

CITATION: *Inquest into the death of Kumanjayi Rubuntja* [2026] NTCC 09

TITLE OF COURT: Coroners Court

JURISDICTION: Alice Springs

FILE NO(s): A0060/2023

DELIVERED ON: 23 October 2026

DELIVERED AT: Darwin

HEARING DATE(s): 18 – 22 May 2026

FINDING OF: Judge Elisabeth Armitage

CATCHWORDS: **Suicide by Hanging; Form 7 – Notification re Apprehension by Police; Form 9 – Entry into Mental Health Services; Form 60 – Police Assistance Request; powers of containment and detention; role of hospital security guards; take own leave (TOL); prioritisation of NT Police Force response to TOL; cultural competency; communication with family.**

Mental Health and Related Services Act 1998

REPRESENTATION:

Counsel Assisting: Sandra Wendlandt

Counsel for Police: Zac Cleal

Counsel for Health: Michael McCarthy

Counsel for Ms Beth Palmer: Hannah Donaldson

Judgment category classification:	A
Judgement ID number:	[2026] NTCC 09
Number of paragraphs:	147
Number of pages:	44

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

No. A0060/2023

In the matter of an Inquest into the death of

KUMANJAYI RUBUNTJA

ON: 15 NOVEMBER 2023

AT: ALICE SPRINGS GOLF CLUB

FINDINGS

Judge Elisabeth Armitage

Introduction

1. Kumanjayi attempted suicide at his family's home on 15 November 2023. He left the home and walked into nearby bush. When they found a pool of blood in his room and noticed that he was missing, his family called the police at 6.19am and they went out to look for him.
2. The police who attended apprehended Kumanjayi at 7.25am under the *Mental Health and Related Services Act 1998 (MHARS Act)* and took him by ambulance to Alice Springs Hospital (**ASH**) arriving at 8.10am. By 9.58am it was determined he needed a psychiatric assessment and a s34 MHARS Act recommendation/*Form 9* was completed. This meant he was an involuntary patient, and he could be detained for up to 24 hours for the psychiatric examination to occur.
3. Shortly after 11am on 15 November 2023 Kumanjayi left ASH and later took his own life. His body was located on 19 November 2023 at the back of 2/6 Caterpillar Court, Desert Springs, which backs onto Alice Springs Golf Course. He was 45 years old when he passed away.
4. Forensic Pathologist Dr Althea Neblett considered it was possible that Kumanjayi passed away on the day he left the ASH and less likely that he passed away on the

day he was found. As he was an involuntary patient subject to powers under the MHARS Act that permitted him to be controlled and detained (S34(3)), when he ran away from ASH, he was, in effect, escaping from detention. His escape continued while he was at large in the community. In those circumstances I considered that pursuant to s 12(1)(b) and 12(1A) of the *Coroners Act 1993* his death was a death in care and an inquest was mandatory. If I am wrong about that, I would nevertheless have exercised my discretion to hold an inquest under s15(2) of the *Coroners Act 1993*.

5. His wife, Beth Ebatarintja, and daughter actively supported him with his health and mental health issues. In the lead up to his passing, there were signs his mental health was deteriorating and symptoms of schizophrenia were re-emerging. Beth was present at court during the inquest and her insights, through her counsel, assisted me to understand Kumanjayi's circumstances and how important he was to his family and to his community.

Background of Kumanjayi Rubuntja

6. Kumanjayi was born in Alice Springs and lived in Alice Springs, Ntaria and Wallace Rockhole in the Western McDonnell Ranges. He was a western Arrernte man and spoke Western Arrernte and English. With Beth, he had two children and they also had a grandson. When he was living out bush, he worked as a stockman and would frequently be found at Wallace Rockhole riding. When they were staying in Alice Springs, the family lived in Larapinta Valley Camp and Kumanjayi worked at the Brown St Youth Centre and at the learning centre. He enjoyed helping young people.
7. In 2013 Kumanjayi was diagnosed with a delusional disorder and was prescribed Olanzapine. He also had a tentative diagnosis of a traumatic brain injury (**TBI**) after he hit his head when he fell from a horse in 2013 and following an assault in 2019. In April 2014 he was diagnosed with schizophrenia and commenced taking a Paliperidone depot injection and responded well. His schizophrenia was characterised by paranoid delusions, particularly about his wife.
8. His TBI and schizophrenia likely contributed to his history of domestic violence orders and repeat periods of imprisonment for aggravated assault and other offences such

as drink driving.¹ He had a history of struggling with alcohol and cannabis use, though at the time of his death these issues were not readily apparent.

9. Due to his mobility between Wallace Rockhole, Ntaria, and Alice Springs, he commonly received mental health care from the remote mental health team, and primary health care from Central Australian Aboriginal Congress (**Congress**), Ntaria Clinic and Wallace Rockhole clinic.² Kumanjayi sometimes missed his regular depot injection. Kumanjayi received a depot injection on 16 April 2022. After that he was unmedicated for a period but was stable.
10. On 3 November 2022 he was placed on a Domestic Violence Order protecting Beth.³
11. On 9 May 2023 he was seen by a GP at Wallace Rockhole clinic. There were no concerns about risky alcohol or cannabis use, his insight was good, and he did not report any psychotic symptoms. The GP discussed his condition with the remote mental health team Registrar. As he had been stable and was presently well, the plan was for him to remain unmedicated until the remote mental health team reviewed him (when they next visited) to determine whether he needed to restart his antipsychotic depot injections.

Kumanjayi's mental health deteriorates

12. However, by the middle of 2023 and before he was reviewed, the remote mental health team heard that Kumanjayi had started behaving strangely.⁴
13. On 1 August 2023, a family member called the Wallace Rockhole clinic because they were concerned symptoms of Kumanjayi's schizophrenia were re-emerging. In this state he had threatened his wife with a knife and punched her⁵ in breach of his domestic violence order. Following this incident, it appears Kumanjayi was exiled from the community, and an arrest alert was entered into the police systems.

1 Additional documents, Folio 1

2 Additional documents, Folio 21, p 12-13; Folio 35

3 Ex 2, noting that Ms Ebatarinja is referred to as Palmer in this document.

4 Additional documents, Folio 16 [105-107]; Additional documents, Folio 21 [68-77]

5 Inquest Exhibit 2

14. On 22 September 2023 Kumanjayi attended ASH ED with a sore throat and fever. A computerised tomography (**CT**) scan detected a 12mm abscess in the left palatine tonsil consistent with quinsy (a severe tonsillar abscess). He took his own leave (**TOL**) before he was seen by a surgeon. The mental health team do not appear to have been advised of his attendance in ED.
15. On 24 October 2023, the remote mental health team were in Wallace Rockhole, but they could not find Kumanjayi. They were told he had been driven out of the community following the assault on his wife and he was thought to be in Ntaria. The team was concerned that Kumanjayi was becoming unwell and needed further assessment. The next day the Ntaria clinic rang the remote mental health team and confirmed that Kumanjayi was there and unwell. Kumanjayi then returned to Wallace Rockhole and on 26 October 2023 Kumanjayi's daughter rang the Wallace Rockhole clinic seeking medical help. She reported that Kumanjayi had not slept for three days, he was walking around talking to himself and carrying a plastic knife.⁶
16. The Wallace Rockhole clinic consulted with the Crisis Assessment and Treatment Team (**CATT**), and a plan was made to transport Kumanjayi to ASH under the MHARS Act. A *Form 60 – Police Assistance Request* and a *Form 9 – Entry into Mental Health Service* were completed by a psychiatrist so that he could be located and taken to hospital.⁷ On 27 October 2023 Kumanjayi was located by clinic staff and police and he was clearly unwell. He was retrieved by ambulance and admitted into ASH at about 9pm. Before any comprehensive mental health assessment took place he TOL from the emergency department (**ED**) around 1am on 28th October 2023.⁸ High Risk TOL paperwork was completed and at 5.57pm the ED emailed police requesting an update on their efforts to locate him.
17. At about 9pm on 29 October 2023 police located Kumanjayi and arrested him for the assault on his partner. Due to his mental health, he was taken to ASH and admitted into the ASH High Dependency Unit, Inpatient Unit, as an involuntary patient under the MHARS Act. He was given a Paliperidone depot injection on 30 October 2023

6 Folio 35, Volume 1 p83 (P. Wirth)

7 Folio 35, volume 1, p 84 (P. Wirth)

8 Additional documents, Folio 21 [79-84], Folio 35, volume 1, p 85

and a second dose on 3 November 2023.⁹ His next dose was due on 1 December 2023. He was then considered well enough to be released back into police custody and was put on an Interim Community Management Order under the MHARS Act, with a review date scheduled for 17 November 2023.¹⁰

18. On 10 November 2023 two Authorised Psychiatric Practitioners completed a *Form 15 (Clinical Details and Management Plan re Community Management Order)* for Kumanjayi with plans for his care which provided for the following possibilities:¹¹

- a. If Kumanjayi was in custody, he was to be reviewed fortnightly by the Forensic Mental Health Team;
- b. If he was in Alice Springs, he was to be reviewed monthly by the Community Mental Health Team Manager, receive monthly depot, and be reviewed every 3 months by an authorised psychiatric practitioner;
- c. If he returned to community (Ntaria/ Wallace Rockhole), he was to receive monthly depot at the clinic, be reviewed every 4-6 weeks by the local clinic Case Manager, and every 4-6 months by an authorised psychiatric practitioner.

