact for family who gave statements to the inquest. Police will not be able to speak with all family members, and I accept those who were not spoken to feel dissatisfied with the process.

94. However, I am satisfied that significant efforts were made by police in relation to Big Brother. The OIC and ACPO Alice worked collaboratively to identify family to be notified and how to undertake that work. As well as speaking with family in Alice Springs, police travelled to multiple outstations in the Utopia area to explain the inquest process and to provide a letter setting out the date of the inquest and contact information; family were notified in advance of the trip. ACPO Alice is clearly an experienced officer having worked for police for more than 30 years. Importantly he is also a senior Arrernte man with strong family connections to Alice Springs and remote communities. The message was not delivered solely in English, the ACPO is an Arrernte speaker who also understands Alyawarr, Lurijta, Warlpiri and Pitjantjatjara.

95. The written letter provided to family on behalf of the Office of the Coroner is only in English and the family requested that it be translated into Arrernte or ideally converted to an audio format as can now occur in some languages for the police caution.

96. Two plain language information or fact sheets about the coronial and inquest processes have been prepared with the assistance of interpreters and are available on the Office of the Coroner's website. This information has been translated into Yolngu Matha and an audio of this translation is available on the website. The Aboriginal Interpreting Service has been engaged to add a Walpiri interpretation. It is proposed to continue to add further interpretations in widely used Aboriginal languages as an ongoing project. The plain language fact sheets are also included with letters sent to families from the Coroners Office.

97. A separate communication issue exists in relation to who is responsible for keeping family apprised of information that is obtained throughout the coronial investigation and what issues are being explored. There is no easy answer to this. While, in my view, police investigating on behalf of the Coroner should to some degree keep family appraised of issues that arise, they are not always best placed to provide that information. It is common for the Coroners Office to obtain documentary material or additional statements separate or adjacent to the police investigation.

98. Where NT Health have undergone a process of open disclosure with family, that department rather than police may be the appropriate conduit for some information. In the later stages of an inquest investigation, Counsel Assisting or the legal representatives of interested parties play a role. Where family is represented, I would expect their lawyers to update family. I commend the North Australian Aboriginal

Justice Agency for the care it takes in legally representing family in inquests and for the extra care taken to engage and support family through the process.

99. The Office of the Coroner has recently made changes to the briefing process in which Counsel Assisting are reminded of the importance of contacting family and the role of Counsel Assisting in that space.

100. The representatives involved in individual inquests will need to continue to work together collaboratively to ensure appropriate communication with family in each case.

Correctional Services

Notification of next of kin

101. That there was limited family information available to the police OIC is of greater concern in circumstances where Big Brother was in custody and custodial directives require next of kin information to be recorded. Related issues were considered in the *Inquest into the death of Mati Tamwoy* [2025] NTLC 1. In that inquest NT Corrections undertook to apply their directives and ensure prisoner next of kin information was up to date and next of kin were notified in the event a prisoner was hospitalised with a life threatening illness. [56] It was identified that this was the responsibility of the General Manager or his/her delegate. In that inquest I recommended to the Department of Corrections:

"that relevant Directives and Standard Operating Procedures be reviewed to ensure that up-to-date next of kin and/or emergency contact details are accurately recorded, and alternatively, that it is clearly recorded that a prisoner declines to provide such details and/or declines to consent to persons being contacted."

102. The issue of Corrections failing to notify Big Brother's family of his hospitalisation was not directly considered in his inquest, but I remind the Department of Corrections of their obligations and the above recommendation.

Use of spit hoods

103. During Big Brother's admission to hospital, a spit hood was twice used by Corrections officers. Although the forensic pathologist found no indication that the spit hood contributed to Big Brother's death,[57] I must investigate and report on the care, supervision and treatment of Big Brother which includes these two uses of force, in the days just before his death.[58]

[56] *Inquest into the death of Mati Tamwoy* [2025] NTLC 1 at pp 22-25.
[57] 1.4A – Forensic pathologist.
[58] *Coroners Act 1993* s 26.

