CITATION: *Inquest into the death of Kumanjayi Johnson* [2026] NTCC 02

TITLE OF COURT:	Coroners Court
JURISDICTION:	Alice Springs
FILE NO(s):	A0076/2022
DELIVERED ON:	23 January 2026
DELIVERED AT:	Darwin
HEARING DATE(s):	7 – 11 April 2025
FINDING OF:	Deputy Coroner Chrissy McConnel
CATCHWORDS:	**Supported Independent Living; Positive Behaviour Support Plan; Communication with family; Cultural Support; Return to Country; Office of the Public Guardian; NDIS; 000 calls; Missing Person; Search Urgency Assessment**

REPRESENTATION:

Counsel Assisting:	James Lowrey
Counsel for Police:	John Stirk
Counsel for Lifestyle Solutions:	Holly Veale
Counsel for Public Guardian and Trustee:	Tina Tomaszewski
Counsel for Family:	Greer Boe

Judgment category classification:	B
Judgement ID number:	[2026] NTCC 02
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IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. A0076/2022

In the matter of an Inquest into the death of
KUMANJAYI JOHNSON

ON: 9 December 2022
AT: Alhekulyele (Mount Gillen)

FINDINGS

Deputy Coroner Chrissy McConnel

Introduction

1. Kumanjayi Johnson died after walking away from his supported accommodation in Larapinta, Alice Springs, on 3 December 2022. His body was located six days later, in a gully on the southern side of Mount Gillen (Alhekulyele) in the West MacDonnell Ranges.[1] It was the opinion of Forensic Pathologist, Dr Marianne Tiemensma, that the cause of death was from environmental exposure and dehydration.[2]

[1] 6.5 Statutory Declaration of Snr Constable Conelius (28 Feb 23) [23] - location coordinates S23° 42.964' E 133° 48,782'.
[2] Coronial Brief, Folio 4, Post Mortem Examination report for the Coroner dated 30 January 2023.

Mount Gillen (Alhekulyale), West MacDonnell Ranges, Alice Springs

Kumanjayi

2. Kumanjayi was 45 years of age when he passed away. He was a proud Arrernte man, strongly connected to his culture and beliefs. He was one of five children to Judith and Aubrey Johnson. His father was a stockman known for his horsemanship skills, who worked on stations in Santa Teresa and Papunya. His parents passed away when he was young and other immediate family have also passed away, but he is survived by sisters, Leah and Audriana.

3. The family lived at Santa Teresa before moving to Hidden Valley Town Camp where Kumanjayi attended Hidden Valley primary school and I was told that he loved learning to read and write.

4. When he was a little older, Kumanjayi moved to Papunya to live with his maternal aunt, Sabina Brown, and her partner Dick Brown. After becoming an initiated man, he continued to live in Papunya for a time, before returning to live in Hidden Valley with his aunt, Carmel Ryan. He then moved to Larapinta Valley, and later Mt Nancy Camp.

5. Kumanjayi loved birds and going out bush. He particularly liked going hunting in Papunya and eating kangaroo tail with his family members. Leah fondly

recalls her brother cooking kangaroo tail with all his nieces, nephews and grandchildren.

6. Kumanjayi spoke Eastern Arrernte, Western Arrernte and Central Arrernte dialects, as well Warlpiri, Luritja and English. He loved sitting down with his family members and sharing stories in language.

7. From 2016 until he passed away, Kumanjayi lived with two other men, W and R, in shared supported independent living. Kumanjayi reportedly liked both men but was closer to R. The trio shared chores, meals and daily tasks and spent much time together.

8. His uncle, Malcolm Heffernan, fondly remembers that after Kumanjayi went into care, he would take him to church on Sundays which was something they both enjoyed.[3]

9. Kumanjayi's older sister, Leah, lived nearby in Sadadeen and his younger sister, Audriana, lived between Alice Springs and Ntaria. Kumanjayi also had other family at Whitegate town camp, Hidden Valley camp and in Alice Springs including his aunt, Carmel Ryan, cousins, Karen and Angela, and cousin-sister Maureen.[4]

10. Maureen remembers Kumanjayi visiting his nephews, speaking to them in Arrernte and telling them that he loved them and Audrianna remembers Kumanjayi looking after her when she was young and being a loving and caring brother.[5]

11. It is readily apparent that Kumanjayi received love and support throughout his life from family and they were very sad when they could no longer care for him.

[3] Affidavit of Malcolm Heffernan (1 Apr 2025).
[4] 1.2A Affidavit of Leah Johnson (1 Apr 2025).
[5] 1.2D Affidavit of Audrianna Johnson (2 Apr 2025).

Family Concerns

12. Prior to Kumanjayi being placed under a guardianship order, his family cared for him and were involved in his medical treatment and decisions. However, after the guardianship order was made Leah and Malcolm do not recall having contact with anyone other than his Lifestyle Solutions **(LSS)** carers.[6] I understood they felt shut out and wanted more communication from the services who were responsible for Kumanjayi.

13. They were upset when they learned that Kumanjayi had left his residence on 3 December 2022 and that those caring for him did not follow him. Malcolm said that when they found out that Kumanjayi was missing, they did not get much information. This was disrespectful and diminished the potentially important contribution family may have been able to make in assisting the search efforts. Malcolm said that if family had been better informed, they could have helped look for Kumanjayi.

14. Leah did not know that her brother had gone missing until a full day had passed. She was angry and wanted to find out through the inquest whether those caring and searching for Kumanjayi did their job properly.

Background to Guardianship Order

15. Kumanjayi had a complex cognitive and medical history, including diagnoses of; chronic alcohol abuse following several years of alcohol related seizures, polydipsia, hyperlipidaemia, hypertension, epilepsy, diabetes type II, supressed thyroid function, anxiety and depression.

16. In 2010 he suffered a subdural haematoma following an unwitnessed seizure. A CT brain scan revealed a large bleed and he was medically evacuated to Adelaide for a craniectomy.[7]

[6] Affidavit of Maureen Ryan, dated 2 April 2025, [27]; Affidavit of Malcolm Heffernan, dated 1 April 2025, [26].
[7] 3.1 Royal Adelaide Hospital, Final Separation Summary.

17. In light of this history, significant cognitive and memory impairments were suspected, and in 2014 Kumanjayi had a neuropsychological assessment. It was discovered that: his understanding of words and concepts expressed in English was estimated to be equivalent to that of a 6.5 year-old non-Indigenous child; his working memory was in the extremely low range compared to his age peers; visual and non-verbal reasoning ability was comparable to a non-Indigenous 7-year old's performance; and, his memory was severely impaired so that it was impossible for him to compare events at different times to gain an appreciation of change having occurred.[8]

18. Significantly, it was identified that his severe mental impairment and his long-standing history of recurrent seizures, made it likely his condition would continue to deteriorate. His seizures were "expected to render him more cognitively and socially disabled over time since every seizure causes a little more brain damage each time it occurs."[9]

19. It was in those circumstances that on 4 March 2015 the Local Court made an order appointing the Public Guardian as Kumanjayi's guardian with decision making authority for certain personal matters including; financial management, healthcare, accommodation and access to services (the First Order). Subsequent guardianship orders were made on 23 March 2017, 30 October 2019 and 31 March 2020[10] and Kumanjayi continued under the limited decision-making authority of the Public Guardian and Public Trustee until he passed away.

20. At the time of the First Order, Kumanjayi was an in-patient at Alice Springs Hospital **(ASH)**, receiving treatment for thyroid cancer and seizure management. On 9 October 2015, he was discharged from ASH and moved to a shared supported independent living residence, Ironwood, managed by LSS.[11]

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[8] 3.5 Dr Carmel Lum, Neuropsychological Report (10 Nov14).
[9] 3.5 Dr Carmel Lum, Neuropsychological Report (10 Nov14).
[10] 2.5, NTCAT Order 21507657 Renewing Appointment of Public Guardian as Guardian (23 Mar 17); 2.6, NTCAT Order 21507657 Appointing Public Guardian and Public Trustee as Guardian (30 Oct 19); 2.8, NTCAT Order 21507657 Renewing Guardianship Orders (31 Mar 20).
[11] 2.9 Affidavit of AGO (25 Mar 2025) [9].

21. This inquest examined the adequacy of care and support provided to Kumanjayi in the lead up to him leaving Ironwood on 3 December 2022 and the subsequent emergency response.

The events of 3 December 2022

22. On the afternoon of 3 December, Kumanjayi was at Ironwood with the two other residents and two disability support workers (**DSW**), BR and SD. The DSWs shifts commenced at 2pm.

23. At the start of the shift, BR and SD received a handover from the morning DSWs. They were told that the day had gone well, but Kumanjayi had talked repeatedly about wanting to "break down the hill." [12] SD noticed that Kumanjayi was in a negative mood and fixated on Mount Gillen.[13]

24. At around 3pm, SD took Kumanjayi and the two other residents on a drive out to the airport to watch planes. This was a strategy used by the DSWs to try and improve Kumanjayi's mood and redirect his thoughts when his behaviour was escalating.

25. Kumanjayi was in the front passenger seat and the two other residents were in the back of the vehicle. During the drive Kumanjayi started to talk about money and complained that he had not been given his daily allowance. He was shouting that he wanted to "break the van."

26. On the return drive from the airport, Kumanjayi became more verbally aggressive and was unsettled. SD tried to calm him and drove to KFC to get takeaway food for dinner. However, when they arrived at the drive-thru there was a line of cars which made Kumanjayi angrier and more frustrated and his behaviour deteriorated further. He was shouting and banging on the van which frightened SD and the others in the car.

[12] 5.6 Audio statement of SD (24 Feb 2023).
[13] 5.6A, Affidavit of SB (3 Apr 2025) [51].

27. This was the first time that SD had experienced this type of behaviour from Kumanjayi and he was concerned that he might be assaulted.[14] He suggested to Kumanjayi that they return home so that Kumanjayi could have a rest and he then drove back to Ironwood. When he was dropped back at Ironwood, Kumanjayi appeared angry and went to his room and slept. SD returned to KFC to collect dinner.

28. At around 6.30pm, Kumanjayi came out of his room to have his evening medication and dinner with the other residents[15] but he refused to eat his dinner and continued to make references to "breaking the mountain," pointing in the direction of Mount Gillen. BR noticed that Kumanjayi's behaviour was 'weird', he seemed to be hallucinating and was talking about things that did not make sense, such as climbing the mountain to swim in the lake to gain powers and referring to having "men's business" up there. He made verbal threats that he would punch staff and that he wanted to "kill someone."[16] This was not something that BR had heard Kumanjayi say previously and he was scared,[17] and one of the other residents was also frightened by Kumanjayi's escalating behaviour.

29. The two DSWs called the Incident Response Team **(IRT)**. The IRT is a 24/7 telephone service available to all LSS staff as an immediate point of contact for any incidents outside of business hours or when a manager cannot be contacted.[18]

30. Because he was concerned about what might happen if Kumanjayi heard him calling for assistance, BR went outside to call the IRT. The IRT call taker told him to call 000 and request an ambulance but did not provide any further details on what to say.[19] BR could not recall ever having called 000 previously and had

[14] 5.6A Affidavit of SD (3 Apr 25) [9].
[15] 5.5 Statutory Declaration of BR (6 Dec 2022); T98.
[16] Affidavit of BR (29 Mar 2025) [77].
[17] T79,T82,T97.
[18] 7 Affidavit of Damion Lipman (18 Mar 2025) [41].
[19] T100.

not received any training on making such a call or, presumably, on what information he should provide.[20]

The first 000 call

31. The first 000 call **(Call 1)** was made by BR at 7.04pm on 3 December 2022 requesting ambulance assistance. The call was directed to a St Johns call taker and BR reported that "a client was acting weird...mental health problem…having a hallucination and telling stories…tried to punch staff and was acting aggressive because he didn't want me to call an ambulance…was thinking about doing something not good, maybe killing somebody and that he can get access to a weapon, like a stone." BR also requested the attendance of Police.[21]

32. At the time a 000 call is taken, after asking "What's the nature of the emergency?",[22] the call taker must nominate a code for the job. That is, they must decide which computer aided dispatch (CAD) event best represents the nature of the call, such as, 424 for a Welfare Check, 571 for a Missing Person or 597 for Attempt Suicide/Self Harm. Whichever CAD event is selected determines which standard operating procedures (SOPs) are presented to the operator in the form of questions to be asked of the call maker. [23]

33. In Call 1, BR did not inform the call taker that he was a DSW, that Kumanjayi was under a guardianship order or NDIS or that he was calling from an SIL location.[24] The description of his bizarre behaviour was interpreted by the call taker as a suicide attempt, rather than a behavioural issue which was scaring the DSWs and other residents. The call was coded 597, 'Attempt Suicide/Self Harm' requiring a priority 1, or 'immediate response' though also documented that "this is not a suicide attempt."