19. Police charged him with the 1 August 2023 assault on his wife and while he was in custody a Mental Health Nurse completed a *Post-Inpatient Unit Discharge Assessment* which noted no mental health concerns.

20. Kumanjayi applied for and was granted bail on 9 November 2023. His bail conditions required him to report to police and to have no contact with his wife.¹² On 12 November 2023 the Forensic Mental Health Team referred him to the Community Mental Health Team. On 17 November 2023, a Community Management Order (**CMO**) (replacing the interim order) was made with a review scheduled for 1 December 2023. (Of note, this CMO was made the day after Kumanjayi absconded from hospital and at a time when he was likely already deceased.)

⁹ Coronial brief, Folio 35, volume 1, p 85-97, volume 2 p 72

¹⁰ Coronial brief, Folio 35, volume 1, p 97; Additional documents, Folio [90-92]; Folio 35, volume 2 p 26; Ex 3

¹¹ See also Ex 12 Discharge Summary

¹² Coronial brief, Folio 38

Kumanjayi's mental health again deteriorates

21. After his release on bail and less than a fortnight later, just after midnight on 15 November 2023, Beth called 000 requesting assistance for Kumanjayi's mental health. An ambulance attended Larapinta Valley Camp. The paramedics were told he had not slept for several days and was hearing voices, but Kumanjayi assured the paramedics that he was fine, up to date with his depot and did not want to go to hospital. The paramedics recorded both physical and mental health observations of Kumanjayi and, as they identified "*nil indications for SJA to transport*," Kumanjayi was not taken to hospital.¹³
22. Then, at around 6.19am in the morning, Kumanjayi's family again called 000 for help. It was reported that Kumanjayi had been listening to gospel music all night, he had slit his wrists with a tin can lid, was bleeding, had gone off into the bush, and family members had followed him.¹⁴ The information was entered by the call taker as a '*597 - attempt suicide/self-harm*' and copied across to St John. This type of event receives an automated '*Grade 1-Immediate*' response categorization in the NT Police Computer Aided Dispatch (**CAD**) system. Normally CAD events are dispatched to General Duties (uniformed) police. However, given the urgency, rather than waiting for General Duties police to commence shift at the 7am changeover, the Alice Springs Watch Commander (**WC**) issued an urgent callout. Two plain clothes Constables who were on other duties nearby, C and T, responded.
23. During the inquest, the body worn footage of Constable C was played.¹⁵ On arrival at Larapinta Camp the Constables followed the directions of family members and walked into the bush. They found Kumanjayi about 500 metres away seated on the ground in sparse, open bushland. He was bleeding from confronting and significant lacerations to both wrists¹⁶ and had a visible injury to his forehead. Kumanjayi was praying and family members were standing near him out of concern. The Constables told Kumanjayi they were there to help him and he co-operated as they cleaned and dressed his wounds. He told them of concerns about his wife. Kumanjayi told the

¹³ Inquest Exhibit 6

¹⁴ Coronial brief, Folio 14, Folio 36

¹⁵ Coronial brief, Folio 15 BWF; T21-25

¹⁶ Coronial brief, Folio 15

Constables that he suffers from schizophrenia, that he takes medicine for it, and that he had tried to take his own life. Kumanjayi's shoulders were sagging and he appeared despairing and sad. Both Constables reassured him and assisted him to walk back to the family home.

24. Half an hour later the group returned to the house where he was staying, and the Constables assisted Kumanjayi to a seated position on the side of the road. Within minutes a St John ambulance arrived, together with uniformed Constables K and D in a second police car. The job had been re-tasked to these two uniformed General Duties' Constables who were to relieve the Plain Clothes Constables.

25. Constables T and C provided a handover to St John Ambulance and to the newly tasked General Duties Constables. It was noted that the NT Police systems had two prior alerts for schizophrenic behaviour and self-harm incidents on record.¹⁷ Constable T entered the home where Kumanjayi had been staying and saw the pool of blood on the floor of his bedroom.¹⁸ Constable T spoke to family members to get a sense of what had happened and was able to establish that Kumanjayi's concerns about his wife were not based in fact but instead came from his schizophrenia and paranoia.

26. When certain criteria are met, s32A of the MHARS Act permits a police officer to apprehend a mentally unwell person so that the person can be taken to a place for a psychiatric assessment. Even though Kumanjayi was willing to go to hospital, police apprehended Kumanjayi to ensure his conveyance and attendance at ASH. I am not at all critical of this decision as, pursuant to s32A, there were reasonable grounds for the police to believe that Kumanjayi required treatment and care, would likely seriously harm himself if not immediately apprehended, it was not practicable to have a practitioner come to him, and it was necessary for him to be taken to hospital so that he could be assessed. Shortly after, Constable D travelled with Kumanjayi in the ambulance to ASH.¹⁹

Kumanjayi enters hospital as an involuntary patient on 15 November 2023

¹⁷ Coronial brief, Folio 15 BWF p108; T21-25 (Cst T)

¹⁸ Coronial brief, Folio 15

¹⁹ T29-30(Cst T); Coronial brief, Folio 40

27. Dr P. Wirth was the senior consultant in charge of ED and Dr G. Veloz was a senior medical doctor on duty. During their morning briefing they had been told of Kumanjaya's arrival. Kumanjaya arrived at Alice Springs Hospital at about 7.30am. He was placed in a resuscitation bay, and Dr Veloz took over his care.
28. Dr Veloz reviewed Kumanjaya's electronic file and noted that he had a diagnosis of schizophrenia and had recently been an inpatient.²⁰ She recorded that he was calm, alert, oriented and cooperative. He was also paranoid (+++), suspicious of police, and possibly responding to internal stimuli. He told Dr Veloz and nursing staff he had cut himself with a can lid and had tried to kill himself, but he was fine now and "*loved his life.*"²¹ Dr Veloz sutured his wrists at 9.30am.
29. A referral to CATT was made at 8.46am.²² NT Health had been unable to determine who was on CATT duty that day. However, CCTV examined during the inquest captures a nurse speaking to the CATT clinician, who was identified as AS.²³ It was discovered that AS was no longer employed with NT Health and unfortunately it was too late to track him down to give evidence.
30. The emergency department CCTV showed police at Kumanjaya's bedside for more than an hour.²⁴ While police were present, Beth arrived at the hospital, wanting to see Kumanjaya. Constable D stopped her from seeing him because Kumanjaya's bail conditions prevented him from having contact with her.²⁵ Notes reveal that Kumanjaya was told that she had arrived and the reason he was unable to see her.
31. Constable D completed the *Form 7 - Notification re Apprehension by Police* paperwork, which documented that Kumanjaya had been apprehended at 7.25am, no restraint or force was used, and he was accepted into the care of ASH at 9.58am. By that time Dr Veloz had concluded that a psychiatric assessment was warranted and she completed the *Form 9 - Entry into Mental Health Services*, pursuant to the s 34

20 T110; T113 (Veloz)

21 T110; T112 (Veloz)

22 Inquest Exhibit 8

23 T47-48 (GM)

24 Coronial brief, Folio 28, T80-81 (P. Wirth)

25 T40 (Cst D)

of the MHARS Act.²⁶ The identified criteria for psychiatric examination recorded that Kumanjaya *“has a mental illness and requires treatment...without treatment they are likely to cause serious harm to themselves or others or suffer serious mental or physical deterioration.”* Dr Veloz then signed the *Form 7*, effectively ending the police powers of apprehension under s32A/*Form 7*, and releasing them from their guard duties.²⁷ At 10.04am the Police CAD event for Kumanjaya (which had been generated by the 000 call) was closed which occurs when the event is tasked on the Police Real-time Online Management System (**PROMIS**).

32. Security Guard D, arranged by the hospital, arrived, and sat at Kumanjaya’s bedside. Neither Dr Veloz nor anyone else gave him a handover²⁸ as that was not usually done. Security Guard D did not know Kumanjaya’s name or anything about his circumstances. At 10.45 am CCTV footage shows Security Guard D and a nurse escorting Kumanjaya down a hallway. About two minutes later Kumanjaya returned to his room and Security Guard D returned to his chair.

33. Security Guard D said that he saw Kumanjaya praying and talking to himself.

34. At 11.02 am Kumanjaya stood at the entrance of the room, spoke to a nurse, and re-entered the room. By this time Kumanjaya had been at the hospital for over three hours but no psychiatric assessment had been completed.

Kumanjaya takes his own leave (TOL) from hospital on 15 November 2023

35. At 11.05 Kumanjaya abruptly stood up and tried to walk past Security Guard D.²⁹ Security Guard D tried to stop him but did not use any force.³⁰ Security Guard D understood that his only tool was that of persuasion. He did not know that he could potentially exercise reasonable force to detain Kumanjaya.

36. CCTV footage captures the following:

²⁶ T114 (Veloz)

²⁷ Coronial brief, Folio 41, Folio 40 (p205), T128-130(Veloz)

²⁸ T66-67 (Guard D)

²⁹ T69-71 (Guard D)

³⁰ T71-72 (Guard D)

- Kumanjaya left his room and approached the 'Fast Track' door.
- The Acting Clinical Nurse Coordinator radioed for assistance.
- Kumanjaya pressed the unlock/open button next to the door. He raised his fists and struck Security Guard D about two times.
- Dr Wirth approached and remonstrated.
- Kumanjaya pushed the door open and ran through the ED waiting room with Dr Wirth and Security Guard D in pursuit.
- Kumanjaya exited ED through the main entrance doors, fell down the steps, and ran through the car park towards Gap Road at about 11.06am.