104. When a spit hood was used on Big Brother, he was a very sick man and in a particularly vulnerable position. Not only was he dying, but he also had an underlying cognitive impairment and there was no one who could speak his language. It would have been a challenging, frustrating and, at times, very distressing situation for him. Big Brother's difficult behaviours were not intentional. They arose from his cognitive impairment and in response to the situation in which he found himself where he was unable to communicate his needs and no-one spoke his language.

105. The use of a spit hood has distressed his family.

106. The officers involved in using the spit hood impressed me as being compassionate towards Big Brother. They used voice and physical touch to assist Big Brother to calm,[59] and importantly they both recognised that Big Brother's actions were not intentional but reflected his health condition. [60]

107. Nursing staff considered the correctional officers to have been calm and professional in their treatment of Big Brother.[61]

108. I make no criticism of the individual officers. The spit hood is a tool they are trained to deploy. The question is whether the system should allow spit hoods to continue to be used.[62]

109. The Anti-Discrimination Commissioner submitted, "generic spit hood policies, procedures and subsequent actions which do not make any accommodations for specific groups of people, particularly people with disabilities, or Aboriginal and Torres Strait Islander people, may fail to accommodate a special need and amount to prohibited conduct under the" *Anti-Discrimination Act*.[63]

110. Although spit hoods remain lawful in a number of jurisdictions, their use has been prohibited in some circumstances in multiple states, mostly by police services:[64]

    a. South Australia criminalised the use of spit hoods in a wide range of settings, including prisons, in 2021;

    b. Tasmanian prisons have recently ceased using spit hoods;[65]

    c. Queensland Police banned their use in 2022;

    d. NT Police ceased using spit hoods on children in 2022 but they were reintroduced for use in detention centres in July 2025, an act which was

[59] Gobett at transcript p 35, Sharma at p 57 and Carroll at p 87.
[60] Transcript p 45.
[61] Mazhakata at transcript p 76 and Edwards at p 81.
[62] Transcript pp 19, 20, 55 and 56.
[63] Submissions on behalf of the Anti-Discrimination Commissioner at [40].
[64] Noting these in the majority refer to use by police not correctional services.
[65] 3.18 – Carroll at [35].

condemned by the Australian Lawyers for Human Rights as a violation of children's internationally recognised human rights;[66]

e. in 2023 the Australian Federal Police and ACT Police announced they would no longer use spit hoods, with their internal review concluding that "the risk of using spit hoods outweighed the benefits of their use, given they are ineffective in protecting against transmissible disease" and instead police are provided with procedures and equipment which better protects members from spitting and biting. [67]

f. police in Victoria and New South Wales do not use spit hoods.[68]

111. In considering whether spit hoods should be permitted on prisoners in hospital (and in other locations) the following matters need to be considered:

a. the reason hoods are used;

b. the suitability of alternatives; and

c. the potential for harm to the prisoner.

Reason for use

112. The only justification put forward by Correctional Services for the use of spit hoods is to protect their staff, and others, from being spat on. The protection is said to be for two purposes:

a. the risk of transmission of disease; and

b. the psychological impact that comes from fear of transmission of disease.

Risk of disease

113. Evidence from multiple sources indicates that **the risk of disease transmission is an insufficient justification for the use of spit hoods**:

a. The AFP's Chief Medical officer advised that the risk of a blood borne infection from a spitting or biting incident was non-existent to extremely low and the use of spit hoods could not be justified on medical grounds.[69]

b. Similarly, the Health+Law briefing on transmission of blood borne viruses states, "transmission of serious blood-borne viruses by events of spitting or biting is so unlikely that attempting to justify the use of spit hoods on this basis is unfounded."[70]

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[66] ALHR Media release July 31, 2025
[67] Freckelton, *Spit Hoods: Reforms to Law and Practice* (2023) 30 JLM 507 pages 514-519, annexure to 7.6 – Dr Sullivan's report, commencing at page 41; 7.3 Ombudsman NT Investigation Report p 83.
[68] 7.1 – AFP review, page 10.
[69] 7.1 – Additional Documents, p 265 of Brief.
[70] 7.7 – Additional material, page 2.