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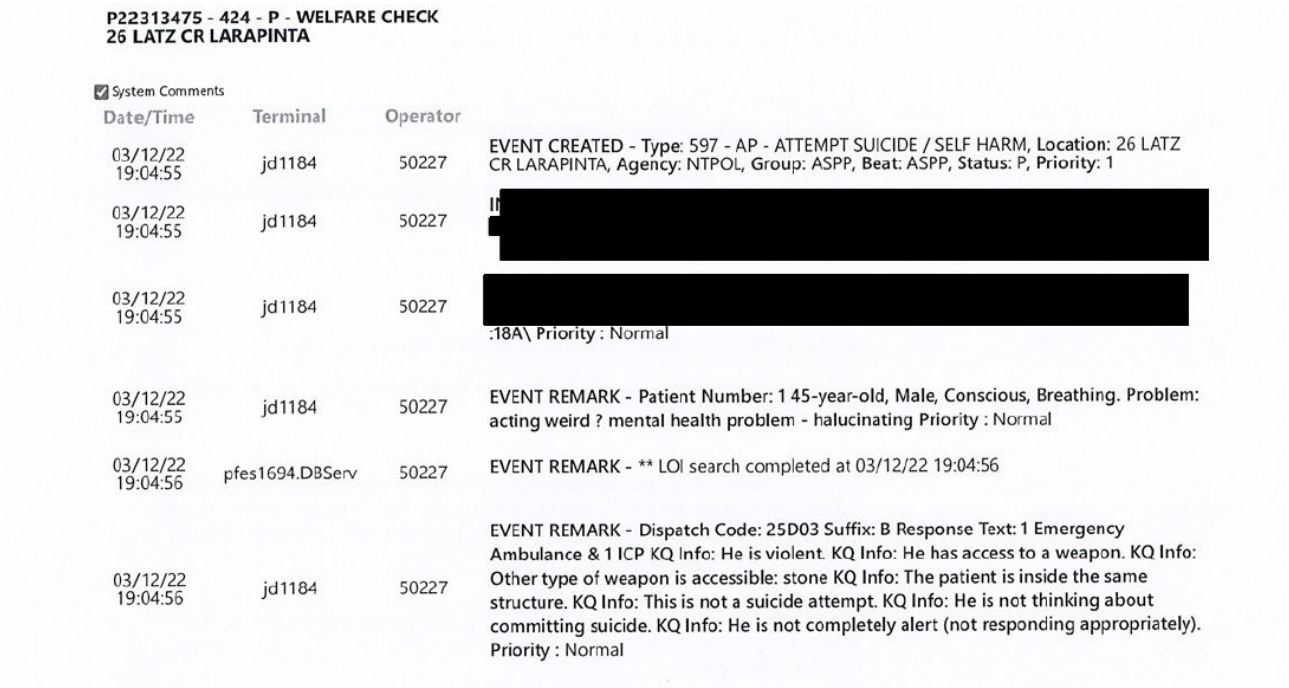
[20] T100.
[21] 6.12 000 (Call 1) from BR (Ambulance) (3 Dec 2022).
[22] T339.
[23] T263.
[24] Folio 2, CAD and Calls to Emergency Services.

34. The CAD log entry was recorded as:



P22313475 - 424 - P - WELFARE CHECK
26 LATZ CR LARAPINTA

☑ System Comments

Date/Time	Terminal	Operator	
03/12/22 19:04:55	jd1184	50227	EVENT CREATED - Type: 597 - AP - ATTEMPT SUICIDE / SELF HARM, Location: 26 LATZ CR LARAPINTA, Agency: NTPOL, Group: ASPP, Beat: ASPP, Status: P, Priority: 1
03/12/22 19:04:55	jd1184	50227	I[redacted]
03/12/22 19:04:55	jd1184	50227	[redacted] :18A\ Priority : Normal
03/12/22 19:04:55	jd1184	50227	EVENT REMARK - Patient Number: 1 45-year-old, Male, Conscious, Breathing. Problem: acting weird ? mental health problem - halucinating Priority : Normal
03/12/22 19:04:56	pfes1694.DBServ	50227	EVENT REMARK - ** LOI search completed at 03/12/22 19:04:56
03/12/22 19:04:56	jd1184	50227	EVENT REMARK - Dispatch Code: 25D03 Suffix: B Response Text: 1 Emergency Ambulance & 1 ICP KQ Info: He is violent. KQ Info: He has access to a weapon. KQ Info: Other type of weapon is accessible: stone KQ Info: The patient is inside the same structure. KQ Info: This is not a suicide attempt. KQ Info: He is not thinking about committing suicide. KQ Info: He is not completely alert (not responding appropriately). Priority : Normal

Extract of Event Chronology (CAD log) from Call 1

35. While BR was making Call 1, Kumanjayi went into his bedroom and dressed in a red jumper and boots. He came out of his room, told SD that he was going for a walk,[25] and walked out the front door.

36. SD and one of the other residents followed him for a short distance but when he asked them to leave him alone they stopped following him. BR also followed for a while but stopped when Kumanjayi picked up rocks and threatened he would kill him.[26] Kumanjayi was last seen by SD and BR walking through bush in front of Ironwood, in the direction of Larapinta Drive.[27]

[25] Affidavit of SD (3 Apr 2025) [60].
[26] Affidavit of BR (29 Mar 2025) [85].
[27] T106; T140.

The second 000 call

37. BR made a second 000 call (**Call 2**) at 7.22pm.[28] By this time, the job had been reviewed by the Watch Commander who, based the information provided in Call 1 in the CAD log, and an assessment of resources and operational requirements, had downgraded the job to a 'welfare check', reducing the level of urgency for an emergency services response to a priority 3 or 'routine response'. This meant that police were to attend when operationally available and the call maker was to be advised of the delayed response.[29]

03/12/22 19:06:08	jd7447	3205	EVENT REMARK - WC HEALEY - BASED ON THE INFORMATION PROVIDED - PLEASE CONFIRM AS WELFARE CHECK Priority : Normal

CAD log entry @ 19.06hrs

38. On the evening shift on 3 December 2022, I was told that there was an "unusually high rate" of reported domestic violence incidents with 39 reported incidents and three NT Police response units available. Domestic violence reports are graded as priority 1 graded response,[30] which is the highest response. This job was now a welfare check, attendance by police was 'subject to operational circumstances', and at 7.21pm the CAD log notes that there were no Police units available for the dispatch to 26 Latz Crescent.[31]

39. I note that the reference in the CAD log to the report of a threat to hurt the caller and "kill others" was logged at 7.09pm and was not considered by the Watch Commander when he reviewed the job at 7.06pm. On review the Watch Commander acknowledged that, while this was information which would have been useful to know,[32] it would not have changed his decision to

[28] 6.15 000 (Call 2) from BR (Ambulance) (3 Dec 2022).
[29] Affidavit of Commander – Southern Command, James Gray-Spence [12]-[16]; 6.33 NT Police General Order - *Graded Response* [22].
[30] T253-254.
[31] Folio 2, CAD and Calls to Emergency Services.
[32] T344.

change the coding of the job to a welfare check[33] and I do not criticise this decision on the information that was available.

40. In Call 2 BR told the call taker that Kumanjayi had left the location and walked away through the Desert Park (which is across the road from Ironwood).[34] As Kumanjayi had left Ironwood, it was agreed that an ambulance was no longer required. However, BR stated that he still wished to speak with police to make a "missing complaint". Again, he did not tell the call taker that Kumanjayi was highly vulnerable, was cognitively impaired, had behavioural issues, that he was Aboriginal, or that he was under NDIS or an Adult Guardianship Order.

41. The call taker said that police could still attend and she would make a note for police to call BR back on his mobile, to which he commented "that makes sense."

42. The CAD log entry was recorded as:

03/12/22 19:22:40	je0081	50115	EVENT REMARK - HEADLINE: Priority : Normal
03/12/22 19:23:26	je0081	50115	EVENT REMARK - FURTHER CALL, PT HAS APPARENTLY LEFT THE SCENE, CALLER HOWEVER WOULD LIKE POLICE TO STILL ATTEND/CALL HIM TO DISCUSS THE PT - NIL AMBULANCE NEEDED HOWEVER Priority : Critical
03/12/22 19:24:21	je0520	50002	EVENT REMARK - SJA - CANCELLING JOB AS PER MOST RECENT CALL SAYING SJA NO LONGER REQUIRED. VKM TO COPY BACK IF SJA ARE REQUIRED ONCE ATTENDED SCENE AS CALLER STILL WISHES TO TALK TO VKM. Priority : Normal

Extract of Event Chronology (CAD log) from Call 2

43. Although BR provided more information and stated that he still wanted to speak with Police, he did not insist on it or convey a high sense of urgency. The information provided was insufficient to convey the level of increased

[33] T273.
[34] Folio 2, CAD and Calls to Emergency Services.

risk to Kumanjayi (and potentially to others) by him being unsupported in the community in an elevated state.[35]

44. Importantly, the CAD log entry did not identify that this was now a "missing complaint." The call was not recoded to a missing person code (571). This was a missed opportunity for the urgency of the response to be re-assessed.

45. At 7.52pm, the 000 dispatch operator left a message on BR's voicemail advising of lengthy delays and that Police would follow up tomorrow. A further message was left on his phone at 1.45am on 4 December 2022, requesting a call back to provide an update.[36] This was in accordance with the NT Police General Order - Graded Response.[37]

46. BR believed that Kumanjayi would return to Ironwood overnight and was concerned for his own safety and the safety of others in the house.[38] He asked to be relieved for the remainder of his overnight shift and left Ironwood at 9pm when a replacement DSW arrived. SD also thought that Kumanjayi would likely return in the following hours and held similar concerns should he return in an escalated state.[39] SD's shift ended at 8pm but he stayed with BR until 9pm when they both left.

47. LSS contacted Kumanjayi's family the next day and told them that he had left Ironwood.[40] As discussed earlier, Leah and Malcolm were upset by both this delay and the lack of information provided.[41] Mr Damion Lipman, Chief Operating Officer – Disability and institutional respondent for LSS, accepted that this was an error and there should have been earlier contact with

[35] 6.15 000 (Call 2) from BR (Ambulance) (3 Dec 2022); Folio 2, CAD and Calls to Emergency Services.
[36] Folio 2, Event Chronology.
[37] 6.33 NT Police General Order Graded Response [22.3].
[38] Affidavit of BR (29 Mar 2025) [92]; T110-111.
[39] T153.
[40] 1.2A Affidavit of Leah Johnson (1 Apr 2025).
[41] 1.2A Affidavit of Leah Johnson (1 Apr 2025); 1.2B Affidavit of Malcolm Heffernan (1 Apr 2025).

family.[42] BR also acknowledged that family should have been contacted and that he wished he had done so.[43]

48. When Kumanjayi went missing, LSS policy required a Missing Person Checklist to be completed and provided to police. The LSS 'Missing Persons Checklist' was not completed as required when he was reported missing or at any time.[44] This was a missed opportunity to provide detailed information about Kumanjayi which would likely have assisted police in assessing the risks to him and the urgency of the response.