37. A brief search of the hospital grounds failed to locate Kumanjaya.

What happened after Kumanjaya left the hospital?

What did the hospital do on 15 November 2023?

38. From the NT Health perspective, after Kumanjaya left the hospital any further task of actively looking for him fell to police. NT Police were notified of this request for assistance by phone calls and a *Form 60* pursuant to the MHARS Act.

39. Although he was not the doctor who treated Kumanjaya, Dr Wirth completed the *Form 60 - Police Assistance Request*³¹ which included information that: Kumanjaya was under a *Form 9* for a suicidal act (cut wrists that morning) and had ran out of ED towards the airport after punching a security guard; his suicide risk was unknown; his risks of harm to others and self-harm were high; he was aggressive; the next of kin details were left blank; and there was no tick in the tick-box for "*Urgent – Immediate Police Response Required*". In evidence Dr Wirth agreed the *Form 60* was incomplete but said he wrote it quickly to expedite the process.³²

³¹ Coronial brief, Folio 27

³² T84 (Wirth)

40. A Senior Nurse added to the *Form 60* that the *Form 9* expired on 16 November 2023.³³ Senior nursing staff also completed relevant NT Health forms being a *TOL Management Checklist*³⁴ and *High Risk TOL Form*.³⁵
41. The *TOL Management Checklist* included a reminder that ED high risk patients are to be discharged after 4 hours. A tick-box was ticked for “*Patient to be formally discharged TOL after 4 hours -->Complete Section 6*” but Section 6 was not completed, and no follow-up was specified on the *Form*.
42. The *High Risk TOL Form* included a description of Kumanjayi, his family contact details with his daughter identified as next of kin, and boxes were ticked indicating that Kumanjayi “*poses a significant risk to himself and others*” and was “*sectioned under the Mental Health and Related Services Act.*”
43. At about 11.20am a Senior Nurse rang Alice Springs Police Station and spoke to Shift Sergeant M. Watson about Kumanjayi assaulting a security guard and absconding. Sgt Watson requested that the *Form 60 - Police Assistance Request* be sent through.
44. At about 11.30 a Senior Nurse sent to the generic police assistance email address: the *Form 9 – Entry into Mental Health Services*, the *Form 7 – Notification re Apprehension by Police*, the *High Risk TOL Form*, and the *Form 60 – Police Assistance Request*.³⁶ The Senior Nurse also called the police assistance line at 11.31am to check the *Forms* had been received.
45. At 2.17pm the Senior Nurse completed Riskman and entered the Riskman notification number into Kumanjayi’s records.
46. Having heard that Kumanjayi had absconded, at 11.32am Dr Veloz made retrospective notes of his treatment.³⁷ Later, at 9.48pm, Dr Veloz completed his discharge summary. She documented his presentation, that he was talking to family

33 T56 (GM)

34 Ex 7

35 Inquest Exhibit 9 p1; T185 (ER)

36 Additional documents, Folio 20 [10-109] as to process

37 Inquest Exhibit 10; T120-123 (Veloz); Inquest Exhibit 12

who were not there, his paranoia, his self-harm, his treatment and that she had discussed his case with CATT. She included that he had “*no plans to kill himself.*” The ED diagnosis was “*threatening self-harm/injury not suicidal.*” It was noted that ED had not taken blood for testing or given a tetanus injection or oral antibiotics. If he returned (or was returned) to ED, the plan was for CATT review. Dr Veloz made no reference to Kumanjaya’s suicide attempt (prior to his admission) in the discharge summary. When giving evidence she agreed that it should have been included as it was relevant information.³⁸

47. Apart from searching the hospital grounds the hospital staff took no further steps to actively search for Kumanjaya as the responsibility for any further active search was effectively tasked to the NT Police by the *Form 60*. The hospital did not contact Kumanjaya’s family to report him missing or to seek their assistance with his search and return.

What did the Police do on 15 November 2023?

48. The inquest heard about the process by which police assess and prioritise jobs.³⁹

49. NT Police learned that Kumanjaya had absconded in the 11.20am phone call from ASH. This was recorded by the call taker as a ‘719 – *Missing Person – Hospital*’ event which is automatically categorized as ‘*Grade 3-Routine*’. The NT Police Chronology noted that Kumanjaya had “*absconded on a Form 9*” and lacerations to both arms were bandaged. There is no record of the police being told that Kumanjaya was at further risk of suicide or self-harm. Documents emailed to the generic police assistance email address go to a central inbox which is monitored every 5-10 minutes.

50. The JESCC Watch Commander (**WC**) who reviewed the event did not change the grading and directed that a ‘*Be on the Lookout For*’ (**BOLOF**) be issued over the police radio, which occurred at 11.37am.⁴⁰ At 11.38 the WC determined that the “*original case officers*” were to be tasked to “*conduct patrols.*”

³⁸ T123(Veloz)

³⁹ Additional documents, Folio 20 [109-111]; T205-210 (Commander Slape)

⁴⁰ Additional documents, Folio 20 [112]

51. At 2.07pm a Senior Auxiliary in JESSC identified that the '719 - *Missing person-Hospital*' event was connected to the earlier '597- *Attempt Suicide/Self-Harm*' event. The connection was marked '*critical*' which did not alter the priority of the response but was done to ensure the connection was noted by the Supervisors.
52. At 3.15pm the JESSC Supervisor manually allocated the event to Constable T on PROMIS and sent him the *Form 60* and the *Form 9*. However, by this time Constable T was no longer on duty as his shift ended at 2pm.
53. At 3.57pm Security Guard D attended the Alice Springs Police Station and reported that he had been assaulted by Kumanjayi at the ASH.
54. At 5.16pm the *Form 60* CAD event was closed because it had been tasked to Constable T on PROMIS.
55. Noting that police promptly issued a BOLOF, there is no evidence of any police engaging in any active search for Kumanjayi that day. The police did not contact Kumanjayi's family to report that he was missing or to seek assistance with his search and return.

16 November 2023

What did the Police do on 16 November 2023?

56. Constable T returned to duty at 6am and discovered that he had been tasked to look for Kumanjayi. As he had only attended the original incident out of urgency (and it was outside his normal role), he requested his supervisor to re-task the *Form 60* request for assistance to another Constable.
57. At 6.39am the CAD event was re-opened and a comment was added "*please call hospital and have paperwork sent through- also check if Police still required.*" ASH had sent the *Forms* to the generic police assistance email which had been picked up by JESSC the night before and sent to Constable T but they had not been sent to the Alice Springs Police Station. At 6.40am Shift Sgt Watson called ASH and requested the *Forms* be re-sent, which was done by 7.01am. A Senior Nurse also returned his call and sent the *Forms* for a third time, this time to Sgt Watson's direct email.

58. Sgt Watson was going off shift and handed over to the Day Shift Sergeant, T. Simpson. At 7.25am the *Forms* were sent from JESSC to Sgt Simpson, and he determined that an immediate police response was *not* required. At 2.11pm Sgt Simpson uploaded the forms to the PROMIS event.
59. Sometime during the day, a Police Officer phoned Kumanjayi's daughter and was told (and recorded in PROMIS) that Kumanjayi never returned home.⁴¹
60. At 9pm Sgt Simpson handed over to the returning Night Shift Sergeant, M. Watson. Sgt Watson reviewed the *Forms* and noted that the *Form 60* may have expired because it included a 16 November 2023 expiry date for the *Form 9*. Sgt Watson was confused because in his experience a *Form 60* referring to a *Form 9* is normally valid for 14 days, not 24 hours.⁴² Sgt Watson phoned ASH to clarify whether a police response was still required. He spoke to Dr M. Hussey.⁴³ Dr Hussey was a locum doctor from New Zealand with some experience of Alice Springs. Dr Hussey read Kumanjayi's discharge summary which stated Kumanjayi was "*not suicidal*." On being told that the "*forms for the patient had expired*" and because he did not think there was a high level of risk, Dr Hussey told Sgt Watson that there was no further requirement for police to look for him or bring him back to the hospital.⁴⁴
61. As a result of a) the decision by Sgt Simpson that an immediate response was not required, and b) the conversation with Dr Hussey; police did not engage in any active searching for Kumanjayi on 16 November 2023 or thereafter.

What did the hospital do on 16 November 2023?

62. Following police requests the *Forms* were re-sent to the generic police assistance email address and again directly to Sgt Watson's email address at around about 7am.
63. At 9.25am ASH staff attempted to call Kumanjayi on his phone, but his phone did not accept incoming calls. They also tried to call his daughter (who was recorded as

41 Additional documents, Folio 37

42 T153 (M. Watson)

43 T147-151 (M. Watson)

44 Coronial Brief, Folio 27, p228, T150 (M. Watson).

his next of kin) but that call also went unanswered. These attempts were noted on the *TOL Management Checklist*.

64. As already noted, Dr Hussey spoke to Sgt Watson sometime after 9.30pm and advised that there was no further need for the police to locate Kumanjayi. In evidence Dr Hussey conceded that he was not the best person to make that decision. He did not know what the *Form* was that the Sergeant was asking about and he did not make any enquiry of the CATT or any other person who had been involved in Kumanjayi's care.⁴⁵

18 November 2023

65. At about 3.26 pm hospital staff again attempted to phone Kumanjayi and his daughter without success and this was noted on the *TOL Management Checklist*.