c. In respect of HIV risk the Health+Law briefing found, "three separate expert consensus statements from around the world each reach the conclusion that there is no possibility of HIV transmission from a single event of spitting."[71]

d. In 2022 Hepatitis Australia, in response to misinformation in the media, released a statement explaining that hepatitis B and C are not spread through saliva. "The evidence shows that saliva can contain but not transmit blood borne viruses unless there is sufficient blood contamination. Even then, the risk of transmission of these viruses to police, bus drivers and other workers in the community via occupational exposure is negligible."[72]

e. In 2024 the NT Ombudsman determined that "the evidence shows the risk of contracting communicable disease from being spat on are negligible."[73]

114. Mr Carroll gave evidence that while the risk of disease transmission is low, the risk is still present.[74] Whether this is an accurate understanding of the available medical evidence is questionable. According to the Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine, the risk of transmission of HIV and hepatitis through blood or saliva contacting unbroken skin is zero.[75] A risk may be present, for hepatitis B only, in relation to saliva in bites that break the skin or blood contact, but these were not the risks being managed by use of a spit hood with Big Brother.

115. Where there might be a legitimate risk of other diseases spreading through saliva, for example active state tuberculosis or covid, that risk already exists for Corrections officers guarding a patient at hospital (or anywhere else) without any incidents of spitting. That is because these diseases are airborne viruses which can be spread through coughing in an enclosed space or through the patient and officer touching the same surfaces.[76] The airborne risks increase with proximity, for example, if a Corrections officer moves towards a prisoner to apply or remove a spit hood.

116. This is not the place to determine the exact extent and nature of risk, but I am satisfied that **the evidence concerning risk of disease in this inquest is insufficient to justify the use of spit hoods in a hospital or any other setting**.

[71] The briefing also noted that conditions for risk of transmission via bite were 'unlikely' and even then the risk of transmission as no more than negligible, 7.7 – Additional material, page 2.
[72] 7.7 – Additional material, p 1.
[73] 7.3 – Additional Material, "Ombudsman statement on spit hood use by NT Police"
[74] Transcript p 124.
[75] 7.7 – Additional material, p 3.
[76] Transcript pp 198, 191.

Psychological harm

117. The inquest also heard evidence of the psychological impact on officers that arises from the fear of disease transmission and the testing regime that is followed after an incident.[77]

118. I heard evidence from multiple health workers about their own experiences of patients spitting which is a behaviour that is encountered in the health setting. Health staff also go through the same testing regime as Corrections officers and must manage any anxiety or concerns. Yet there is no perceived need for introduction of spit hoods by NT Health to meet their duty of care responsibilities to staff. There is also no indication that spit hoods are an appropriate tool to protect workers (or modify behaviour) in dementia management encountered in aged care settings[78] and nor are they used by St John Ambulance.[79]

119. I agree with Dr Delima, if the impact to be addressed is the worry of disease transmission, the appropriate response is to provide:

    a. robust, frank education (developed and, if necessary for efficacy, delivered by medical experts) about the negligible level and nature of any risk and steps to be taken post incident; and

    b. internal rostering management for officers with life circumstances which cause increased concern.[80]

Suitability of alternatives

120. There are clearly alternatives to the use of spit hoods which is evidenced by the capacity of health staff to manage this behaviour in patients who are not under the guard of Corrections officers and as evidenced by those jurisdictions which have banned or limited their use. Alternative responses include additional training focused on situational awareness, tactical positioning and body language, additional PPE for workers, and surgical masks instead of spit hoods for use on the person spitting.[81]

121. The position of health professionals is clear. Dr Holwell stated, "I actually don't think that there is any place for spit hood use in an acute hospital. With the availability of PPE and the mitigation of the risk of infection in the hospital setting, I don't believe that their use is appropriate."[82] The primary response of health staff is the use of PPE.

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[77] Transcript p 45-6, transcript p 124.
[78] 7.4 – Additional Material, K.Burns, R. Jayasinha, R. Tsang, H. Brodaty, "Behaviour Management A guide to Good Practice, Managing Behavioural and Psychological Symptoms of Dementia", ISBN 978-0-7334-3166-1.
[79] 7.3 Ombudsman NT Investigation Report Extraordinary Restraint 2023 pp 85-86.
[80] Dr Delima at transcript p 184 and p 192.
[81] 7.3 Ombudsman NT Investigation Report Extraordinary Restraint 2023 pp 83-84.
[82] Transcript p 199.