4 December 2022

49. Police and LSS communicated during the day, but it was not until 6.06pm on 4 December 2002 that NT Police attended Ironwood to speak with LSS staff to complete a missing person report.

50. The missing person report included the information that on 3 December Kumanjayi had been talking about men's business and said that he was going up Mount Gillen to be washed in a watering hole.[45]

51. Neither of the attending officers were search and rescue **(SAR)** trained but I heard that it would be 'incredibly rare' that a first responder completing a search urgency assessment form would be SAR trained.[46] The completed search urgency assessment returned a score of 26, which requires a 'measured response'. Comparatively, a score of 9-17 requires an urgent response, 28-40 requires that NT Police evaluate and investigate, and a score of 26 is at the higher end of 'measured response'.[47]

52. At 9.49pm on 4 December 2022, the Watch Commander emailed the search urgency assessment to the Territory Duty Superintendent and copied in the

[42] T234.
[43] T131.
[44] 7.50 LSS Missing Persons Procedure.
[45] 6.13 NT Police Missing Persons Report.
[46] T256.
[47] 6.1 Annexure, NT Police Search Urgency Assessment.

incoming day shift supervisors. In this email, the Watch Commander noted that; Kumanjayi required daily medications for his brain injury, diabetes and epilepsy, he had not been seen for 27 hours, he had expressed a desire to climb Mount Gillen and bathe in a pool of water and the primary resolution strategy was to involve Aboriginal Liaison Officer's.[48]

53. Between 9.59pm on Sunday 4 December and 9am on 5 December 2022 general duties police continued to make enquiries.[49] The SAR response commenced at 9am on 5 December and continued through to Friday 9 December 2022 when Kumanjayi was located deceased at 2.20pm in a gully on Mount Gillen.

Kumanjayi's Supports

Adult Guardianship Officer (AGO)

54. Since 4 March 2015, Kumanjayi was a 'represented person' with the NT Office of the Public Guardian and Trustee **(OPGT)**. The First Order granted the Public Guardian decision-making authority as to where and with whom he was to live, health care and day to day care.

55. Almost all represented persons are eligible for NDIS supports[50] and an Adult Guardianship Officer **(AGO)** makes decisions on behalf of represented persons concerning those services and supports.[51] Many represented persons, like Kumanjayi, reside in supported independent living (SIL).[52] Accordingly, AGO's are responsible for; approving and overseeing SIL, and ensuring the living environment and support services meet the represented person's needs.[53] One of the first decisions Kumanjayi's AGO made was that he was

[48] 6.1 Statutory Declaration of A S/Sgt Healey, (22 Jan 2022) [24].
[49] 6 Affidavit of Commander – Southern Command, James Gray-Spence, [36].
[50] 2.1 Lorraine King Affidavit (27 Feb 2025) [66]-[67].
[51] Ibid [72], [64]: When the NDIS was rolled out in the NT in 2019, the funding for this SIL moved from the NT Office of Disability to the NDIS, though nothing turned upon this in the Inquest.
[52] 2.1 Lorraine King Affidavit (27 Feb 2025) [76].
[53] 2.1 Lorraine King Affidavit (27 Feb 2025) [79].

to reside in 24/7 shared SIL managed by Lifestyle Solutions (Aust) Ltd **(LSS)**.[54]

NDIS

Supported Independent Living (SIL)

56. From 9 October 2015, Kumanjayi's NDIS package and plan included funding for Supported Independent Living (**SIL**). His SIL provider was LSS.[55]

57. SIL funding covered:

    a. his accommodation[56] which on 3 December 2022, was Ironwood[57] located on the corner of Latz Crecent and Kramer Street in Larapinta, Alice Springs, near the MacDonnell Ranges. It is directly across from the Alice Springs Desert Park which is located at the base of Mount Gillen; and

    b. a support service within his living arrangement.[58] The level of support provided is determined by an assessment of the participant's needs, the type of support and the level of supervision required, and the number of residents in a shared living arrangement.[59]

58. In the lead up to his passing, the staff employed at Ironwood to care for Kumanjayi were, CJ, the house team leader, and DSWs, BR and SD.

59. CJ commenced working with LSS and Kumanjayi in 2019. He described Kumanjayi as a kind and generous person with a great sense of humour.[60] BR started working with Kumanjayi in 2020 and he said Kumanjayi was a

[54] 2.9 Lisa Anderson Affidavit (25 Mar 2025) [9].
[55] 7 Affidavit of Damion Lipman (18 Mar 2025) [3]: Shortly before Kumanjayi Johnson's death, on 12 October 2022 Lifestyle Solutions merged with the charity Possability Group Ltd (ACN 638 044 327). Since that merger, Lifestyle Solutions has operated as a wholly owned subsidiary of Possability.
[56] 7.23 NDIS Plan (29-Jul-22).
[57] T11. Ironwood was the service outlet name for whatever address Kumanjayi resided at. In November 2021, Ironwood moved from Irvine Crescent, to Latz Cresent.
[58] 2.1 Lorraine King Affidavit (27 Feb 2025) [77].
[59] 2.1 Lorraine King Affidavit (27Feb 2025) [78].
[60] 5.4 Statement of CJ, (6 Dec 2022; 5.4A Affidavit of CJ (4 Apr 2025).

really good guy who was very caring towards the other residents.[61] SD was a casual employee and had less experience working with Kumanjayi but had worked with him on around 10 to 15 shifts prior to 3 December 2022. SD described Kumanjayi as a friendly and independent person who would like to help with chores and was caring towards the other residents.[62]

60. All workers were familiar with Kumanjayi's 'behaviours of concern' and had been trained in his 'positive behaviour support plan' **(PBSP)** and CJ and BR were involved in its implementation. BR understood that the PBSP did not authorise workers to use any restrictive practices (such as physically restraining Kumanjayi) and, if he became angry or violent workers were to 'give him space' to ensure the safety of the workers and the two other residents. SD also knew that that he was not allowed to physically restrain clients and could not force them to do anything that they did not wish to do.[63] To 'give him space' might mean that workers and the other residents left Ironwood and Kumanjayi so that he could calm down, alternatively, Kumanjayi might leave the residence to go for a walk.[64]

61. It was not unusual for Kumanjayi to leave Ironwood and walk into town by himself. When Kumanjayi left Ironwood during a behavioural incident, DSW's were required to call the manager (or, if after hours, the IRT) for instruction on the best action to take.[65] His DSW's were commonly instructed to walk behind Kumanjayi. However, if this caused Kumanjayi's behaviour to escalate or he threatened violence, then the DSW's were commonly instructed to cease following and to call for an ambulance or the police.

[61] 5.5 Statement of BR, (6 Dec 2022); 5.5A Affidavit of BR, (29 Mar 2025).
[62] 5.6A Affidavit of SD (3 Apr 2025).
[63] 5.6A Affidavit of SD (3 Apr 2025) [20].
[64] 5.5A Affidavit of BR (29 Mar 2025).
[65] 7. Affidavit of Damion Lipman, (18 Mar 2025), Annexure DLJ-1, 29-33. Lifestyle Solutions Incident Reporting Procedure.

62. Following any behavioural incident, the DSW's completed incident reports and provided a handover of any behaviours of concern to incoming staff.[66]

Coordinator of Support (COS)

63. Kumanjayi's NDIS Plan included funding for a Level 2 COS[67] and his COS provider was Australian Regional and Remote Community Services (**ARRCS**).[68]

64. A COS is a 'service intermediary' who assist NDIS participants with procuring, establishing and coordinating service arrangements with providers.[69] There are three levels of this type of funding:[70]

    i. Level 1: provides support connection funding and a Level 1 COS assists participants to understand their NDIS plans, connect with service providers and achieve the most out of their plans.

    ii. Level 2: provides funding where there is greater complexity in the support environment and/or the participant's circumstances. A Level 2 COS assists participants to understand their plans, reduces barriers to engagement, maintains supports, designs support approaches, establishes supports and monitors supports.

    iii. Level 3: provides the highest level of funding for specialist support coordination. A Level 3 COS uses expert or specialist approaches for NDIS participants with specific high and/or complex support needs, or where risks have been identified that require active specialised management.

[66] 5.5A Affidavit of BR, (29 Mar 2025) [67].
[67] 7.23 NDIS Plan (29 Jul 2022). The terms Support Coordinator and Coordinators of Support are used interchangeably in the sector see T279.
[68] T279-280.
[69] 1.8.1, Royal Commission Final Report, Volume 10, Disability Services *Introduction* (29 Sep 23) 33.
[70] 1.8.1, Royal Commission Final Report, Volume 10, Disability Services *Introduction* (29 Sep 23) 33–34; see also 5.1 COS Statement (21 Mar 2025) [3]; T281.

65. Kumanjayi's COS worked alongside his AGO to ensure his NDIS plan was implemented,[71] which included approving service agreements with providers.

Positive Behaviour Support

66. Kumanjayi's NDIS Plan included funding for a behaviour support provider delivered by Veritable Pty Ltd **(Veritable)**, a NDIS registered behaviour support and allied health provider.[72]

67. A behaviour support practitioner **(BSP)** tries to understand a NDIS participant's lived experience in order to identify what is likely to influence their behaviour.[73] The BSP may prepare a Positive Behaviour Support Plan **(PBSP)** which provides guidance as to how to improve the supports around the NDIS participant to support positive behaviour. Kumanjayi's PBSP focussed on strategies to improve his interpersonal engagements and his engagement in positive activities of interest to him.[74] The PBSP contained recommendations to service providers (such as the SIL, COS and AGO) about:[75]

    a. how to improve his environment; and

    b. strategies to manage escalated behaviours.

Cultural Support

68. From July 2022 Kumanjayi's NDIS plan identified that his short term goal was to "gain and maintain strong connections and my country"[76] and from mid-October 2022 Kumanjayi's NDIS Plan included funding for cultural support. The service provider was Spirit of the Gumtree **(SOG)**[77] which is

[71] 5.5A Affidavit of BR (29 Mar 2025) [9], [43].
[72] 5.52 Statutory Declaration of Sophie Straughton (24 Mar 2025) [1].
[73] T213–214.
[74] T209.
[75] T209.
[76] 7.23 NDIS Plan, 29 July 2022.
[77] 5.4.1 Spirit of the Gum Tree service agreement, dated 26 August 2022.

the only provider of this type of service in the region. There were three components to the work of SOG:

a) Ironwood visits,

b) Jay Creek visits, and

c) Return to Country.

69. Mr L Jnr and Mr L Snr, both traditional Aboriginal men from the central desert area, provided the cultural support services to Kumanjayi.[78] They dropped into Ironwood each week for periods of 5 to 45 minutes to meet with and check up on Kumanjayi.[79]

70. During the Ironwood visits, Mr L Jnr said that Kumanjayi was always happy to sit and talk about his life in SIL, his cultural connections and men's business. But Mr L Jnr also noticed that there was no 'cultural security' for Kumanjayi at Ironwood. There were no indigenous staff, and the staff who were present never engaged him in conversations about culture or asked his advice on how to make the environment or their relationship with Kumanjayi more culturally appropriate. He noted the absence of any paintings of the ranges (Kumanjayi's country) and there were no photos of his family.[80]

71. Mr L Jnr made an important point concerning language. He explained how important it was for Aboriginal SIL participants to speak in their first language. He said that if support workers spoke in language, even at a very basic level, this would support rapport building and would assist in breaking down barriers to mutual understanding.[81] Mr L Snr explained that 'culture' was an avenue which supported cognitively impaired Aboriginal people to "revisit something they already know", to reconnect and rejuvenate.[82] As I

[78] 5.2 Mr L Snr Statement (22 Mar 2025); 5.3 Mr L Jnr Statement (24 Mar 2022); T157.
[79] 5.3 Mr L Jnr Statement (24 Mar 2022) [10].
[80] T165.
[81] T166.
[82] T167.

understand it more generally, memories (learnings and experiences) from early childhood are often the longest retained and accessible memories for the cognitively impaired.