Family Response

66. When she learned that Kumanjayi had run away from the hospital Beth and his daughter looked for him but could not find him. Beth also went to the police station. She was worried about him, and she wanted the police to look for him and to update her.⁴⁶

19 November 2023 and following days

67. At 9.21am on 19 November 2023, a community member called 000 to report that she had found an Aboriginal man hanging from a tree at the back of a nearby property. Police and ambulance attended. At 9.29am a St John paramedic pronounced the Aboriginal male deceased. NT Police Forensics attended and identified the deceased as Kumanjayi by fingerprint.

68. On 20 November 2023 Police notified ASH that Kumanjayi was deceased.

69. On 23 November 2023 a Mental Health Nurse spoke to Kumanjayi's daughter and Beth to offer sympathy, support and an opportunity to discuss what had happened

⁴⁵ T177-181 (M. Hussey)

⁴⁶ Coronial Brief, Folio 36

with the Clinical Nurse Manager and Medical Director.⁴⁷ There were further phone calls and correspondence, including with Ntaria clinic, to set up the meeting. Effective contact with Beth was not achieved and the case was closed on 29 August 2024.

Autopsy and opinion of the Forensic Pathologist

70. An autopsy was conducted on 27 November 2023. The Forensic Pathologist concluded that Kumanjayi's death was due to hanging.⁴⁸ Decomposition was identified and the Forensic Pathologist opined that it was possible he died on the same day he left hospital (15 November 2023) and less likely that he died on the day that he was discovered (19 November 2023).⁴⁹

71. The evidence established that after he left the hospital:

- he was last seen running in the general direction of where he was found deceased,
- he was found less than 1km from the hospital,
- there were no further sightings of him after he was seen running away,
- he did not answer his phone,⁵⁰
- he had no contact with his family and did not return home,
- a neighbour noticed a foul smell at 11am on 18 November 2023 emanating from the location where he was later found,⁵¹ and
- one attending paramedic documented *"Pt has been there for over 12 hours with the amount of water from the storm on pts clothes."*⁵²

72. Alice Springs is not a large place, and it is compelling evidence that Kumanjayi was

47 Ex 3

48 Original Brief Folio 5

49 Additional documents Folio 15

50 Coronial brief, Folio 31, attempts to further analyse his phone were unsuccessful

51 Coronial brief, Folio 7

52 Coronial brief, Folio 26

not seen or heard from again after he left the hospital and that he was found deceased only a short distance from the hospital. The circumstances satisfy me that it is likely that he took his own life on 15 November 2023.

Response to Kumanjayi's passing and issues considered in the inquest

73. Kumanjayi's family were undoubtedly distressed to learn that there was effectively no active search for Kumanjayi after he ran away from the hospital. That there was only one successful phone contact with a family member was also highly distressing (though there is evidence of further attempts by hospital staff). Given the tragic outcome, understandably they thought more should have been done to proactively search for Kumanjayi and to keep them informed.
74. Although there was no proactive search, the discussion below largely demonstrates that both NT Police and NT Health staff followed their respective procedures. It is important to understand that, in the context of other competing demands, NT Police cannot always prioritise locating missing hospital patients. This reality makes it even more important to ensure that a) family are notified when a patient leaves hospital, b) they are realistic about the speed and extent of any police response, so that c) family members can activate their own networks to look for their missing family member if they can or choose to do so. It also means that there might be a need for other agencies to be notified and involved, such as the Central Australian Aboriginal Congress (**Congress**).
75. NT Health completed a Root Cause Analysis (**RCA**) following Kumanjayi's death. While no single root cause was identified, issues about his care and improvements that could be made were identified. NT Health's responses to Kumanjayi's death were addressed in its institutional response provided by Professor Richard Johnson, Deputy Director, Medical and Clinical Services.⁵³
76. Acting Commander Drew Slape provided the institutional response for NT Police.⁵⁴ In his affidavit he explained in detail the legislation, various policies, procedures, General Orders, and a cooperative protocol between NT Police and NT Health,

⁵³ Additional documents Folio 21

⁵⁴ Additional documents Folio 20

which together govern police responses to mental health related events. He carefully outlined the police responses and explained the NT Police processes. I was grateful for that assistance. It is not necessary for me to repeat all that information in these findings except where it is pertinent to a specific issue.

Is there a hierarchy of medical versus psychiatric assessment in ED?

77. Although Kumanjayi had been in ED for 3 hours, he had not yet been assessed by CATT when he absconded. The RCA Panel found that there was a short delay in Kumanjayi's care due to a misunderstanding between CATT and ED practitioners as to whether Kumanjayi needed to be 'medically cleared' before being placed on a *Form 9* and assessed by CATT. The RCA Panel found that there was *no* requirement for a 'medical clearance' before review by CATT.
78. To clarify roles and responsibilities, NT Health promulgated the *MHAOD CAR CATT Clinician Roles and Responsibilities in ASH ED Procedure (CATT/ED Procedure)* which now makes it clear that:
- Parallel (simultaneous) decision making is required by mental health practitioners and ED doctors, to enhance timely transit through ED and (if needed) admission into the Mental Health Unit,
 - When an ED patient is referred to CATT, the CATT clinician must manage mental health presentations in ED and escalate decision-making early,
 - The CATT must inform ED of the outcome at the conclusion of the psychiatric assessment,
 - The CATT must provide support and information to (among others) family and carers of the patient, and
 - ED and CATT staff are expected to collaborate with and seek advice from cultural support teams and services, such as Aboriginal health staff, and translation services.
79. This procedure seemingly makes CATT responsible for informing family members if an ED patient, who is referred to CATT, goes missing. In fulfilling this and other

functions, CATT are expected to collaborate with Aboriginal staff and translation services. If this procedure was in place and followed, it *may* have improved communication with Kumanjayi's family.

Form 9

80. There were inconsistencies in the risk assessments recorded across the various forms and other records including the *High Risk TOL Form*, *Form 9*, *Form 60* and the Discharge Summary. Prof Johnson explained that the greater collaboration expected from the implementation of the CATT/ED Procedure should improve the quality of risk assessments and the consistency of the *Forms* and records.
81. Prof Johnson acknowledged that there was confusion among NT Health staff as to the duration of *Forms* and the powers that are authorised by the MHARS Act. As to confusion about the effect of *Forms*, their duration, and powers, in his institutional response Prof Johnson asked:⁵⁵
- Does a *Form 9* (in the absence of a *Form 60*) permit police to apprehend a patient and bring them to an approved treatment facility?
 - Where a person detained under a *Form 9* absconds, how is the 24-hour limit on detention treated?⁵⁶
 - Where a person on a *Form 9* is detained but then absconds, will a request for police assistance under the *Form 9* continue to operate?
 - If a patient is transferred from ASH to Darwin for assessment, does the 24 hour detention limit run during transfer or can it be extended?
 - Are there practical differences for the person if the *Form 9* is completed when the person is in community as compared to it being completed when the person is in an approved treatment facility?
 - When a *Form 9* is completed, who is the right person to provide directions to

⁵⁵ Additional documents Folio 21 p37

⁵⁶ See for example evidence of Dr Wirth T 85, "*if a person leaves that presses pause on the clock.*"

police concerning their assistance?

82. It is beyond the scope of this inquest to answer these questions for all cases. I consider that some of these questions may be resolved by statutory interpretation and some may be resolved by departmental policy and procedure. However, careful consideration of what happened in this case may assist.
83. Section 32A of the MHARS Act confers a power on NT Police to apprehend a mentally ill person with the use reasonable force (s32A(7)). If that power is used, police are to promptly bring the apprehended person to a person or location for a mental health assessment. Police are required to inform the receiving practitioner of the reasons for apprehension and of any force used. In practice this is done through both a verbal handover and the completion of a *Form 7 – Notice of Apprehension by Police*.⁵⁷ In this case police apprehended Kumanjaya without the use of force, took him to ASH ED and completed the *Form 7*.
84. The *Form 7* is signed by the receiving medical practitioner to signify their acceptance (or refusal to accept) the apprehended person. If the apprehended person is accepted by the mental health service, police are released from providing further assistance. In practice this means that police are no longer responsible for ensuring that the apprehended person remains at the location until the psychiatric assessment is completed, instead this responsibility transfers to a security guard.
85. Section 33 of the MHARS Act requires a medical practitioner to assess and determine whether the person needs treatment under the MHARS Act. When making that assessment, if the medical practitioner is satisfied that the person fulfills the criteria for involuntary admission under the MHARS Act, s34(1) of the MHARS Act makes it mandatory for the medical practitioner to make a recommendation for psychiatric examination. This recommendation is documented via the completion of a *Form 9* (s34(2)).
86. The recommendation/*Form 9* is in force for up to 14 days but will expire (earlier than 14 days) as soon as the psychiatric examination is completed or if/when the

⁵⁷ NT Police General Order Mentally Ill Persons (OP-FO1) – 2 February 2012 [32]

recommendation/*Form 9* is revoked (s34(7)).