122. Corrections staff maintained concerns around PPE including: the speed with which a spit hood can be donned versus PPE; the inability to leave prisoners alone while donning PPE and the potential for goggles and masks to be upsetting or intimidating to prisoners.[83] Given the regularity with which Health staff are required to deal with spitting incidents I am confident that all of these concerns can be addressed if options are thought through, planned for and training is provided.

123. Big Brother escalated quickly but also de-escalated quickly. De-escalation techniques should be prioritised in training and in practice.

124. There would seem to be no good reason why a covid style mask cannot be placed on a prisoner instead of a spit hood. Corrections staff should be trained on how to do this.

125. Dr Delima gave evidence of additional steps that can be taken, such as administering medication, if a patient's behaviour cannot be controlled.[84] While these options are not necessarily available in the prison, they were available in this case as Big Brother was in hospital. If Corrections continue to take the lead in managing behavioural incidents of prisoners in the hospital setting, they should do this collaboratively with health staff and utilise the availability of health responses before spit hoods.

126. At the very least, if a spit hood is used, the next step should be for the Corrections officer to immediately don protective equipment (for example, a covid style face mask) and then remove the spit hood.[85] This would address the issue discussed below about the length of time that spit hoods are left on a prisoner.

Potential for harm to prisoners

127. I looked at and handled an example of the type of spit hood that was used. It is constructed of lightweight mesh material that can be seen through by the person wearing it. If someone is calm and chooses to put the hood on themselves, it is not a distressing experience. The evidence of the General Manager of Alice Springs Correctional Centre is that in his experience people often de-escalate fairly quicky when a spit hood is applied.[86]

128. Because of this it is easy to understand why a spit hood might be viewed by the Department of Corrections as a reasonable and proportionate response in certain circumstances. However, such a view minimises the impact and risks involved. The appearance of apparent de-escalation may in fact be a freeze response indicating psychological harm.[87]

[83] Transcript pp 89 and 59.
[84] Transcript p 185.
[85] Transcript p 89.
[86] Transcript p 87.
[87] Transcript p 185.

129. The Australian Federal Police review into spit hood states that, "It is generally accepted... that the use of spit hoods can be dangerous in certain circumstances" and ultimately concluded that the risks outweigh any potential benefit.[88]

130. Dr Sullivan in his report noted the following as circumstances which should amount to a contraindication for the use of a spit hood:

"when a person is at risk of vomiting, is in respiratory distress, is experiencing delirium or an acute confusional state or has significant cognitive impairment" due to the potential for "increased agitation, respiratory distress, or inhalation of vomitus."

131. It cannot be assumed that Corrections officers are able to adequately assess these risks, both because of a lack of medical training generally as well as lack of information about an individual prisoner's health. Indeed, the AFP review identified a high level of risk for those agencies or persons applying spit hoods because "it is clear that if [spit hoods] are used inappropriately or incorrectly they may contribute to injury or death."[89]

132. In Big Brother's case he had previously been on oxygen because of breathing problems, though he was not having any difficulties breathing immediately before the hood was applied on one occasion.[90]

133. There is also a significant risk of psychological harm to the person subjected to a spit hood. Dr Sullivan opined that the use of a spit hood has the potential to be "distressing, demeaning or humiliating, [and] might exacerbate past trauma."[91] Dr Delima considered that the use of a spit hood in Big Brother's situation would "likely increase and effectively prolong the level of biologic stress response with now the added impact of prolonged neural cortisol exposure to further adversely impact their cognition."[92]

134. The length of time before harm can be caused is surprisingly short. Dr Delima gave evidence that, "Any life threat stressor that goes on for longer than five to 10 minutes, then starts to roll over into the prolonged response… cortisol is said to be toxic for the brain if it's longer than 10 minutes."[93]

135. This time sensitivity may be not well understood. One officer gave evidence that the spit hood was kept on Big Brother for 20 minutes to a maximum of 30 minutes to be sure that he was not going to spit again. [94] Based on the medical evidence presented

[88] 7.1 Additional Documents – p 248 of Brief.
[89] 7.1 Additional Documents – p 273-274 of Brief.
[90] Transcript p 78.
[91] 7.6 – Dr Sullivan at [41].
[92] 7.2 – Dr Delima p 14 [11.5].
[93] Transcript p 186.
[94] Transcript p 20.

in the inquest this is dangerously too long. If protection was necessary, masks should have been donned by the Corrections officers and the spit hood removed.