72. The only relevant training module about Aboriginal culture available to the DSWs was an on-line module (accessed through a staff intranet portal) which new employees are required to complete as part of an induction[83] titled 'Promote Aboriginal and/or Torres Strait Islander Cultural Safety'. This was 'generic' training. There was no evidence that Kumanjayi's DSWs had received any in-person cultural training, or any training specific to Kumanjayi's specific culture or language.

73. LSS accepted that it needed to deliver culturally safe accommodation and services and that its knowledge base and training in this regard was inadequate, dare I say, woefully so. Damion Lipman, acknowledged the benefits of working with elders, the local community[84] and organisations such as SOG to improve LSS cultural awareness and to promote cultural safety.[85]

74. I heard that LSS are introducing 'cultural support plans' for First Nations clients. The plans are intended to assist staff to understand a resident's specific cultural background, language, connection to family and local community.[86] It is intended that these plans will be developed in consultation with the resident's family.[87] I note that in addition to the development of the plan, this could provide an opportunity for a) DSW's to engage directly with family members so family and DSW's can get to know each other, and b) family could be encouraged to provide photos, artworks or other cultural

[83] 7 Affidavit of Damion Lipman, (18 Mar 2025) [49].
[84] T233.
[85] T241.
[86] T235.
[87] T240.

items for inclusion in the residence, to enhance the amenity and cultural safety of the accommodation.

75. Each Saturday, over a 4 to 5 week period, Mr L Snr took Kumanjayi for a visit to Jay Creek. They cooked kangaroo tail over the fire. Kumanjayi helped to build the fire, cooked the kangaroo and 'opened up' during conversations.[88] This reinvigorated Kumanjayi's early memories of his culture and started conversations. Mr L Snr explained that he never had issues with Kumanjayi's behaviour on these trips.

76. Over the years and on several occasions, Kumanjayi told CJ that he wanted to go to Papunya for men's business. However, this was not a decision that LSS could make independently as it required NDIS funding and the approval of the AGO.[89] It was raised with the COS but it never eventuated.

77. Sophie Staughton, the Behaviour Support Practitioner, and Lorraine King, Director Guardianship, both gave evidence that although the NDIS will fund respite for persons living in community to come into town, it would not fund 'reverse respite', for persons living in town to return to their communities.[90] The NDIS may fund a 'return to country' (**RTC**) 'if needed' but not 'if wanted'.[91] RTC costs about $5000 per day and Kumanjayi was only funded for $300/week for community access.[92] His community access funding was insufficient for RTC.

78. Ms King told me that the OPGT has made several submissions to the NDIA in support of RTC funding when a client/NDIS recipient has been removed from their country in order to access services and supports[93] and similar submissions were made to the Commonwealth Royal Commission into

[88] 5.2 Affidavit of Mr L Snr (22 Mar 2025).
[89] 5.4A Affidavit of CJ (4 Apr 2025).
[90] T198, T390.
[91] T379.
[92] T380.
[93] T390.

Violence, Abuse, Neglect and Exploitation of People with Disability (the Disability Royal Commission):[94]

> "RTC trips provide enormous benefit for First Nations people with disability, and should be classified as reasonable and necessary support. First Nations participants should receive sufficient funding to undertake an appropriate number of RTC trips with the adequate level of support."

79. Indeed, the Disability Royal Commission recommended that:[95]

In consultation with the First Nations Advisory Council, the National Disability Insurance Agency (NDIA) should:

- create a new line item in the Pricing Arrangements recognising cultural supports and return to Country trips;
- develop guidelines for NDIA staff on including cultural supports and return to Country trips as reasonable and necessary supports in plans;
- educate First Nations participants about the availability of cultural supports and return to Country trips included in their plans.

80. The OPGT supports these recommendations and at NDIS planning meetings I was told that AGOs continue to advocate for RTC funding for clients in circumstances similar to Kumanjayi's.[96] However, if RTC funding is refused I was told that the decision is unlikely to be 'appealed' because the review process is time consuming and resource intensive and consumes scarce COS funding allocations.[97]

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[94] 1.5 Statement to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, 1 June 2022 at [57].
[95] 1.7.1A Royal Commission Final Report, Volume 9 First Nations People with Disability, Recommendation 9.8.
[96] T390.
[97] T390-391.

81. I accept that it would have benefitted, perhaps even significantly benefitted, Kumanjayi if he was provided with RTC opportunities, at least annually, and I also support these recommendations of the Disability Royal Commission.

Behaviours of concern

82. Due to his complex health conditions (cognitive impairment due to traumatic brain injury and a secondary seizure disorder), Kumanjayi exhibited challenging behaviours including physical aggression.

83. He was particularly reactive to:

a) financial management and he struggled to understand why he did not receive what he referred to as 'big money' in his bank account and routinely made unachievable financial demands.

b) his fluid intake as he suffered from polydipsia, or excessive thirst. He frequently demanded his preferred drink, Coke, and when his demands were not met he responded with verbal and physical outbursts.[98]

84. The following table, extracted from his 2022 Functional Behaviour Assessment Report, describes the type of challenging behaviours Kumanjayi was known to exhibit:[99]

[98] 2.9 Affidavit of Lisa Anderson (25 Mar 2025) [10].
[99] 2.9.8 LA-8 Functional Behavioural Assessment Report, Veritable (28 Feb 22) 11.

Type	Description
Verbal outburst	**Swearing** – [redacted] swearing in English or in language in a raised voice ('this is fucking bullshit' 'fucking hell' 'I need fucking money' 'I thought you were my fucking friend') **Demands** – [redacted] using a raised voice to make demands of a target person for assistance ('give me Coke', 'I want big money, $8000', 'take me bank', 'I want 5 jeans, $100 each') **Threats** – [redacted] indicating that he will harm the target person or take his own leave from the house ('I'm going to hit you', 'I'll leave house, walk away')
Physical outburst	**Threats** – [redacted] making physical actions indicating imminent physical assault, such as clenching his fist **Throwing** – [redacted] picking up a heavy or sharp item and swinging or throwing it in order to cause injury or damage to the target person (eg a knife, a chain, a metal object, rock, chair). **Hitting** – [redacted] using his arm to hit a nearby object (such as the wall) or to punch a target person (usually aimed high at the face). **Property damage** – [redacted] picking up an item nearby and damaging it by throwing it (object or target requiring repair or replacement)

Incidents of concern prior to 3 December 2022

85. Between 2015 and 2022, Kumanjayi was reportedly involved in a number of incidents of violence. The most serious of these resulted in police involvement. The incidents are briefly summarised below and provide insight into the decision making underpinning the implementation of Kumanjayi's supports and the response of LSS workers to the events of 3 December 2022.

- *11 December 2015* An LSS worker reported to NT Police that Kumanjayi had smashed windows, was walking around his SIL residence holding a stick and had chased a staff member. When NT Police arrived Kumanjayi was aggressive. He was restrained and taken to ASH for psychiatric assessment and treatment. [100]
- *15 December 2025* An LSS worker reported to NT Police that Kumanjayi was walking around in public with a big stick and rocks and he held concerns for the safety of people in the area. When NT Police located Kumanjayi he was upset and raising rocks in a

[100] 4.1 PROMIS Case Summary 7492353 (Removed to ASH) (11.12.15).

threatening manner. He was restrained and taken to ASH for psychiatric assessment.[101]

- *18 December 2015* NT Police were called to ASH in response to a report that Kumanjayi had assaulted a security guard because the exits were locked. When NT Police arrived Kumanjayi was asleep and no action was taken.[102] Later on the same day, NT Police were again called to ASH in response to a report that Kumanjayi was threatening security staff with a metal pipe.[103]
- *26 October 2016* NT Police were called to the SIL residence because Kumanjayi was fighting with another resident, punches were thrown and a car was damaged. Upon NT Police arrival, Kumanjayi and the resident shook hands and apologised to one other, and no further action was taken.[104]
- *30 October 2017* An LSS worker reported to NT Police that Kumanjayi had struck the worker to the forehead. The incident resulted in no injuries, and no action was taken.[105]
- *12 November 2017* An LSS worker reported to NT Police that Kumanjayi had become upset and struck a LSS worker to the face causing a nosebleed, no action was taken.[106]
- *24 November 2019* An LSS worker reported to NT Police that Kumanjayi was damaging property inside the SIL residence and acting in violent manner. When Police attended he was standing in the front yard of the residence aggressively holding a large rock in each hand.

[101] 4.2 PROMIS Case Summary 7495432 (Removed to ASH) (15.12.15).
[102] 4.3 PROMIS Case Summary 7497357 (Assault ASH) (18.12.15).
[103] 4.4 PROMIS Case Summary 7497205 (ASH Ward Armed) (18.12.15); 4.5 PROMIS Case Summary 7497907 (ASH ICU Armed) (18.12.15).
[104] 4.6 PROMIS Case Summary 7986433 (Fight) (26.10.16).
[105] 4.7 PROMIS Case Summary 8308000 (Assaulted staff) (30.10.17).
[106] 4.8 PROMIS Case Summary 8322523 (Assaulted staff) (12.11.17).

Kumanjayi was tackled to the ground by Police, ground stabilised, handcuffed and taken to ASH for assessment.[107]

- *31 October 2020* CJ reported that during a drive Kumanjayi had made repeated demands for Coke and when told that he needed his own money to buy Coke, Kumanjayi clenched his fist and threatened to hit CJ. CJ got out of the car but was chased by Kumanjayi. CJ ran into a shop where Police were located. Kumanjayi left the area and at 1745hrs Police attended the SIL residence to advise LSS workers that Kumanjayi had not been located. CJ told police that he did not have any concerns about Kumanjayi finding his own way home.[108]
- *23 November 2020* An LSS worker reported to NT Police that Kumanjayi had approached a worker, threatened them with a chain from a gate, and asked the worker for money. When Police attended workers reported that Kumanjayi had put down the chain, apologised and was asleep in bed. No action was taken.[109]
- *21 March 2021* An LSS manager reported to NT Police that on the previous day Kumanjayi had been restrained by two of the LSS workers to avoid further escalation.[110] The trigger was a demand by Kumanjayi for workers to take him to the shop to purchase soft drink which, when not immediately agreed to, escalated to physical aggression, an assault on one member of staff and an attempted assault on another.[111]

[107] 4.9 PROMIS Case Summary 9141662 (Removed to ASH) (24.11.19).
[108] 2.9.13 LA-13 LSS Incident Report, (31 Oct 20); T14.
[109] 4.10 PROMIS Case Summary 9489496 (Threatened staff) (23.11.20).
[110] 4.11 PROMIS Case Summary 9595047 (Restrained by staff) (21.03.21).
[111] 5.20 Confidential Investigation Report (13.05.21).