87. Once the recommendation/*Form 9* is made, s34(3) permits powers to be exercised against the person the subject of the *Form 9* (who I will now refer to as the **involuntary patient**). Those powers can be exercised by *the* practitioner, a paramedic, or anyone else *specified* as authorised in the recommendation/*Form 9*. The s34(3) powers that may be exercised against an involuntary patient are:
- they can be controlled,
 - they can be brought to a treatment facility,
 - they can be held at a hospital,
 - immediately necessary treatment can be administered, and
 - they can be detained at a treatment facility for up to 24 hours.
88. In exercising s34(3) powers, the *specified*/authorised person can use reasonable force and receive assistance (presumably from others who have not been *specified*/authorised) (s34(8)).
89. In a nutshell, the recommendation/*Form 9* requires a psychiatric assessment to take place and facilitates this by giving *specified* persons powers to a) control and take the involuntary patient to an appropriate person or location for psychiatric assessment, b) to administer immediately necessary treatment, and c) to detain the involuntary patient at that location for up to 24 hours for the purpose of psychiatric assessment. The police can be *specified* to exercise these powers if there is no other alternative (s34(4)). As the *Form 9* is in effect for 14 days (unless earlier revoked or the psychiatric assessment is completed) it remains in force if a person TOL from a hospital (or other location) before the psychiatric assessment takes place thereby facilitating their return with the use of control and reasonable force.
90. Dr Veloz completed Kumanjayi's recommendation/*Form 9* (in force for up to 14 days) at 9.58am on 15 November 2023. *Importantly*, in Kumanjayi's *Form 9*⁵⁸ Dr

58 Coronial brief, Folio 41 p2/7

Veloz did not *specify* any additional “*person/entity/agency*” who could exercise powers against Kumanjayi. I am uncertain whether this was an oversight or consistent with normal practice. However, as a result, a *plausible* interpretation is that only Dr Veloz (*the* practitioner) or a paramedic (any paramedic) could exercise any of the s34(3) powers against Kumanjayi (and a non-specified person could provide assistance).

91. I am not critical of Dr Veloz for not completing this part of the recommendation/*Form 9*. This was the first time she had seen, let alone completed, this *Form*⁵⁹ and, to my mind at least, the proforma *Form 9* is not very intuitive. Where information is required to be entered by the person completing the *Form 9* there are, in most instances, either a) clear blank spaces (to be filled), or b) tick-box options next to prefilled statements (to be ticked). The part concerning who may exercise powers looks different and, although the writer is invited to “(*select appropriate*),” no specific persons, entities or agencies are identified (by tick-box or otherwise) for selection. Given the nature of the powers that may be exercised, the person(s)/entity/agency to be granted powers is potentially quite broad and might include, by way of example:

- NT Health staff
- ED staff,
- CATT staff,
- Aboriginal Health Practitioner (AHP)
- Personal care assistant (PCA),
- Hospital orderly,
- Aboriginal Liaison Officer (ALO)
- Hospital (in-house) security guard,

59 T 129 - 130 (Veloz)

- Contracted security guard (for example, Talice Security Guard),
 - NT Police (s34(4)).
92. When Kumanjaya absconded, police were *not* specified in the *Form 9* as persons who could exercise s34(3) powers. Once he had absconded it is *possible* that police could have been specified on the *Form 9* (added to the *Form 9*), and so could have been given *Form 9* powers to control him and bring him back. However, this was not done.

Form 60

93. The *Form 60* notifies police that an involuntary patient has absconded and requests their assistance. This *Form* has several tick-box options referencing various sections of the MHARS Act for which police assistance can be sought and the specific powers available to police when actioning assistance.

Nature of assistance required

- ☒ **Section 34** (Form 9) Police Assistance following recommendation for a psychiatric examination
- NOTE: The primary responsibility for the person's custody and safety rests with the health service/facility/agency of the clinician that has authorised the Form 9 (which may also include an authorisation for police to assist). Any action or assistance provided by police under this authority will be at the direction/guidance of the assessing clinician. The preferred approach is for police to assist rather than act independently of mental health clinicians unless there are clear risks to safety.
- ☐ **Section 53** (Form 20) Control and take the person to an approved treatment facility following suspension of a Community Management Order.
- ☐ **Section 37** (Form 8) Apprehend and convey person to an approved treatment facility for assessment pursuant to assessment warrant issued by the Tribunal (Magistrate).
- ☐ **Section 83A (2) and (4)** (Form 45) Apprehend a prisoner who is absent without leave from an approved treatment facility.
- ☐ **Section 166A** (Form 52) Locate, detain and return an involuntary patient absent without leave from an approved treatment facility.
- ☐ **Section 166B** (Form 52) Report 'missing patient' to police.
- ☐ **Section 30** (Form 52) Request to locate and detain and return a voluntary patient being detained by a nurse or medical officer because their condition has deteriorated since admission and may fulfil the criteria for involuntary admission.
- ☐ **Section 165** Request for police to assist to prevent a person harming themselves or another person; or to maintain the good order and security of an approved treatment facility or the approved treatment agency.
- ☐ **Part IIA NT Criminal Code** (Unfitness to plead and not guilty by reason of mental impairment) s43ZF 'Emergency Power of Apprehension'.
- ☐ **Letter of Agreement between NT Police and Department of Health** (Disclosure of information pertaining to terrorism, radicalisation to violent extremism, fixated persons, grievance fuelled violence, lone actor activity or concerns where there is a threat or risk to an individual or members of the community).

94. For Kumanjayi the tick-box option for assistance selected was 'Section 34 (Form 9)' and the attached NOTE explains how police should proceed and the limits of their powers. Without *Form 9* powers, it seems that if police located Kumanjayi (the absconding involuntary patient) they could transport him back to hospital with his *consent* or, if he met the criteria under s32A of the MHARS Act, police could re-apprehend him and take him back to hospital. The fact that Kumanjayi (or any involuntary patient) was on a *Form 9*, had absconded, and the medical practitioner was seeking assistance with his return, are all matters that police could consider when determining whether the s32A criteria are met, in my view.
95. It is worth noting, and it is evident from the tick-boxes on the *Form 60*, that there are a variety of circumstances when requests for assistance concerning missing patients can be made. Police powers available under the MHARS Act vary in accordance with the applicable section and *Form*. For example, a *Form 52* (which authorises police to apprehend and return of a patient with reasonable force) was not available in this case because Kumanjayi was still at the *assessment* phase. He had not yet been *admitted* to an approved treatment facility (s166A, s166B).⁶⁰
96. The type of *Form 60* request for assistance also affects the grading/priority of the police response, which I will return to later in these findings.
97. Confusion arose in this case because the *Form 60* contained an incorrect expiry date for the *Form 9*.

☐ Voluntary	Section	Expiry Date
☒ Involuntary	<i>Form 9</i>	<i>16/11/23</i>
	Section	Expiry Date

98. This date seemingly reflects the 24 hour detention period specified in s34(3)(d) and not the 14 day period specified in s34(7) that applies to the recommendation/*Form 9*.
99. In response to identified issues about powers, *Forms*, and general confusion I heard

⁶⁰ I do not consider that Protocol 10 of the NT Police Mental Health General Order was available-contra Additional Folio 21 [101]

from Prof Johnson that NT Health:

- through its ED Education team, is developing training for mental health and ED staff,
- through its Approved Procedures and Quality Assurance Committee (**APQAC**) is reviewing the *Forms* under the MHARS Act and training, and
- has introduced an orientation handbook for locums which includes MHARS Act information.

100. Under the current legislation these concerted endeavours are necessary to improve compliance, but they are resource intensive and fail to address the bigger issue which is whether the current legislation, processes and procedures for mental health services are up to date and accord with best practice.

101. In the *Inquest into the death of Kumanjayi Brogus Ungawanaka*⁶¹ I considered a death at ASH of a patient under the MHARS Act and noted that the current Act is “*clunky, non-sequential, overcomplicated.....[and] well overdue for reform.*” I consider that the questions raised by Prof Johnson and the variety of efforts being undertaken by NT Health in relation to further training, refinement of *Forms*, and enhanced staff orientation, all point to the practical problems inherent in the current Act and the urgency that should be afforded to the modernisation (and if possible, the streamlining) of mental health legislation in the Northern Territory.

Recommendation No. 1

I recommend to the **Northern Territory Government and the Department of Health** that they take immediate steps to modernise mental health legislation for the Northern Territory by diligently finalising a new Mental Health Act through to commencement within 12 months of publication of these findings; noting the extensive consultation and drafting already undertaken.

61 [2026] NTCC 12 p 74

Reducing TOL - Security Staff

102. The Talice Security Company (**Talice**) provides security personnel to ASH ED. Talice provides 3 permanent security guards 24/7 (**ASH Security Staff**) and additional staff as required (**Additional Security Staff**). The ASH Security Staff consist of 9 security guards who have received 2.5 days of face-to-face specialised training with a focus on positive approaches to managing challenging behaviours, effective communication, de-escalation, and restraint. Additional Security Staff are not dedicated to the hospital; they receive an orientation to the physical layout of the hospital but not the specialised hospital training.
103. Security Guard D was an Additional Security Staff member who had worked about three shifts at the hospital. He was given a chair to sit on at the end of Kumanjayi's bed.⁶² Although he was not told anything specific about Kumanjayi and they were not even introduced to each other, he understood his role was to prevent Kumanjayi from leaving the hospital. To do this Security Guard D understood that "*we are not allowed to restrain them,*" "*we cannot physically hold them...we can just communicate with them.*" He did not seem to be aware of s34(3) MHARS Act powers or that he might be empowered to use reasonable force to detain Kumanjayi.
104. In accordance with his understanding of his powers, when Kumanjayi stood up and started walking as though to leave, Security Guard D intervened by saying "*stop*" and "*please don't leave, you have to wait for the doctor.*" He did not touch Kumanjayi, or attempt to hold his arm, and he did not use any force to prevent Kumanjayi from leaving the hospital. The only physical contact between the two was when Kumanjayi punched the Security Guard.
105. Consistent with Security Guard D's evidence, Dr Wirth said that the outsourced (Talice) security guards in ASH ED have a very hands-off role. He said he had seen examples where these guards "*seemed at a loss to know what their role is*" and it seemed to him that "*they believe they're not allowed to touch patients...and in many cases they don't even inform us that the person has left....So I think it's a hugely deficient part of our system.*" In those circumstances, Dr Wirth considered that

62 T 66 -72 (Guard D)

Aboriginal Liaison Officers (**ALOs**) or family members were better at diffusing situations than “*an African security guard*.”⁶³ In contrast to the ASH hands-off approach, Dr Wirth explained that in-house security guards at Royal Darwin Hospital physically restrain an involuntary patient to prevent them from leaving the hospital or they will hold a patient on the ground so that a sedative injection can be administered.