136. Mr Carroll indicated 30 minutes was lengthy in his experience and would see 15 minutes, perhaps 20 minutes as a more common timeframe.[95] 15 minutes is still beyond the time frames given by Dr Delima for risk of psychological harm to the prisoner.

137. While this inquest uncovered no sound evidential basis to justify the continued use of spit hoods, if Corrections assume the risk to prisoner health and wellbeing of their continued use, then there should at a minimum be a firm requirement that they be used for no more than 5 minutes, which is sufficient time for PPE to be donned by Corrections officers and the hood must then be removed.

Conclusion on spit hoods

138. Ian Freckleton AO KC, reviewed the national and international use of spit hoods and the movement to reform in his paper, "Spit Hoods: Reforms to Law and Practice."[96] After thorough consideration Dr Freckleton concluded[97]:

> It does not advance the debate about the use of spit hoods to rename such forms of restraint "spit and bite guards", as proposed by the Police Ombudsman for Northern Ireland.[90] The use of fabric hoods placed over the head of persons in custody has highly adverse connotations and is likely to be experienced by many detainees, both children and adult, to be frightening and demeaning. In addition, the evidence that the use of such a form of restraint is necessary to protect police and custodial officers is mostly anecdotal assertion and lacking in empirical justification.
>
> Often spit hoods have been used along with other forms of dangerous forms of restraint and there have been instances where the combination of such restraints has resulted in deaths. On many other occasions it has caused counter-therapeutic fear, panic and distress. Notably, spit hoods have particularly been used against persons from minority groups, persons with mental illnesses and children. The South Australian initiative of banning the use of spit hoods by legislation is a significant development in Australia but it is clear that internationally the tide of public opinion has turned against viewing the use of such hooding as legitimate and proportionate. This trend has been reflected in Australia too by the decisions by multiple investigative agencies to stop using spit hoods and instead to negotiate, use other forms of restraint (such as personal protective equipment that has become common during the COVID-19 era) and to wear visors for protection. On both physical and mental health grounds, it is time to recognise that the era of the spit hood should come to an end.

139. Save for the subjective fears of Corrections officers which, on the evidence available to me are not based in empirical medical evidence, there was no evidence produced at the inquest which justified the continued use of spit hoods by Corrections in a hospital (or any other) setting. I strongly recommend that the Department of Corrections reassess the need for spit hoods as a tool for use in hospital or any other setting, including by liaising with NT Health or infectious disease experts, to properly understand the risks to both staff and prisoners.

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[95] Transcript p 95.
[96] 7.6 Annexure to Sullivan Psychiatric report; (2023) 30 JLM 507.
[97] (2023) 30 JLM 507 p 519.

Service Gaps

140. These inquests highlighted several gaps for which simple solutions are not available, either due to resourcing or the complexity of the issue.

Meeting health needs

141. Managing health needs of persons under adult guardianship was an example of a "glaring gap" according to the Public Guardian. In 2019 and then again in 2022 health service providers notified the Office of the Public Guardian about the need for Little Brother to take medication and of their concerns that he was not doing so.[98] At one point a support service was engaged to assist with medication, but it was discontinued due to lack of efficacy given Little Brother was not engaging. [99]

142. While Adult Guardianship officers are not health case managers, neither are the support coordinators who are funded by NDIS. This left Little Brother in a gap where no-one was formally responsible for supporting him with medication compliance.

143. When asked about this issue the Adult Guardianship officer explained their expectations that the support coordinator would think 'outside the box' in relation to finding a service to support Little Brother's medication needs.[100] However, this expectation was potentially inconsistent with the NDIS restrictions that place general health care outside the permissible scope of NDIS service providers.[101]

144. The Public Guardian gave evidence that in future the office will be "more clearly articulating with support coordinators that we would like a minimum of an annual GP review to be organised."[102] While this is a positive step, it does not address the gap, namely, there was no service responsible for providing support to Little Brother to access his regular medications.