- *27 August 2021* NT Police received a report that Kumanjayi had been hit in the face with a crutch at a bus stop. LSS workers took him to ASH for a check-up. Police spoke to Kumanjayi the following day, but Kumanjayi could not confirm the event or describe the offender.[112]

Implementation of Response to Behaviours of Concern

Functional Behaviour Assessment

86. Against this background, in February 2022 Kumanjayi's behavioural support practitioner (BSP) completed a functional behavioural assessment (**FBA**) for the preparation of an updated comprehensive positive behaviour support plan (PBSP).[113]

87. It was important to Kumanjayi to have a sense of independence. Increasing his independence with appropriate supports was identified in the FBA as a key element of the PBSP[114] and this was to be achieved with support from the LSS DSWs. When he would allow it, the DSWs helped Kumanjayi by driving him to places, offering to go shopping with him and supporting his daily tasks, but, as already noted, it was understood by the DSWs that they could not force supervision on Kumanjayi.[115]

88. The FBA summarised Kumanjayi's daily routine including:

    a) His repetitive queries about his money and his daily trip into town each morning to check his bank balance. If he was impatient or particularly

[112] 4.12 PROMIS Case Summary 9776782 (Alone, Assaulted) (27.08.21).
[113] T179; 5.52 Statutory Declaration of Sophie Straughton (24 Mar 2025) Annexure 1, 4; 5.54 NDIS QSC Fact Sheet: Behaviour support and restrictive practices (Jul 20); 5.55 NDIS QSC: Regulated Restrictive Practices Guide (Oct 20).
A FBA is mandatory for persons subject to restrictive practices such as chemical restraints, and informs a later Comprehensive PBSP. In June 2021 and January 2022, Veritable had identified and confirmed through medical review that Kumanjayi was subject to chemical restraints, and accordingly an FBA was required. Nothing turns upon this for this inquest.
[114] 2.9.8, LA-8 Functional Support Assessment, Veritable (28 Feb 2022).
[115] 5.6B, Affidavit JC (2 Apr 2025).

frustrated, he might start walking into town and get collected by his DSW on the way.

b) That he spent about one third of each day in town or at the homes of his family. If he had an incident with a DSW, he usually walked off and found family and might stay away for most of the day, but he normally returned for dinner.

89. Despite spending a lot of time away from his residence without a DSW, Kumanjayi did not have his own phone. However, the FBA concluded that if Kumanjayi expressed an interest in having a phone, "this would be important to enable his ongoing independence."[116]

90. The LSS team leader,CJ, explained that there was a period of time when one DSW would stay with Kumanjayi when he was dropped off in the community, but that ended when Kumanjayi wanted the DSW to stop following him. Even though Kumanjayi did not have a mobile phone, he could use the pay phones in town for free, and he had a card with the house phone number and address if he got a ride home.[117]

91. Similarly, his BSP explained that Kumanjayi was not only coming home independently, he was also demonstrating "effective help seeking behaviours" to return to his supports, for example, by approaching people and getting them to make calls on his behalf. [118]

92. However, when questioned, neither the LSS team leader nor the BSP could think of any strategy Kumanjayi might use if he got into a situation where he felt vulnerable, scared, lost or confused; such as immediately following seizure. The BSP said that as Kumanjayi was engaging in the community

[116] 2.9.8 LA-8 Functional Behaviour Assessment Report, Veritable (28 Feb 22) 11.
[117] T86-87.
[118] T174.

everyday there were lots of people who were familiar with him and informal supporters would help.[119]

93. The evidence established that Kumanjayi could access public phones or other supports in the community and I accept that in a small community like Alice Springs he was generally well known. I make no criticism of him not having a mobile phone in those circumstances and am left in some doubt as to his capacity to use and retain a mobile phone.

Comprehensive Positive Behaviour Support Plan (PBSP)

94. On 14 March 2022, the BSP sent the completed Comprehensive Positive Behaviour Support Plan (PBSP) to LSS.[120] On 8 April 2022, the AGO consented to the PBSP.[121]

95. The purpose of the PBSP was to translate the recommended strategies identified in the FBA into practical protocols for the DSWs to implement. In this sense, it was the main resource for DSWs.[122] It also established an online data gathering tool, which would enable the implementation of the PBSP protocols to be monitored.[123] The protocols were:[124]

- Protocol 1: Supporting Kumanjayi's access to money;
- Protocol 2: Supporting Kumanjayi's access to coke;
- Protocol 3: Supporting Kumanjayi's access to family and community;
- Protocol 4: Culturally safe interpersonal style that works for Kumanjayi;

[119] T174.
[120] 5.52 Statutory Declaration of Sophie Straughton (24 Mar 2025) Annexure 1, 4; 7.20 Behaviour Support Plan (15 Mar 22).
[121] T180; 5.52 Statutory Declaration of Sophie Straughton (24 Mar 2025), Annexure 1, 8.
[122] 5.52 Statutory Declaration of Sophie Straughton (24 Mar 2025) Annexure 1, 4.
[123] 5.52 Statutory Declaration of Sophie Straughton (24 Mar 2025) Annexure 1, 4.
[124] 7.20 Behaviour Support Plan (15 Mar 22).

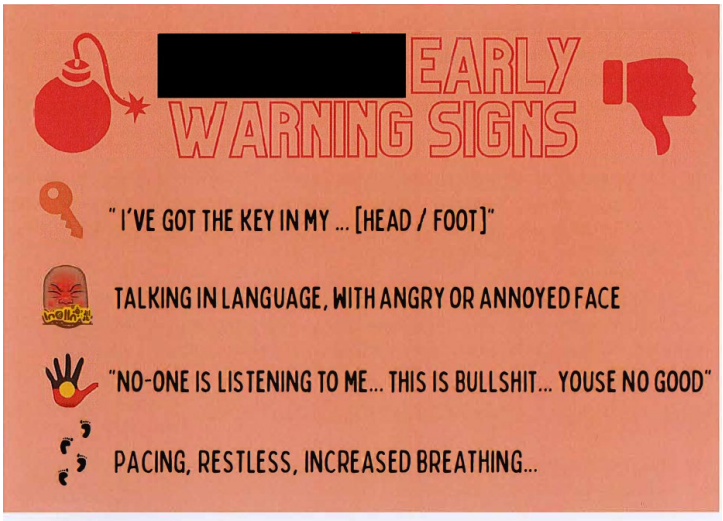
- Protocol 5: Helping Kumanjayi learn new skills;
- Protocol 6: What to do if Kumanjayi uses behaviours of concern; and
- Protocol 7: Completing the data sheet after every behavioural episode.

96. Each Protocol included two sections. The 'Background' explained why the Protocol was required, and the 'Procedure' contained practical, numbered advice about actions.

97. Protocol 6 contained seven strategies (actions) for behaviours of concern, namely:

- Strategy 1 – Active Listening;
- Strategy 2 – Use Humour;
- Strategy 3 – Listening and Redirect;
- Strategy 4 – Make a Plan of Action (and Start Step 1);
- Strategy 5 – Environmental Scanning and Positioning;
- Strategy 6 – Proximity Control;
- Strategy 7 – Strategic Capitulation ('Lose the Battle, Win the War');
- Strategy 7b – 'Surprise' or 'Unexpected' Event.

98. The final page of Protocol 6 identified the warning signs for behaviours of concern:



Comprehensive Positive Behaviour Support Plan

99. During the inquest I heard that the DSWs struggled to implement the PBSP including for the following reasons:

- *Challenge 1: Useability* The PBSP was a long (40 page) document for DSWs to read and absorb.
- *Challenge 2: Transition* The PBSP involved a change in strategies and protocols from what had been used[125] and it would take time for staff to fully adjust to and implement the new actions. Training and implementation was further complicated and delayed because of the mix of permanent, casual and agency workers; the mix of backgrounds, cultures and experiences of the workers; and because PBSP implementation is generally complex.[126]
- *Challenge 3: Inconsistencies* Real, possible, or perceived inconsistencies arose between requirements in the PBSP. For example, in Protocol 4 item 8 required finding a way to agree with Kumanjayi if he is making demands, compared to Protocol 6 which required active listening, humour, redirection, making a plan, scanning and positioning, proximity control, and only once all of these strategies had been exhausted was strategic capitulation (i.e. finding a way to agree) to be used.[127]
- *Challenge 4: Multiplicity* Kumanjayi lived with two others, both of whom were NDIS Participants with their own BSPs, their own PBSPs, and their own reporting obligations. DSWs were trying to concurrently implement all three plans.[128]
- *Challenge 5: Reporting Obligations* Reporting demands were too great. The PBSP required the DSWs to provide incident data reporting via a QR code, a LSS incident report, further background information

[125] T216.
[126] T217.
[127] T219; 7.20 Behaviour Support Plan (15 Mar 22) 30, 36-39.
[128] T226.

about how the incident came about, and a debrief of the incident as soon as possible after the incident occurred.[129]

- *Challenge 6: Briefing High Severity Incidents* The PBSP required Lifestyle Solutions staff to debrief high severity incidents with the BSP. Between 8 March 2022 and 23 November 2022, there were about 14 high severity incidents but no debriefings occurred.[130]

- *Challenge 7: Monthly Meetings* The PBSP required the BSP attend monthly team meetings with LSS workers.[131] However, there was limited evidence of the occurrence of these meetings and I am not satisfied that they occurred regularly, as required. There were no records of LSS staff sending calendar invites to these meetings,[132] no record keeping of who attended or of what was discussed[133] and informal supports (such as family members) were not invited.[134] The PBSP provided for eight (8) meetings in 2022, but only 4 proceeded; in April, May, June and August. [135] Damion Lipman said that LSS now expected monthly team meetings and the Alice Springs Regional Manager has been working with Practice Leads and the Operations Manager on establishing a standard agenda and minutes, with a requirement that both of the Operations Manager and the Regional Manager ensure that the process is in place.[136]

100. Challenge 8: Community Access On 11 October 2021,[137] the COS made a case note,[138] "Discussion needs to be had with [Kumanjayi] about what activities he would like to participate in during the week now Bindi has

[129] T185-186.
[130] T180; 7.20 Behaviour Support Plan (15 Mar 22) 19; 5.52.3 Appendix C: Detailed Summary of PBSP Implementation Contact (Undated).
[131] T180; 7.20 Behaviour Support Plan (15 Mar 22) 19; 5.52.3 Appendix C: Detailed Summary of PBSP Implementation Contact (Undated).
[132] T28.
[133] T71.
[134] T72.
[135] T184; Inquest Exhibit 3.
[136] T236.
[137] 5.51 ARRCS, Client Dated Note Report p 132; T294.
[138] 5.51 ARRCS, Client Dated Note Report p 132; T294.

ceased. Previous calculations have $51,859.68 available per year for community access supports (approx. 3 hours x 3 days per week as per ROC)." On 24 May 2022, the BSP queried with the COS whether there were sufficient funds in the NDIS plan to enable a referral.[139] On 15 June 2022, the BSP again contacted the COS to follow up on that query.[140] On 25 June 2022, the COS submitted a NDIS Progress Report,[141] listing 7 goals under the NDIS Plan,[142] and actions taken to date on those goals. Goal 5 (employment options) included, "COS sent referral to NT Friendship for assistance with supported employment, training on the job, 1:1 case management to develop skills in finding work".[143] At this time the community engagement options in Alice Springs were very limited and the COS also made a referral for Kumanjayi to Life Without Barriers to participate in a 'day program'.[144] Unfortunately, nothing came of those referrals and the COS did not proactively pursue them. It was accepted by the COS that despite the PBSP (which was approved by the AGO on 9 April 2022) making recommendations for community access, active steps were not taken by the COS until June 2022[145] and it was conceded that the COS could have been, "a lot more supportive to Kumanjayi."[146]

101. The BSP said that the PBSP was a form of advocacy in that it made recommendations which would assist and enhance the life of the participant. However, it was the responsibility of the COS to make it happen.[147]

[139] T288.
[140] T288.
[141] 5.30 NDIS COS Progress Report (25 Jun 22).
[142] 7.23 NDIS Plan (29 Jul 22).
[143] 5.30 NDIS COS Progress Report (25 Jun 22) at 3; T283.
[144] T283.
[145] T299.
[146] T288.
[147] T215.

PBS Progress Report

102. On 7 July 2022, a PBS Progress Report was sent to the AGO and the COS[148] and an updated implementation checklist was sent to LSS.[149]

103. From an email exchange between the BSP and AGO and from the evidence of the BSP at inquest, it was evident that the BSP was frustrated by the failure of LSS to implement the recommendations contained in the PBSP and the "challenging organisational and governance issues that get in the way of really effective implementation of behaviour support interventions, principally related to 'base' training, support and mentoring of staff internally."[150]

104. The PBS Progress Report identified several LSS impediments to implementing the plan, including:[151]

- a lack of structured processes whereby regular meetings and communication with the BSP can occur;
- a lack of responsiveness to offers to debrief critical incidents;
- considerable delays in responding to requests for training and follow up;
- delays in implementing behaviour data recording;
- difficulties in establishing reliability of the data;
- a 'problem-oriented' culture, which is difficult to steer towards solutions and collaboration; and
- a crisis-driven, reactive approach to responding to behaviours of concern.