106. Although the RCA Panel considered Security Guard D “*had done the right thing*,” Prof Johnson said that there was an expectation that security guards would use physical restraint to prevent (or attempt to prevent) an involuntary patient from leaving the ASH. He said he had seen that happen and he had also seen what he called a ‘take-down’ (restraint on the ground so medication could be administered), on many occasions.
107. Given their hospital specific training, the RCA panel considered that the ASH ED should use ASH Security Staff for 1:1 MHARS Act patients. However, Dr Johnson explained that the current level of demand for security guards meant that it would not be efficient or cost effective to always use the ASH Security Staff in ED. NT Health is considering employing a fourth ASH Security Guard and I was told that ASH is working with Talice to ensure *all* security guards used at the hospital receive Aboriginal Cultural Awareness Training and Occupational Violence and Aggression Training (which focusses on deescalation and restraint).
108. Further, in response to this and other instances of TOL, NT Health has produced an ‘*Involuntary Mental Health Patient Security ASH Guideline*’⁶⁴ to provide clear guidance to security staff as to their role and responsibilities. It includes the following:

Some facts

- The entire ASH Campus is deemed an approved treatment facility – affording employees and SO’s the authority to prevent an involuntary patient from leaving the ASH Campus, with **reasonable force** as indicated in the [Mental Health Act under section 34](#) & MAYBO Training.

⁶³ T 79-80 (P. Wirth)

⁶⁴ Published 26 March 2024

Security are here for the safety of all clients/staff and must be prepared to utilise effective de-escalation, restraint and take down skills as required, as outlined in MAYBO training.

109. I am concerned that the premise of this guideline is legally incorrect, as far as it applies to s34 recommendation/*Form 9* patients (which is all that I am considering in this inquest). As I noted earlier, in this case the recommendation/*Form 9* did not specify anyone with s34(3) powers. One plausible interpretation is that in those circumstances only Dr Veloz (*the practitioner*) or a paramedic is authorised to use s34(3) powers. If that is correct, only Dr Veloz or a paramedic could use reasonable force with Kumanjayi before a security guard could use any force to assist them (s34(8)(a)).
110. I consider it likely that the failure to specify persons with s34(3) powers in the *Form 9* is systemic. I consider this gives rise to risk; that involuntary patients will not be detained, or reasonable force might be exercised by a non-authorised/*specified* person. To protect both its staff and its patients, NT Health should urgently undertake a review of recent *Form 9*s to determine whether they are completed in a way that adequately addresses the potential security and treatment needs of the involuntary patient, specifically, whether they *specify* persons who can exercise s34(3) powers. NT Health should also obtain clear legal advice about when, in what circumstances, and to what extent a *non-specified* person can provide assistance.
111. In the *Inquest into the death of Kumanjayi Brogus Ungwanaka* [2026] NTCC 12 at [56] and [57], in considering another circumstance of s34/*Form 9* use, I reflected on the principles that apply to the provision of mental health care. This includes the principle of ‘least restrictive environment.’ The following fundamental principles set out in Part 2 of the MHARS Act are worth repeating:
- s9(p) any assessment of the person to determine whether he or she needs to be admitted to an approved facility is to be conducted in the least restrictive manner and environment possible; and
- s10(a) the person should only be admitted [as an involuntary patient] after every effort to avoid the person being admitted as an involuntary patient has been taken.

112. It must be clearly understood that these principles apply to the exercise of s34(3) powers. These powers are to be exercised as a last resort, and the minimum amount of force is to be used as may be necessary to control or detain the patient.
113. The s34(3) powers of control and detainment are designed to ensure that seriously mentally ill persons receive appropriate treatment and care and are not simply permitted to remain in or re-enter the public when they are considered a risk to themselves or others. The failure to properly understand and exercise the s34(3) powers to control and detain involuntary patients has significant implications. In this case, a potentially suicidal involuntary patient left the hospital and tragically committed suicide. Further, overreliance on police assistance for missing patients has consequences for police resourcing and as seen in this case, when police are juggling competing tasks, this impacts their capacity to meaningfully respond to all requests for assistance.
114. Consideration should be given as to whether for all *Form 9* involuntary patients their allocated security guard should have s34(3) powers. If they have those powers directly (if they are *specified*) or even if they only have those powers in a capacity to assist, every security guard should:
- be informed of his/her powers,
 - be adequately and sufficiently trained in the fundamental principle of 'least restrictive manner and environment,'
 - be adequately and sufficiently trained with a variety of de-escalation skills known to be helpful in managing mental health patients,
 - be adequately and sufficiently trained in the use of reasonable force to prevent an involuntary patient from leaving the hospital, and
 - be willing and able to use their powers to prevent an involuntary patient from leaving the hospital in a manner consistent with the fundamental principle of 'least restrictive manner and environment.'

115. In the *Inquest into the death of Xysz Tacdliwaazy @ Josh Ngalarina @ Mayinaj*⁶⁵ I considered the death of Ngalarina,⁶⁶ an involuntary mental health patient with a bed in a general ward in Royal Darwin Hospital (an **RDH outlier**). The inquest considered how the risk of volatile substance abuse (**VSA**) was not identified or mitigated by security guards who were given no information about the patient they were supervising. The security guards allocated to Ngalarina understood their only job was to prevent absconding (TOL). The security guards were not told that Ngalarina was a volatile substance abuser and so, the allocated guard did nothing to intervene when they purchased deodorant, a volatile substance, at the hospital pharmacy. Later that evening Ngalarina engaged in VSA in a hospital bathroom using the deodorant they had purchased and tragically passed away. The inquest identified that there was no procedure for security guards to be advised of a patient's individual risks. I reflected that *"without this vital information it was difficult for security staff to discharge their responsibilities, manage risk and keep Ngalarina and others safe."*⁶⁷ In response to Ngalarina's death NT Health developed an 'Outlier Constant Supervision Instructions Form' (**Instruction Form**). A RDH outlier's allocated nurse was made responsible for directing supervisory staff (security guards or PCAs). The Instruction Form documents the patient's risks and supervision requirements, and the supervising staff member is required to sign the Instruction Form when they come on shift (and/or at handover).
116. I am loathe to suggest that another *Form* is required, however, if I am correct and it is necessary or desirable for persons to be *specified* with s34(3) powers in the *Form* 9, then it may be possible to re-work the *Form* 9 so there is space for specified persons to be informed of their powers and for this to be documented. Only by way of example, perhaps a separate page could be allocated for the medical practitioner to specify persons authorised to exercise s34(3) powers. That page could include, again by way of example only, something like: *[Name of involuntary patient] is an involuntary patient under s34/Form9 of the MHARS Act. From [time and date] he/she may be detained (stopped from leaving the hospital) using the minimum reasonable force necessary. This authorisation remains in force for a period of 24*

⁶⁵ [2024] NTLC 3

⁶⁶ Uses they/them pronouns

⁶⁷ *Inquest into the death of Xysz Tacdliwaazy @ Josh Ngalarina @ Mayinaj* [2024] NTLC 3 p 22

hours of detention."⁶⁸ This single page, addressing only specified persons and their powers could be shown to the security guard (and/or other specified person) and space could be allocated for the security guard (and/or other specified person) to sign, indicating that he/she has read and understood the statement. If there is a handover, for example, of security guards, the same process should be repeated with the on-coming security guard.

Recommendation No. 2

I recommend to the **Department of Health** that it should take steps (including by way of seeking legal advice) to:

- a) clarify the scope and application of section 34 of the *Mental Health and Related Services Act* 1998 and the *Form 9*. Specifically concerning s34(3) and s34(8), NT Health should clarify who can exercise s34(3) powers and in what circumstances; and
- b) all applicable policies, procedures, training, and the *Form 9* should be reviewed (and amended if necessary) to ensure conformity with the correct application of s34.

Recommendation No. 3

I recommend to the **Department of Health** that it ensures that all security guards used for mental health patients have received appropriate training specifically in the task of guarding a mental health patient and can demonstrate:

- a) cultural competency,
- b) an understanding of relevant principles, their powers and the limitations of

⁶⁸ Consider whether: concerning the 24 hour detention timeframe there should be space for 'stop the clock calculations' if a person absconds but is then returned within the 14 day timeframe of the Form 9; and /or space to document known risks or behaviour relevant to the security officer's duties, by way of example only, history of TOL, history of spitting (guard might choose to wear a mask); and/or space to document known effective deescalation techniques

their powers under the *Mental Health and Related Services Act 1998* (or its replacement Act),

c) de-escalation skills, and

d) reasonable use of force.