145. One of the few people who managed to meet Little Brother regularly was his support coordinator who then later became his support worker. Although this person worked with Little Brother for more than a year, he was never told that Little Brother was diabetic and should have been taking medication.[103]

146. It would be common for people on adult guardianship orders to have health needs. That there is no service pathway for supporting these needs is clearly a significant gap in available care.

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[98] Transcript p 318.
[99] Transcript p 258.
[100] Transcript p 258.
[101] Transcript p 174.
[102] Transcript p 319.
[103] Transcript p 227-8.

Advocacy and case management

147. There was a divergence in views about the roles of the OPG and the NDIS Support Coordinators.[104] This should be clarified in a document which clearly sets out respective roles and responsibilities.[105] What is more challenging is a potential gap, in that neither organisation/provider felt responsible for overall case management. Neither organisation/provider had responsibility for evaluating the adequacy of existing services and identifying additional support needs for an individual.[106]

148. I acknowledge the evidence of the witnesses from the OPG about the limitations of their role. Their office does not offer case management services, and, even if funding were available, the Public Guardian does not consider that a case management service should sit within their office.[107] The OPG considered that specific cultural considerations for Aboriginal people under guardianship orders meant that a different (unidentified) service was more appropriate to undertake this role.[108]

149. However, under section 21 of the *Guardianship of Adults Act*, a guardian is both a decision maker and advocate for the person the subject of the orders. Where the Public Guardian is required by legislation to "act as an advocate for the adult", this arguably covers at least some of the work that falls within the concept of case management.

150. On face value, addressing the health and medication issues raised above would seem to fall within the concept of advocating for Little Brother.

151. Despite evidence against assuming responsibility for case management, there are examples of the OPG taking proactive steps and advocating for services, for example, the OPG pushed for aged care assessments and facilitated the NDIS application. The Public Guardian gave evidence that her team "work very hard to try and secure accommodation for people."[109] That *advocacy* for individual clients is within the Public Guardian role is supported by the OPG review which indicated collaborative proactive strategies such as case conferencing should have been undertaken.[110]

152. I recommend that the OPG review their understanding of their advocacy role to identify when they should be advocating on behalf of their clients and, when service gaps are identified, how that is to be addressed.

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[104] Compare Alleman at transcript p 267, 5.22 – Hamilton and 10.26 – Forsyth [10].
[105] Transcript p 256.
[106] See for example Alleman's evidence at transcript p 252-3 compared with Ms Forsyth at [11] and [18]; see also Public Guardian's response at transcript p 318.
[107] Transcript p 317.
[108] Transcript p 317.
[109] Transcript p 311.
[110] 10.11G, p 4.

Alcohol and other drug treatment

153. For both brothers' alcohol abuse was longstanding and a significant factor in their poor health. There was a need to provide both short term acute care and longer-term treatment/support. Their attendances at the emergency department or hospital admissions were opportunities for health interventions.

154. The inquest was particularly assisted by the evidence of Dr Delima, an expert in addiction medicine amongst other fields, and Dr Wilson, who is also an addiction medicine specialist currently employed as the clinical director of the Addiction Medicine Service in Alice Springs.

155. Dr Delima considered treatment and support needs in three categories:

    a. acute care;

    b. transitioning to aftercare; and

    c. medium to longer term residential care.

Acute care

156. Acute treatment for alcohol withdrawal is not only important to alleviate the symptoms patients experience while withdrawing but it also reduces the risk of patients taking their own leave (TOL) before receiving treatment for other health conditions. If alcohol withdrawal is managed well, this can create an opportunity for longer term assertive interventions for addiction or other health conditions and/or the engagement of community based supports. Medicated responses to withdrawal also likely decrease the frequency of aggressive outbursts which assists staff and improves the hospital experience for other patients.[111]

157. The benefits of proactive and assertive treatment and support should not be understated. In an Alice Springs study following patients with Wernicke-Korsakoff Syndrome,[112] by the second year of proactive identification and treatment there was:

    a. improved cognition;

    b. a significant decrease in the number of patients with severe delirium tremors;

    c. reduction in agitation requiring a security response; and

    d. fewer intensive care admissions.[113]