[148] T187; 5.34 Progress Report - Behaviour Support (7 Jul 2022).
[149] 5.52 Statutory Declaration of Sophie Straughton (24 Mar 2025) Annexure 1, 7; 5.33 Email re BSP Implementation and Data (7 Jul 22).
[150] T188; 5.52 Statutory Declaration of Sophie Straughton (24 Mar 2025) Annexure 1, 7; 5.34 Progress Report - Behaviour Support (7 Jul 22); 5.52.9 Appendix I: Case Note of Corro with OPG (8 Jul 22).
[151] T187; 5.34 Progress Report - Behaviour Support (7 Jul 22) 4.

105. On 29 July 2022, Kumanjayi's final NDIS Plan was promulgated.[152] A team meeting which was scheduled for that day was rescheduled to 2 August 2022, then to 8 August 2022, but ultimately did not proceed.[153]

106. On 10 August 2022 the BSP held a PBS Review Meeting with LSS.[154] At this meeting the BSP "la[id] it on the line" with LSS[155] pointing to the need for more collaboration with the BSP and a focused team approach; difficulties in implementing and getting 'traction' with the PBSP, including miscommunication and cancellations; difficulties for the DSWs in having multiple behaviour support providers for all residents of the house; lack of reliable behaviour data recording; prioritising implementing strategies before reintroducing restrictive practice; and the need to engage Kumanjayi more directly in behaviour support interventions.

107. In August 2022, Kumanjayi's COS was contacted by a colleague who had information and expressed concern about the care being provided to Kumanjayi at Ironwood. The COS informed the AGO, and organised and attended a meeting at Ironwood. The COS was satisfied there were no issues in the house.[156]

108. Reflecting on the problems of service delivery to Kumanjayi, the BSP described the communication between her and LSS as 'struggling' rather than 'broken down'[157] and accepted that the BSP could have taken a leadership role in establishing a monthly PBSP review meeting.[158] Mr Lipman accepted that it was "clear" that there was a breakdown in communication, as well as a failure of implementation including in data

[152] 5.52 Statutory Declaration of Sophie Straughton (24 Mar 2025) Annexure 1, 5; 7.23 NDIS Plan (29 Jul 22).
[153] 5.52.3 Appendix C: Detailed Summary of PBSP Implementation Contact (Undated).
[154] T188; 5.52.3 Appendix C: Detailed Summary of PBSP Implementation Contact (Undated); Inquest Exhibit 3, Item O.
[155] T188.
[156] 2.9.3 LA-3 Emails between Anglicare NT, NDIS & PGT (28/29-Jun-22) p 1; T300.
[157] T189.
[158] T190.

recording and follow-up in the form of regular team meetings and debriefing of serious incidents.[159]

109. Noting the challenges to implementation discussed earlier in these findings, I accept the BSP's evidence that the implementation of the PBSP by LSS DSWs was unsatisfactory. Mr Lipmon explained that LSS has instituted new procedures and guidelines to ensure DSW's are better trained, supervised and supported to implement PBSPs.[160] Ultimately, if there are difficulties with implementation these should be a) identified, and b) raised with the BSP through the Practice Leader. This would give the BSP an opportunity to consider whether the PBSP should be amended and/or whether the DSWs required further guidance and/or training in implementing the PBSP.[161]

110. Comparing what happened with Kumanjayi and the way the SIL, COS, AGO and BSP worked together now, the BSP said that things had improved. Stakeholder meetings between Veritable and LSS are now said to be open, transparent and collaborative discussions of concerns and the BSP also identified improvements in workforce training and support.[162]

Attempts to Leave and the LSS Safety Plan

111. Between March and June 2022, Kumanjayi attempted to leave Ironwood on five occasions as follows:

- *23 March 2022* CJ reported to LSS that Kumanjayi demanded money to buy jeans, then Kumanjayi threatened and chased CJ and threw rocks. After getting a bottle of Coke, Kumanjayi left Ironwood and started walking towards town. CJ followed at a distance. NT Police

[159] T232.
[160] 7 Affidavit of Damion Lipman (18 Mar 2025) [144]-[146]; 7.46 Developing Behaviour Support Plans Procedures; 7.47 Implementing Behaviour Support Plans Procedure; 7.48 Positive Behaviour Support Guidelines.
[161] 7.47 Implementing Behaviour Support Plans Procedure.
[162] T228.

were called and spoke with Kumanjayi who eventually agreed to return to Ironwood.[163]

- *6 April 2022* CJ reported to LSS that Kumanjayi demanded that he be taken him to the bank to get $15,000. He chased CJ with a wooden rolling pin and threw it at CJ but missed. He then picked and threw rocks but they also missed. Kumanjayi then picked up more rocks and threw them at CJ's vehicle, smashing the windscreen and headlights and damaging the roof and bonnet, and he then chased CJ down the road. CJ reported the matter to NT Police for insurance purposes only. Kumanjayi was last seen walking towards town, spoken to by Police and left to make his own way home.[164]

- *10 June 2022* Report to NT Police at 2215hrs that Kumanjayi had left his SIL residence at 2030hrs after threatening staff with a weapon. Kumanjayi was later located walking to Leah's house in Sadadeen, 13km from his SIL residence.[165]

- *15 June 2022* Report to NT Police at 0216hrs after CJ found Kumanjayi missing from the SIL residence, which was the first time this had happened. After multiple attempts to locate Kumanjayi throughout the day, he returned to his SIL residence by 2200hrs on 15 June, having reportedly walked to Amoonguna Community, 21km southeast of Alice Springs.[166]

112. In the absence of any guidance on this issue in the PBSP,[167] and following an LSS audit of clients who left their SIL residence alone and unsupported to access community, on 16 June 2022 a senior DSW developed a 'Safety Plan' to address Kumanjayi's attempts to leave Ironwood.[168] The stated

[163] [163] 5.25A Incident Report 55871 (23.03.22); 5.4A CJ Affidavit (04-Apr-25) p 47; T15.
[164] 4.13 PROMIS Case Summary 9972306 (Criminal Damage) (06.04.2022); 2.9.14, LSS Incident Report 6 April 2022.
[165] 4.14 PROMIS Case Summary 10030665 (Missing Person) 10.06.2022.
[166] 4.15 PROMIS Case Summary 10033847 (Missing Person) 15.05.2022.
[167] T42-43, T52.
[168] 7.21 LSS Safety Plan (16 Jun 2022); T48.

purpose of the Safety Plan was a "quick guide" "to provide strategies to support Kumanjayi safely accessing the community" and it contained Protocols to be followed in the event that Kumanjayi did not return home at the discussed time, or in the event that he left Ironwood upset and did not say where he was going.[169]

113. Whilst I accept that it was well intentioned, the development of the Safety Plan by a DSW in the absence of any involvement or input by the BSP was less than ideal for several reasons including the following:

(a) There was some overlap between the new Safety Plan and LSS's existing Missing Person's Procedure[170] including checking surrounds, and contacting other people, services and the hospital[171] but the Missing Person Procedure required staff to complete a Missing Person Checklist,[172] and this was not replicated in the Safety Plan and was overlooked when Kumanjayi was missing;

(b) Given the extent of Kumanjayi's PBSP, another plan was overloading the DSWs; and

(c) The Safety Plan (similarly to other policies and procedures) was not properly shared or communicated with all of Kumanjayi's DSWs.

114. During the inquest it became apparent, and Mr Lipman accepted, that several DSWs did not know where to locate LSS policies and procedures and that some workers were introduced to policies for the first time in preparation for the inquest.[173] He acknowledged that there was confusion about the Safety Plan and that some workers had never seen it. He also accepted that despite it being a policy requirement, Kumanjayi's file did not contain a

[169] 7.21 LSS Safety Plan (16 Jun 2022); T48.
[170] 7.8 LSS Missing Person Procedure (2 Apr 2019).
[171] T45.
[172] 7.13 Missing Person Checklist (April 2019); T45.
[173] T232.

'missing person profile' which ought to have been completed within two weeks of him entering a SIL service.[174]

115. Mr Lipman told me that there is now a new Missing Persons Procedure[175] in place for all clients, and so, as I understand it, individual safety plans to address attempts to leave are no longer required.

116. The new Missing Persons Procedure provides that when notifying police of a missing person the Support Professional must:

- Call Police to report the missing client
- Provide information (Page 1 of the DS Personal Emergency Evacuation Plan) and assistance to the Police as requested to assist with locating the client
- Record the name, rank and personal identification number of the police officer who compiled the report
- Submit an Incident Report - refer to DS Client Incident Management and Reporting Procedure

117. Page 1 of a client's 'Personal Emergency Evacuation Plan'[176] (which contains information similar to the old Missing Peron Checklist) contains "NOTE Page 1 may be provided to emergency services as a missing persons alert in the case the client may be missing."(Page1)

118. I am concerned that ambiguity remains about whether; the provision of Page 1 is mandatory or discretionary (noting the word 'may'); and how the information contained on Page 1 of the client's Personal Emergency Evacuation Plan is to be provided (orally over the phone or in document

[174] T232.
[175] 7.50 LSS Missing Persons Procedure (28 Feb 2024).
[176] Submissions of Lifestyle Solutions (Aust) Ltd in response to recommendations on behalf of the Family [44], Annexure.

form). Given that Page 1 includes a recent photo of the client, it is necessary that a hard, colour copy of Page 1 is provided to police when a missing person report is made. The Missing Persons Procedure should be reviewed and strengthened to include an instruction as to how (for example, by email with the relevant police email address) Page 1 is to be provided to police. In my view an email is insufficient, and the procedure should also require that hard copies should also be handed to any attending police or other emergency services personnel.

119. While staff are instructed to call police, they are not instructed to call 000, and in my view they should be. The Missing Persons Procedure does not contain specific guidance about what information must be conveyed in a 000 call.[177] As demonstrated by the 000 calls made on 3 December 2022, the ability of DSWs to provide accurate and relevant information to call takers and to convey the level of risk, is an essential part of the emergency services assessment and coding, which in turn determines the priority of the response. To address this the guidelines and training should include specific direction as to the minimum information to be provided. Scenario based training on what to say in a 000 should be developed and provided to all LSS DSWs.

120. At the risk of stating the obvious. I point out that any policy or procedure, however well intentioned, will only assist clients if workers know of, can access and are trained in the application of the policy or procedure. Mr Lipman told me that there has been a comprehensive review of staff training. I would expect that all staff are fully trained in all applicable policies and procedures relevant to a client, and where to find them.