The NT Police response to the *Form 60*

117. Dr Wirth completed the *Form 60* as quickly as possible as he believed police would have a better chance of finding Kumanjayi if they looked for him immediately. However, his expectation (and indeed the expectation of Kumanjayi's family) that there would be a prompt and active search for Kumanjayi, did not align with the reality of NT Police practice, as it applied to this case.
118. On receiving the *Form 60*, although NT Police immediately issued a BOLOF, there was *no evidence* of any active search being engaged in by police *at any time*. I reiterate that considering this from Kumanjayi's family's perspective, it is highly distressing and hard to accept.
119. NT Police nevertheless submitted that its response to the *Form 60* was appropriate in the context of the grading priority attached to this type of request, the information provided and factoring in the competing demands for police responses.
120. Commander Slape explained that all incident events reported to NT Police are graded in order of response priority. The CAD system requires call takers to select appropriate event types which are automatically allocated a response grading. The Watch Commander (**WC**) or Supervisor reviews all matters and can re-grade/re-prioritise based on the information available, if warranted.
121. The original 000 call to police by family at 6.30am on 15 November 2023 was correctly identified as a '*597- attempt suicide/self-harm*' which is a '*Grade 1 – immediate*' event requiring an immediate response, which NT Police actioned. Event types '*594 – Mentally ill person*' and '*719- Missing person- Hospital*' are automatically classified as '*Grade 3 – routine*' which requires police action as operational requirements allow.

122. When he absconded from the hospital police were not informed that Kumanjayi was actively suicidal or at risk of suicide or that their assistance was urgently sought. Based on the information that was provided, when the matter was reviewed by the WC the grading was not increased. Over the following days and through the various handovers between shifts, NT Police continued to review the available information and the determination that an immediate response was not required did not change. Commander Slape agreed with these decisions.
123. These decisions can only properly be understood when one considers the high volume and dynamic workflow of NT Police. Between 15 November 2023 when Kumanjayi went missing and 19 November 2023 when he was found deceased NT Alice Springs Beat police received graded reports for police response as follows:
- Grade 1 – 106,
 - Grade 2 – 252,
 - Grade 3 – 304,
 - Grade 4 – 61, and
 - Grade 5 – 225.
124. In the *Inquest into the death of Kumanjayi Johnson* [2026] NTCC 02 at 50, the high demand for police assistance for missing persons was considered. In addition to hospital absconders, police receive notifications and requests for assistance to locate NDIS recipients missing from supported accommodation, children in out-of-home care who do not return to their allocated residence, and intoxicated persons departing sobering up shelters.
125. From the time Kumanjayi absconded Police resources were fully occupied with higher priority or more urgent matters, and operational requirements did not permit an active response to this matter. Commander Slape explained:⁶⁹

Across the Northern Territory, NT Police face resourcing constraints, in the context of the volume of calls made to us for Police assistance. NT Police

⁶⁹ Additional Documents Folio 20 p 37

resources are often stretched thin by the number of active events that must be dealt with at any given time. It is therefore necessary to prioritise events based on available resources and known risks. In the 24 hours after NT Police were notified that Kumanjayi had absconded, 78 other events were reported to us in Alice Springs that were classified as Grade 1 or 2 (requiring a more urgent response). NT Police were unable to reassign any General Duties officers to this Grade 3 event in the absence of explicit medical information highlighting the immediacy of Kumanjayi's suicide risk. We acknowledge that, based on Dr Hussey's conversation with AS Watson, at the time he absconded, Kumanjayi may not have been considered by NT Health at such a high level of risk.

126. It is important that NT Health (and the public more widely) has a realistic understanding of NT Police's capacity to respond to missing patients. Except in cases where there is a high or immediate risk, there may be a limited police response, for example, the issue of a BOLOF, or a delayed police response. This makes it even more important for NT Health to ensure that its staff and security guards fully understand and appropriately exercise their responsibilities and powers under s34 of the MHARS Act. The RCA identified that between 8-10% of ASH patients TOL and between 5-16 November 2023 there were 7 instances of requests for assistance being sent to police from the ASH ED printer. It is plausible that many *Form 9* hospital absconder attempts could be prevented if security guards were well trained and versed in the exercise of powers under s34(3) of the MHARS Act and exercised them appropriately.
127. Accepting that there are limitations to police resources, there was still room for police to improve their response to this *Form 60*.
 - The attempt to allocate the matter to the first responding constable failed because that constable was plain clothes (not general duties) and was off duty when the matter was tasked to him on PROMIS. The JESSC process did not identify these problems. If the matter had instead been promptly tasked to the general duties Constable(s) who remained on duty, it is possible that they may have engaged in a more active search for Kumanjayi and/or actively communicated with Kumanjayi's family (with whom they already had some rapport).
 - The Shift Sergeants at Alice Springs Police Station were not provided with the *Form 60* (or accompanying *Forms*) by JESSC. This meant the matter was not

as actively on their radar as it could have been. It also meant there were follow-up phone calls to ASH the next morning and ASH ended up sending the *Forms* three times (which they should not have to do). This clunky approach used up both police and health resources. Having said that I do not wish to undermine or underestimate the importance of person to person phone calls. That direct line of communication is a strength and is to be commended.

- Those dealing with the *Form 60* and *Form 9* in both NT Police and NT Health did not demonstrate a robust understanding of s34 of the MHARS Act. This gave rise to real risks, not only for patients but also for NT Police and NT Health staff.
 - a. The error on the face of the *Form 60* (the *Form 9* expiry date) was not identified as an error. This error directly led to the premature cancellation of the *Form 60* response, when that should not have occurred.
 - b. There was no indication from NT Police or NT Health that they ever identified a problem with the *Form 9* failing to authorise police with s34(3) powers over Kumanjayi.

NT Health response to the incorrect *Form 60* cancellation

128. Concerning the cancellation of the *Form 60*, NT Health acknowledges the decision was made on incomplete information.
129. NT Health identified that Dr Hussey was not the appropriate team member to make the decision and said that the enquiry should have been referred to CATT. Prof Johnson said that NT Health's updated training, handbooks, and revised *High Risk TOL Form* together should ensure that the CATT responds to police mental health enquiries in the future.

Sending the *Forms* from ASH ED

130. As noted above, the need for ASH ED to communicate with police is common. The RCA Panel identified that the current method of communication, via the ED printer, was risky. Addresses could be incorrectly entered, this could go undetected because no error message is generated, and there was no ability to confirm receipt.

Although these risks are currently in part overcome by a procedure which requires follow-up phone calls (to confirm receipt), in a high volume ED, the entire process requires too much human input and is overly burdensome, unwieldy, and ripe for communication breakdown.

131. I heard that this has changed. Phone calls are still required to obtain the police PROMIS number and for 'heads-up' purposes, but the *Forms* are now scanned to a generic NT Health email (Ward Clerk). They are then emailed from that address to the relevant police contacts using one of two email templates which include:

- For a High Risk TOL, various police addresses (Police Assistance, ASH Constable, and Alice Springs Supervisors) for simultaneous notification, or
- In the case of an Aboriginal High Risk TOL, the above addresses plus additional addresses for ASH ALOs and the Aboriginal Engagements Strategy Unit, and
- In either case, automatic read receipts are turned on.

132. Hopefully, these changes will improve the reliability of communication and go some way to eliminating requests for multiple re-sending of the *Forms* as experienced in this case.

Cultural Competency – a role in reducing TOL, improving a search, and communicating with Family

133. Kumanjayi's family raised cultural competency and its potential impact on reducing TOL, increasing the efficacy of a search and improving communication with the family.

134. While security guards are one way of reducing TOL, the delivery of a culturally competent health service will likely also reduce TOL. Improved communication should more effectively engage patients in their health care, and culturally appropriate encouragement and support will likely assist patients to complete their hospital admissions. Associate Professor Danny Sullivan, Consultant Psychiatrist,

who assisted the inquest with an expert report,⁷⁰ said in evidence that an Aboriginal patient's *"sense of safety or of being supported or of having allies in the unit improved if there were Aboriginal mental health workers there."*⁷¹

135. The Nurse Manager of ASH ED told me that:⁷²

The ALO team comes from different language groups, different genders, and kind of different experience levels as well, so getting them involved early, especially in the emergency phase, really helps put our patients at ease, either with just being able to speak a language or having a friendly face or being able to coordinate their family to come in, helping us, especially during high-pressure trauma environments, they're very helpful with relatives when there's lots of people who come in, helping explain, kind of help us find out who the right person is to speak to, especially when there's decision-making to happen. Sometimes, if they're a translator, which not all ALOs are, they're very useful in helping explain medical terminology. We do use them a lot during the consent process and try to encourage our surgical teams to utilise them and they'll be on the ward rounds with them. And I guess it's just really helpful when we've got patients that maybe have extra family staying who need assistance just in town because they're not from here, so they're very helpful.

136. The MHARS Act includes this:

11 Principles relating to admission, care and treatment of Aboriginal and Torres Strait Islander persons

When providing treatment and care to a person of Aboriginal or Torres Strait Islander background the following principles apply:

- a) as far as possible, the persons treatment and care is to be appropriate to and consistent with the person's cultural beliefs, practices and

⁷⁰ Additional documents Folio 16

⁷¹ T192 (D. Sullivan)

⁷² T55 (GM)

mores, taking into account the views of the persons family and community;

- b) if the person is an Aboriginal or Torres Strait Islander person, the involuntary treatment is, where possible, to be provided in collaboration with an Aboriginal and Torres Strait Islander health practitioner.