158. While there were some concerns that the brothers did not receive treatment for their alcohol withdrawal, Dr Wilson, who had access to additional medical records that were not available to Dr Delima, confirmed that the appropriate acute treatment was

[111] Transcript p 188.
[112] A cognitive impairment syndrome typically the result of thiamine deficiency in the context of high alcohol consumption, 7.2 - Dr Delima, p 10 [9.3].
[113] 7.2 - Dr Delima, page 10, see also Transcript p 188.

provided. He said, "the risk of alcohol withdrawal was consistently identified by admitting medical staff to Alice Springs Hospital that plans were put in place and were documented, and I can see in clinical notes where observation of alcohol withdrawal was identified, and treatment was provided."[114]

Transitional care

159. Dr Delima explained that following acute care in a hospital setting, transitional residential options are a critical part of care. From 2016 until April 2024 this type of care was provided in Alice Springs through the Integrated Withdrawal and Assessment Service (IWAS). "This program provided a period of 2 weeks of intensive, nurturing therapy in a secluded closed environment, away from the Alice Springs CBD, to prepare patients for discharge to existing residential rehabilitation facilities or community after improved cognitive function to do so." The treatment facilitated brain function stabilisation and nutritional support.[115] Dr Delima gave evidence of one client who no longer required guardianship orders following treatment.[116]

160. However, the service was both underutilised and resource intensive and is no longer operational. The location of the facility, a significant distance from town, supported patients to remain but created challenges for staffing.[117]

161. Dr Wilson said that if there was sufficient funding he favoured an inpatient unit on the hospital campus that could admit patients with higher acuity and complex care needs. Such a unit could offer acute care, transition to after care, and support a patient to access other inpatient and community-based services. As Dr Wilson noted, alcohol misuse is invariably intertwined with social, physical and emotional health issues.[118]

162. NT Health is currently considering the 'Take a Break Program' which, in simple terms, is respite care for those who do not need hospital based acute care but are not engaging with longer term residential facilities. Additional funding to support such a program would be required.[119]

163. It is trite to say that alcohol misuse in Central Australia is a complex issue. Resources are finite and stretched. There is clearly a need and benefit to be obtained from an aftercare environment that provides post-acute residential care. There is a gap in the availability of this kind of care in Alice Springs.[120]

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[114] Transcript p 301.
[115] 7.2 - Dr Delima, p 10 [9.7].
[116] 7.2 – Dr Delima at p 10, [94].
[117] Dr Delima at transcript p 189-190; Dr Wilson at transcript p 302.
[118] Transcript p 302.
[119] Transcript p 304-5.
[120] Transcript p 303.

164. Determining the best design for a program or service is a matter for NT Health, but clearly without transition and longer term options patients will, "continue to rotate into the hospital and back into community with increasing frequency as their cognitive dysfunction worsen[s] to irreversible stages of disability."[121]

Residential facilities for people with cognitive impairment

165. Another clear gap is the lack of medium and long term residential facilities.

166. In Alice Springs there are no dedicated residential facilities that are "well equipped to deal with significant or higher level cognitive impairment."[122] This is the case in respect of:

    a. emergency, medium and long term accommodation;

    b. drug and alcohol rehabilitation facilities; and

    c. residential aged care services.[123]

167. Dr Delima also identified that services and programs are delivered in English making them largely inaccessible to non-English speakers.[124] The *Anti-Discrimination Act* imposes positive duties on organisations to take reasonable and proportionate measures to eliminate certain forms of discrimination. Many Aboriginal people in the Alice Springs region are fluent and more comfortable in languages other than English, and the need for suitable services for language speakers is significant.

168. Concerning Big Brother, there was a real risk that the local aged care facilities would not be equipped to manage his behaviour,[125] and that they would simply refuse to accept him. But without suitable options, the risk is that people like Big Brother will instead end up in the criminal justice system, the prison, and the hospital, at great expense and harm to the broader community.