Contact with the OPGT

121. On 4 July 2022, the AGO conducted an annual review and visited Ironwood with the CSO.[178] They met the managers, DSWs and Kumanjayi and viewed

[177] 7.50 LSS Missing Persons Procedure (28 Feb 2024).
[178] T283; 2.9.4 LA-4 Visit Report (04 Jul 22).

the facilities. Following that visit, the AGO reported to the COS, including on several goals for the COS to follow up.[179] This was the only occasion between September 2021 and 3 December 2022 that the AGO met Kumanjayi.[180]

122. No communication with Kumanjayi's family was recorded in the OPG file at the time of annual visits or guardianship order reviews (NTCAT reassessments).[181] In fact, despite the AGO knowing "for a fact" that Kumanjayi had extensive contact with his family:[182]

- the OPG file contained no contact details for Kumanjayi's family in the allocated space (on the front page of the electronic file);[183]
- case notes contained only "occasional" references to family;[184] and
- between September 2021 and 3 December 2022, the AGO never met any of Kumanjayi's family.[185]

123. Kumanjayi's family submitted that the fact that their names were not even recorded in the OPG file is "incomprehensible".[186]

124. The AGO said that she would only meet a represented person more often than once a year if there was a reason to do so, for example, for a NDIS Plan review, or a NCAT Guardianship Order review.[187] The AGO said that if a family member contacted her she would speak to them[188] but she said there would have to be a specific reason for her to contact Kumanjayi's family, despite there being several OPGT policies and practice guidelines which establish obligations for AGOs to communicate with family members

[179] T283-4, 311; see 2.9.4 LA-4 Visit Report (04 Jul 22).
[180] T3 (9 Apr 25) 362.
[181] 2.10 Internal File Review (18 Mar 25) 17.
[182] T375.
[183] 2.10 Internal File Review (18 Mar 25) 17, T364.
[184] 2.10 Internal File Review (18 Mar 25) 17.
[185] T364.
[186] Submissions and Recommendations on behalf of the family, 17 April 2025.
[187] T362.
[188] T371.

and interested parties.[189] Given the absence of any established relationship or lines of communication between the AGO and family, it is unclear how any communication might have occurred and the AGO conceded that there are barriers to families being able to contact the AGO.[190] Lorraine King, Director Guardianship considered that annual visits were the minimum expectation but acknowledged that the heavy workloads of the AGOs would make it difficult to mandate more regular contact.[191]

125. After the OPGT received notice of this inquest, a desktop review of information contained on the OPGTs internal system concerning Kumanjayi was conducted.[192] That review produced seven recommendations, which the OPGT has accepted as necessary for systemic reform of OPGT practice.[193] The recommendations are:

Recommendation 1: Development of a practice guideline for management of concerns raised about service provided competency;

Recommendation 2: Review of the 'Initial visits and annual visits with a represented person practice guideline to ensure compliance;

Recommendation 3: Team managers to undertake a routine review of reports for initial and annual visits with represented persons to ensure practice direction compliance;

Recommendation 4: Development of a practice guideline to assist AGOs in monitoring effectiveness of nominated support coordination services;

Recommendation 5: Annual refresher AGO training on communication obligations with family members/interested parties;

Recommendation 6: Annual AGO training on the engagement of cultural brokers/advisors and interpreters;

[189] 2.10 Internal File Review (18 Mar 25) 17; T387.
[190] T374.
[191] T394 – 395.
[192] T384; 2.10 Internal File Review (18 Mar 25).
[193] T385.

Recommendation 7: Record keeping.

126. Recommendation 3 identified the need to: ensure compliance concerning the use of interpreters and cultural brokers; monitor service provider effectiveness; monitor and ensure adequate family, service, and/or stakeholder contact or communication; adequately record the details of a represented persons circumstances, issues, risk assessment, analysis and actions required; keep effective case notes; conduct action planning and record the analysis of issues, any outstanding actions, risks and mitigation strategies and forward planning.

127. Kumanjayi's case exemplifies that this is needed because:

a) the 4 July 2022 home visit report[194] did not include all the information required by the *Initial Visits and Annual Visits with a Represented Person* Practice Guideline (**Visits Practice Guideline**),[195] and

b) had the report contained such information, the AGO may have better understood why the BSP was expressing concerns about the failure to implement the PBSP and consequently may have been more alert to monitoring the effectiveness and service delivery of the BSP, the SIL, and the COS.[196]

128. Counsel for the family requested that I make a recommendation that the OPGT must meet with a represented person a) as soon as practical (and no less than 3 months) after taking over the represented persons' file, and b) regularly thereafter, that is, more regularly than once a year. In my view this seems very reasonable. If it cannot be achieved because of insufficient resourcing, then the Director of the OPGT should advocate for increased funding.

[194] 2.9.4 LA-4 Visit Report 04 Jul 22.
[195] 2.10 Internal File Review (18 Mar 25) 16.
[196] 2.10 Internal File Review (18 Mar 25) 16.

Police Response

129. Once Kumanjayi had been formally reported missing, the search and rescue response was well executed. However, I was interested to understand the reasons behind the delay in commencing the missing person and search and rescue processes.

4 December 2022

130. At 2pm on 4 December 2022, Acting Senior Sergeant Healey assumed Watch Commander duties. The 39 reported domestic violence incidents from the previous night had been reduced to 18 outstanding jobs and the available response units had increased from 3 to 4.[197]

131. The Watch Commander reviewed the outstanding jobs and noted that a number of comments had been added to Kumanjayi's CAD job since the conclusion of his shift at 1am that morning.[198]

132. The comments included:[199]

- 1.42am - direction from the watch commander that the complainant be contacted to obtain an update;
- 1:45am – comment that a voicemail was left.
- 2.46am - comment from the watch commander that the job be held for the dayshift.
- 6.31am - comment that a telephone call was received from TL (at 6.25am), confirming that he is conducting changeover at 26 Latz Crescent [Ironwood] and that Kumanjayi had not returned.

[197] T255; 6.1 Statutory Declaration of A/S/Sgt (22 Jan 23) [16]-[17].
[198] 6.1 Statutory Declaration of A/S/Sgt Healey (22 Jan 23) [14].
[199] 6.24 CAD Log of Welfare Check 26 Latz Crescent (3 Dec 2022 to 4 Dec 2022).

- 8.00am - comment that there were no units available to attend.
- 10.55am - comment that NT Police called for an update, were told that Kumanjayi had not returned, but that he sometimes goes to his sister's house in East Side.
- 10.59am - comment that NT Police called ASH and confirmed that Kumanjayi was not currently a patient.
- 12.46am - direction from the watch commander that NT Police confirm what enquiries 26 Latz Crescent [Ironwood] have undertaken in relation to locating Kumanjayi.
- 2.42pm - comment that CJ called seeking an update but not seeking police attendance as a priority.
- 3.19pm - comment that NT Police attempted to call the complainant (BR), and a voicemail was left.
- 3.28pm - comment that NT Police spoke to Lifestyle Solutions, who had been out trying to locate Kumanjayi's family as that is who he usually resides with. One staff member is currently out in town looking. They did not have any addresses at the moment of where they have been looking but will call back with that information.

133. Following his review, the Watch Commander tasked two general duties officers to attend at 26 Latz Crescent to complete a missing person report (**MPR**) and a search urgency assessment (**SUA**).

134. He also conducted checks of the Police PROMIS system and found information regarding two occasions on 10 and 15 June 2022, when Kumanjayi had voluntarily left Ironwood and had been located or returned.[200]

[200] 4.14, 4.15 PROMIS Case Summaries 10030665 (10 Jun 2022) and 10033847 (15 Jun 2022).

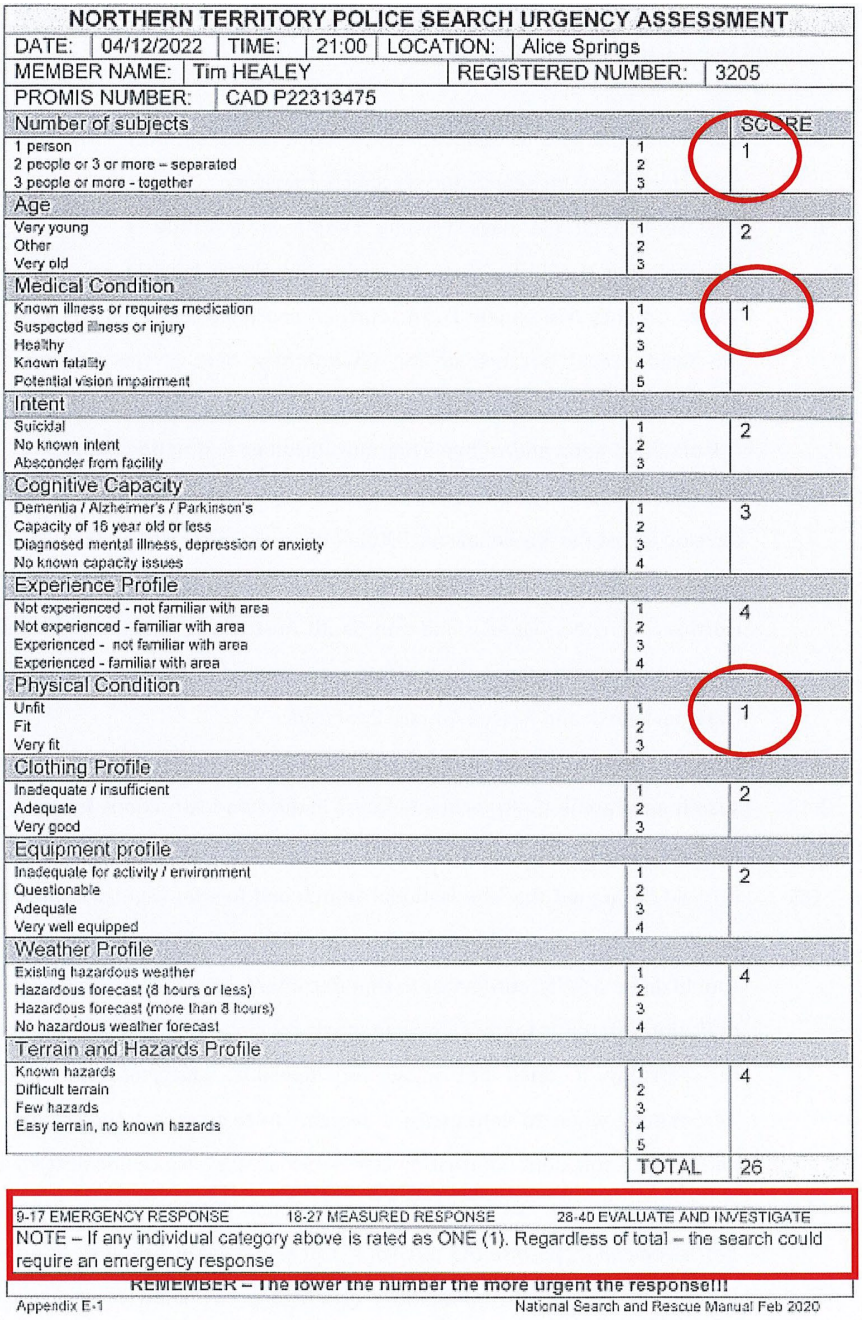
Search Urgency Assessment (SUA)

135. At 6.06pm two officers attended Ironwood and completed the MPR and search urgency assessment SUA. The SUA document used by NT Police is taken from the National Search & Rescue Manual (**NATSAR**).[201] Neither of the officers had ever completed an SUA, nor were they Search and Rescue (SAR) trained. The Watch Commander had completed SUA's previously but was also not SAR trained, which I heard is not unusual.[202] As noted earlier, the police were not given LSS's Missing Person Checklist.

136. The officers returned to the Alice Springs police station with the completed MPR and SUA and the Watch Commander reviewed both documents.[203] On page three of the MPR, under the heading "MP's stated intentions" it was noted, "Going up MT GILLEN."[204] The general information section of the form referred to Kumanjayi "fixating on conversation earlier in the night around 'men's business' and climbing Mount Gillen where he wanted to be washed in a watering hole."[205]

137. The completed SUA was graded as follows:

[201] 6.30 NATSAR Manual, Appendix E-1.
[202] T256.
[203] T256.
[204] T261.
[205] 6.13 Missing Persons Report (3 Dec 2022).