137. However, the RCA Panel found no documented evidence of an ALO or interpreter (and I will add, AHP) assisting Kumanjayi when he was in ED. The Panel considered that this cultural support was essential and should be offered to MHARS Act patients in ED, whenever possible.⁷³ It is therefore necessary to seriously ask why, in 2026, in ASH, is this still the case and when will it change?

138. Prof Johnson advised that NT Health has taken steps to increase its Aboriginal workforce, and advised:

- ALOs are rostered during the day Monday to Friday in ASH, with some casuals working some after hours or weekend shifts,
- In January 2024, the role of Aboriginal Cultural Coordinator was introduced,
- Since April 2024, a full-time ALO Team Leader position was established,
- In January 2025, an Aboriginal Communication Specialist was employed,
- NT Health is in the process of introducing Aboriginal Navigators embedded in teams and wards to support patients through the hospital system,
- NT Health is actively recruiting ALO's, with 8 employed at ASH in the 12 months between May 2025 and May 2026,
- Positions have been created for additional AHP roles, but recruitment has not yet been successful in filling these, and
- The TOL working group is exploring ways Acacia can be used to notify ALOs

⁷³ T250 (R. Johnson)

when a patient enters with a history of TOL, so that ALO's can prioritise early engagement with that patient.

139. Accepting that recruitment (and retention) of ALOs and AHPs is ongoing and appreciating that they are a valuable but limited resource across ASH, as I have suggested in other inquests I reiterate the need to ensure their regular attendance and active involvement with all Aboriginal patients attending ED, and specifically, mental health patients.
140. As discussed earlier, NT Health's ALOs and the Aboriginal Engagement Strategy Unit are now notified by email when an Aboriginal patient TOL. Precisely what their role is after notification is not entirely clear to me, but they could helpfully keep family informed and they could, for example, notify **Congress**. Dr John Boffa, Chief Medical Officer Congress, gave evidence that there could be a role for Congress when there is a *high risk* Aboriginal TOL from ASH. He said that in an ideal system both police and Congress would be notified. He considered it likely that there would be Congress staff who could actively search for such a patient.⁷⁴
141. Commander Slape acknowledged the role of cultural safety in policing. Commander Slape explained that in Alice Springs Station ALOs are now more closely embedded with frontline policing. The ALOs have their own daily muster briefings and are being better utilised to assist with investigations and follow-ups. He considered that the Alice Springs Shift Sergeant could jointly or simultaneously task GDs and ALOs with a *Form 60* request for assistance or a mental health response.⁷⁵

Recommendation No. 4

I recommend to the **Department of Health** and **Central Australian Aboriginal Congress Aboriginal Corporation (Congress)** in furtherance of their Collaboration Agreement, or otherwise, that they together consider whether there is a role for Congress in respect of Alice Springs Hospital (ASH) High Risk Take Own

⁷⁴ T275-277 (J. Boffa)

⁷⁵ T223-224 (D. Slape)

Leave (TOL), and if so, implement policies and procedures to clarify and facilitate that role.

Recommendation No. 5

I recommend to the **NT Police Force** that it actively consider expanding the role of Aboriginal Community Police Officers (ACPO) and Aboriginal Liaison Officers (ALO) when responding to requests for assistance to locate an Aboriginal person, including, for example, responsibilities for ensuring appropriate and timely communication with families of those persons.

Improved collaboration to understand and combat suicide in Central Australia

142. Between 2018 and 2023 Aboriginal Territorians suffered three times the rate of suicide compared to the national rate for non-Aboriginal suicides. Dr Sullivan, forensic psychiatrist, explained some of the risk factors for suicide, which include, indigenous status, male gender, schizophrenia, previous episodes of self-harm and substance use.⁷⁶ The relationship between suicidal ideation, schizophrenia, and suicide is not simple.⁷⁷
143. Schizophrenia is understood to be a range of different conditions; it is not a single illness. Dr Sullivan estimated around five percent of all people with schizophrenia will very sadly die by suicide.⁷⁸ Medication for schizophrenia is commonly given with a depot injection. The injectable depot medication (as well as oral medication) is associated with better outcomes; less hospital admissions, less instances of incarceration, reduced negative physical effects, and reductions in suicide.⁷⁹

76 T189 (D. Sullivan)

77 T189 (D. Sullivan)

78 T189 (D. Sullivan); Folio 16, Folio 17

79 T191-192 (D. Sullivan)

144. Efforts to understand and respond to suicide risk in the Northern Territory grapple with vast distances, many languages and cultural groups, and limited resources for treatment and rehabilitative services.⁸⁰ Multiple health services work in this environment and they do not always work seamlessly together or share information with each other. Patient care and information can be siloed which adds to risk.⁸¹ It was, therefore, encouraging to learn of the Collaboration Agreement⁸² between Congress and the Mental Health and Alcohol and Other Drugs Services Central Australian Region NT Health (**MHAODS**). The Collaboration Agreement recognises that there are shared care responsibilities for many patients. It delineates responsibilities, seeks to enhance information sharing, and delivers a more seamless provision of services.⁸³

145. The Collaboration Agreement also makes provision for a 'Suspected Death by Suicide Response' as follows:

7.3. Following a death by suicide, Congress will facilitate (within 24 hours of a death notification) a Death by Suicide Response Inter-Agency Meeting. The purpose of this meeting is to ensure a coordinated and effective response to deaths by suicide in the Central Australia region. The CNM Community Teams, MHAODS will be the primary liaison to coordinate appropriate MHAOD attendance.

8. Suspected Death by Suicide Response

8.1 The Suspected Death by Suicide Response establishes a clear and structured framework for the exchange of timely and accurate information, ensuring a coordinated and effective response to possible deaths by suicide in the Central Australia region.

8.2 A meeting will be called upon a timely NT Health notification of a death by suicide, suspected death by suicide, or high impact suicide attempt within the Central Australian region.

8.3 The Parties to this Agreement agree to be core response members and will ensure requirements of the response are met accordingly. The core response member positions are;

- a) CNM Community Teams (in consultation with Aboriginal Cultural Advisor), MHAODS
- b) Suicide Prevention Manager, Congress

8.4 Congress is the governing service for Suspected Death by Suicide Response, with necessary and appropriate documentation provided to core response members.

80 T194 (D. Sullivan)

81 T 241 (Johnson)

82 Exhibit 5

83 T269 (J. Boffa); Exhibit 5

146. Dr Boffa also told me about Culture Care Connect,⁸⁴ a nationally funded program for suicide prevention services and after-care following a suicide. Congress delivers the Culture Care Connect program through its Social & Emotional Wellbeing team. Congress's Suicide Prevention Team received an excellence in Aboriginal and Torres Strait Islander health award in 2025. Dr Boffa explained that prompt communication to Congress of suicide events by police, ASH or other health services would make this program more effective.⁸⁵

Formal Findings

147. Pursuant to *section 34 of the Coroner's Act*, I find as follows:

- a. The identify of the deceased was Anthony Rubuntja born 31 January 1978 in Alice Springs, Northern Territory.
- b. He passed away on 15 November 2023. He was declared deceased at 9.21am on 19 November 2023.
- c. The cause of death was suicide by hanging.
- d. The deceased was an Aboriginal man.
- e. The particulars required to register the passing will be provided to the Office of Births, Deaths, and Marriages.

Recommendations

Recommendation No. 1

I recommend to the **Northern Territory Government and the Department of Health** that they take immediate steps to modernise mental health legislation for the Northern Territory by diligently finalising a new Mental Health Act through to commencement within 12 months of publication of these findings; noting the extensive consultation and drafting already undertaken.

⁸⁴ <https://www.naccho.org.au/culture-care-connect/>

⁸⁵ T270 (J. Boffa)

Recommendation No. 2

I recommend to the **Department of Health** that it should take steps (including by way of seeking legal advice) to:

- a) clarify the scope and application of section 34 of the *Mental Health and Related Services Act* 1998 and the *Form 9*. Specifically concerning s34(3) and s34(8), NT Health should clarify who can exercise s34(3) powers and in what circumstances; and
- b) all applicable policies, procedures, training, and the *Form 9* should be reviewed (and amended if necessary) to ensure conformity with the correct application of s34.

Recommendation No. 3

I recommend to the **Department of Health** that it ensures that all security guards used for mental health patients have received appropriate training specifically in the task of guarding a mental health patient and can demonstrate:

- a) cultural competency,
- b) an understanding of relevant principles, their powers and the limitations of their powers under the *Mental Health and Related Services Act* 1998 (or its replacement Act),
- c) de-escalation skills, and
- d) reasonable use of force.

Recommendation No. 4

I recommend to the **Department of Health** and **Central Australian Aboriginal Congress Aboriginal Corporation (Congress)** in furtherance of their Collaboration Agreement, or otherwise, that they together consider whether there is a role for Congress in respect of Alice Springs Hospital (ASH) High Risk Take Own Leave (TOL), and if so, implement policies and procedures to clarify and facilitate that role.

Recommendation No. 5

I recommend to the **NT Police Force** that it actively consider expanding the role of Aboriginal Community Police Officers (ACPO) and Aboriginal Liaison Officers (ALO) when responding to requests for assistance to locate an Aboriginal person, including responsibilities for ensuring appropriate and timely communication with families of those persons.