169. Big Brother should not have been in prison. In June 2023 a rural medical practitioner stated that Big Brother was not able to care for himself and was not fit for custody in Alice Springs Correctional Centre.[126] The Acting Chief Correctional Officer recognised that prison staff were not trained to deal with people with dementia, his incarceration created a risk to staff and the prison was ill-equipped to properly care for Big Brother.[127]

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[121] 7.2 - Dr Delima, p 10.
[122] Transcript pp 248 and 303-4.
[123] 7.2 – Dr Delima at p 11 [9.8].
[124] 7.2 – Dr Delima, p 8.
[125] Transcript p 247.
[126] 2.5 page 3, letter to Big Brother's lawyer.
[127] 2.5, page 2, email from Marcus Polaski dated 1 June 2023.

Formal Findings

Little Brother

170. Pursuant to section 34 of the *Coroner's At 1993*, I make the following formal findings:

    a. The identity of the deceased is Ted Ptjara, also known as Clements.

    b. He was born on about 27 March 1959.

    c. The time and place of death was 9.44 am on 19 July 2023 at the Alice Springs Hospital.

    d. The cause of death was multi-organ dysfunction due to hypothermia, significant contributing conditions were urinary tract infection, pneumonia, ischaemic heart disease, diabetes and hypertension.

    e. The deceased was an Australian Aboriginal man.

Big Brother

171. In respect of Big Brother I make the following formal findings:

    a. The identity of the deceased is Tim Ptjara, also known as Clements.

    b. He was born on about 6 October 1957.

    c. The time and place of death was 9.24 am on 12 September 2023 at the Alice Springs Hospital.

    d. The cause of death was organising pneumonia and coronary atherosclerotic heart disease (ischaemic heart disease), significant contributing conditions were type II diabetes mellitus and hypertension.

    e. The deceased was an Australian Aboriginal man.

Recommendations

I recommend that the Office of the Public Guardian:

172. Implement an alert system to review, act, and/or make decisions concerning homeless clients every three months of continued homelessness.

173. Review whether its current approach to case management and proactive advocacy for individual clients meets its obligations under s 21 of the *Guardianship of Adults Act*.

174. Commence annual reviews of clients, and a process for prioritising these reviews.

175. Develop a strategy to improve culturally appropriate practices to meet the needs of Aboriginal and Torres Strait Islander people who are under Adult Guardianship orders.

I recommend that NT Police:

176. Undertake a review, including by the Cultural Reform Command, of policy, procedure and training concerning visual identification of deceased procedures and communication with Aboriginal families in the coronial process to determine whether improvements based in cultural competency can be implemented.

I recommend that the Department of Corrections:

177. Undertake a thorough inquiry to examine the nature and likelihood of any risk to staff from spitting, the nature and likelihood of any risk to prisoners from the application of a spit hood (including to prisoners who are vulnerable because of illness or disability) and the suitability of alternatives to spit hoods. The review should be well documented and retained for future consideration and scrutiny. The use of spit hoods should be prohibited except if empirical evidence is identified which justifies continued use.

178. *If* spit hoods continue to be available to Corrections officers, I recommend that training, policies and procedures be updated to ensure staff are:

    a. fully informed on the extent and nature of any disease transmission risk to themselves if exposed to spittle (and as compared to blood, other biological matter and air), based on expert evidence;

    b. fully informed on the potential for physical and psychological harm to the prisoner from spit hood use, based on expert evidence;

    c. fully informed concerning the health risks of prisoners that are contraindicators for use, based on expert evidence;

    d. trained on alternative means to managing spitting incidents without using spit hoods including, but not limited to, donning PPE;

    e. trained that where medical practitioners are available their advice is to be sought before a spit hood is used;

    f. trained that the use of the hood is a last resort; and

    g. trained on the requirement for swift removal if hoods are used (maximum application 5 minutes).

179. *If* spit hoods continue to be available to Corrections officers, I recommend that:

    a. personal protective equipment (PPE) be included in any kit containing a spit hood;

    b. if a hood is used Corrections officers be required to immediately don PPE and remove the hood within 5 minutes.

180. *If* spit hoods continue to be available to Corrections officers, I recommend that every use is thoroughly reviewed by the Deputy Commissioner (or his/her delegate) to ensure all policy and procedure has been correctly applied and action is taken on any identified breach.