NORTHERN TERRITORY POLICE SEARCH URGENCY ASSESSMENT

DATE:	04/12/2022	TIME:	21:00	LOCATION:	Alice Springs
MEMBER NAME:	Tim HEALEY			REGISTERED NUMBER:	3205
PROMIS NUMBER:	CAD P22313475				

		SCORE
Number of subjects		
1 person	1	1
2 people or 3 or more – separated	2	
3 people or more - together	3	
Age		
Very young	1	2
Other	2	
Very old	3	
Medical Condition		
Known illness or requires medication	1	1
Suspected illness or injury	2	
Healthy	3	
Known fatality	4	
Potential vision impairment	5	
Intent		
Suicidal	1	2
No known intent	2	
Absconder from facility	3	
Cognitive Capacity		
Dementia / Alzheimer's / Parkinson's	1	3
Capacity of 16 year old or less	2	
Diagnosed mental illness, depression or anxiety	3	
No known capacity issues	4	
Experience Profile		
Not experienced - not familiar with area	1	4
Not experienced - familiar with area	2	
Experienced - not familiar with area	3	
Experienced - familiar with area	4	
Physical Condition		
Unfit	1	1
Fit	2	
Very fit	3	
Clothing Profile		
Inadequate / insufficient	1	2
Adequate	2	
Very good	3	
Equipment profile		
Inadequate for activity / environment	1	2
Questionable	2	
Adequate	3	
Very well equipped	4	
Weather Profile		
Existing hazardous weather	1	4
Hazardous forecast (8 hours or less)	2	
Hazardous forecast (more than 8 hours)	3	
No hazardous weather forecast	4	
Terrain and Hazards Profile		
Known hazards	1	4
Difficult terrain	2	
Few hazards	3	
Easy terrain, no known hazards	4	
	5	
	TOTAL	26

9-17 EMERGENCY RESPONSE 18-27 MEASURED RESPONSE 28-40 EVALUATE AND INVESTIGATE

NOTE – If any individual category above is rated as ONE (1). Regardless of total – the search could require an emergency response

REMEMBER – The lower the number the more urgent the response!!!

Appendix E-1 National Search and Rescue Manual Feb 2020

Search Urgency Assessment (SUA) for Kumanjayi Johnson

138. The grading gave a risk rating of 26, which requires a 'measured response.'

139. Under three headings, 'Number of subjects' (1 person) 'Medical Condition' (Known illness or requires medication) and 'Physical Condition' (Unfit) the score was 1. The SUA notes that "If any individual category above is rated as ONE Regardless of total – the search **could** require an emergency response. (emphasis added).

140. Whether or not an emergency response was required was discretionary and the Watch Commander, decided that an emergency SAR response was not required and the search should commence in the morning in day light, taking into account: [206]

- The individual ratings;
- the total score of 26;
- the time (just before 10pm);
- the likely search area of Mount Gillen; and
- that Kumanjayi had prior incidents of voluntarily leaving Ironwood and returning safely of his own volition.

141. It was accepted by the Watch Commander that some of the ratings given by the officers who completed the SUA could have scored lower (which would have increased the urgency). For example, under 'Weather Profile' a rating of 4 was given, meaning no hazardous weather forecast equivalent to the lowest risk, despite it being summer in Alice Springs. Under 'Terrain and Hazards Profile' a rating of 4 was also given, meaning that it was easy terrain with no known hazards, which did not accurately represent the terrain of Mount Gillen.[207]

142. I accept that the Watch Commander considered a broad range of factors in making his assessment of the search urgency and that to send officers up there at night, in the dark, without more detailed information, was not a realistic option.[208]

143. Despite his assessment that an urgent response was not required, the Watch Commander did consider that the risk was at the upper end of the moderate

[206] T257.
[207] T257.
[208] T261.

risk scale and he was concerned.[209] At 9.59pm on 4 December 2022, he emailed the SUA to his superior for escalation and copied in the incoming day shift supervisors:

> Good evening,
>
> 'Search Urgency Assessment' is attached relating to [Kumanjayi] (28/05/1977). I reviewed the assessment returning at a risk rating of 26 requiring a 'Measure response'.
>
> [Kumanjayi] is a 45 year old male who resides at 26 Latz Crescent Larapinta (Life Without Barriers Care house).
>
> [Kumanjayi] has a traumatic brain injury, diabetes and epilepsy - all of which require daily medications.
>
> [Kumanjayi] left the location 'on foot' at 1900hrs (03/12/2022) - he has not been seen since this time (27 hours at time of writing).
>
> General Duties have provided initial response and completed associated MP report and assessment.
>
> Of note, [Kumanjayi] has recently been speaking about 'Men Business' and the desire to climb Mt Gillen and bathe in a pool of water (Source - Carer: CJ).
>
> Primary risks are unknown location/ access to water/ without medication.
>
> With no designated search area at this time, the primary resolution strategy will involve ALOs on the commencement of duties (AM - 05/12/2022).

144. At that time, ALOs were only rostered for day shifts. The Watch Commander planned for the ALOs to contact family and their extended networks first thing in the morning in an effort to obtain relevant information about where to search for Kumanjayi.[210]

145. Dr Jim Whitehead, who has 35 years practical experience in SAR and SAR training[211] and who authored the National SAR Manual,[212] provided an expert

[209] T260.
[210] T260.
[211] T316; 6.11 Dr Jim Whitehead Expert Report (20 Mar 25) 1.
[212] 6.30 NATSAR Manual (01 Feb 23).

report.[213] In his report Dr Whitehead acknowledged that family and carers are an important source of information in missing person incidents. Given that one of the issues for family was that they were not asked to help with the search for Kumanjayi,[214] it must have been very difficult for them to hear that up until the ALOs came on duty decisions were being made without any consultation with family or requests for their assistance.[215]

NT Police - Institutional Response

Missing person complaints

146. Commander James Gray-Spence provided the institutional response for NT Police. He explained that the large volume of calls to 000 places strain on call takers, whose primary function is to get information as quickly and efficiently as possible. That is why structured call taking through the use of standard operating procedures (SOP's) tailored to specific events is essential to ensure that relevant critical information is requested.[216]

147. Commander Gray-Spence said that it was not uncommon for NT Police to receive complaints from service providers, like LSS, concerning residents leaving premises and their whereabouts being unknown, for example: [217]

- children in out-of-home care;
- people such as Kumanjayi in other care arrangements who have taken their own leave;
- hospital absconders; and
- sobering up shelter absconders.

[213] T316; 6.11 Dr Jim Whitehead Expert Report (20 Mar 25).
[214] 1.2B Affidavit of Malcolm Heffernan [43].
[215] 6.11 Expert Report of Dr Jim Whitehead.
[216] T339.
[217] T276; T338.

148. In response to this heavy workload and to improve the receipt of relevant information the NT Police JESC Call-Taker Instructions for 571 (Missing Person)[218] contains the following requirement:

> "If an Organisation is reporting – For Police assistance please provide a copy of a Risk Assessment and ICAD number by email to Police.Assistance@pfes.nt.gov.au"

149. If received, the risk assessment is provided to the supervisor tasked to the job[219] and the information conveyed is included in assessing the seriousness of risk to the person who is missing and the urgency of the response.

150. The risk assessment is not an NT Police document, it is an internal document prepared by the organisation making the report, for example, the LSS Page 1.[220] It is not clear to me what information the NT Police expect in a risk assessment. If the information contained in the LSS Page 1 (or the risk assessments of any other service provider) is not adequate, then it is incumbent on NT Police to tell service providers what information should be provided so that service providers can update and amend their Page 1 equivalents.

151. The trouble for Kumanjayi was more fundamental. That is because Call 2 did not result in a re-coding to a missing person code (571) and a risk assessment was not requested. Even if it had been re-coded it is not clear that a risk assessment would have been requested because, according to Commander Gray-Spence[221] they are only provided by certain organisations. It seems to me that work needs to be done by NT Police in identifying a) which organisations should provide risk assessments, b) ensuring the

[218] 6.35 JESC Call-Taker Instructions 424 (Welfare Check) 571 (Missing Person).
[219] T277.
[220] T238.
[221] T341.

organisations are aware of their obligation to do so, and c) ensuring they are aware of the necessary content. I will make a recommendation to this effect.

Search Urgency Assessment

152. Commander Gray-Spence explained that it is inevitable that frontline police will often be the first responders to missing person reports and so will be tasked to complete the SUA forms.[222]

153. Dr Whitehead considered that completion of the SUA by an officer not trained in SAR was not best practice [223] but he acknowledged that it would be difficult to change in practice as only a small proportion of NT Police are SAR trained. [224] Dr Whitehead recommended that a SAR trained officer should review SUAs in every missing person incident and Commander Gray-Spence agreed. I understand that NT Police will make changes to ensure that all SUAs are sent to a qualified Search and Rescue Mission Coordinator, SARMC, for review.[225]

154. Commander Gray-Spence told me that since December 2022, the NT Police Specialist Support General Order, Chapter 5 (Search and Rescue) has been updated to ensure that critical decisions in search and rescue operations are made by senior officers who have access to SARMC expertise.[226] Under the new General Order (promulgated 22 June 2023),[227] Commander Gray-Spence said that the SUA would be received by the Territory Duty Superintendent in JESCC, and that there is a 24/7 on call OIC in search and rescue who would be notified.[228]

[222] T347.
[223] 6.11 Dr Jim Whitehead Report (20 Mar 2015).
[224] T321.
[225] T347.
[226] T337.
[227] 6.32 Specialist Support General Order, Ch 5, Search and Rescue; 6.31 Email re Specialist Support General Order (26-Jun-23).
[228] T347.

Conclusion

155. Kumanjayi was known by his family and his carers to be a funny, kind and caring man who had a strong connection to his culture. He was a proud Arrernte man. I have no doubt that his family loved Kumanajyi deeply and that his carers and support workers genuinely liked and cared for him. His death would have been a terrible shock to everyone involved in his life, but particularly devastating for family and I extend my sincere condolences to them.

156. The overall issue in the events of 3 December 2022, was communication about risk and urgency. The failure to properly communicate the risk once Kumanjayi had left Ironwood and the second 000 was made, meant that the CAD job was not re-categorised as a missing person (571) which would have given it level 1 priority, and may have triggered a risk assessment.

157. This miscommunication was exacerbated by the failure of LSS staff to follow the missing persons procedure and provide a missing persons checklist to Police. Combined with the unusually high levels of domestic violence jobs, the limited police resources available to respond, the resulting delay in obtaining a missing persons report and lack of SAR training for frontline officers completing SUA's, meant that were failures on both sides.

158. The starting point though, was the cultural competency of OPGT and LSS. It appears that there have been improvements by both since Kumanjayi's death, but it seems that Kumanajyi's cultural imperatives were not well understood.

159. Services responsible for the care of vulnerable Aboriginal people must have appropriate policies and training in cultural competency but more fundamentally, regular and respectful engagement with families.

Formal Findings

160. Pursuant to section 34 of the *Coroner's Act*, I make the following formal findings:

a. The identity of the deceased is Daniel Johnson.

b. He was born on 28 May 1977.

c. The time and place of death was between 4 December 2022 and 9 December 2022 at Mount Gillen (Alhekulyele), Alice Springs

d. The cause of death was environmental exposure and dehydration.

e. The deceased was an Aboriginal man.

Recommendations

161. **I recommend that** the Office of the Public Guardian and Trustee implement all seven recommendations specified in the OPGT internal review dated 18 March 2025.

162. **I recommend that** the Office of the Public Guardian and Trustee review their policy and procedure concerning the regularity of engagement with represented persons.

163. **I recommend that** Lifestyle Solutions (Aust) Ltd take all necessary steps to improve cultural safety in its workforce and in its physical environment, and that be done in consultation with Aboriginal organisations, with Aboriginal staff and with Aboriginal family members of clients.

164. **I recommend that** Lifestyle Solutions (Aust) Ltd review and strengthen their Missing Persons Procedure to include specific guidance about providing information on the Personal Emergency Evacuation Plan to Police.

165. **I recommend that** Lifestyle Solutions (Aust) Ltd review existing training and guidelines on reporting missing persons and develop 000 call guidelines and

scenario-based training for all staff working in supported independent living facilities.

166. **I recommend** that NT Police review JESCC operations to ensure the integrity of event classification processes.

167. **I recommend** that NT Police review organisations to be directed to provide risk assessments for specific incidents, including direction as to the information required by Police in those risk assessments, to inform call-taking, dispatch and response.