CORONERS ACT, 2003

SOUTH  *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Ceduna and Adelaide in the State of South Australia, on the 14th, 15th, 18th, 19th and 20th days of July 2011 and the 4th day of November 2011, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the deaths of Kunmanara Kugena (female), Kunmanara Windlass, Kunmanara Peters, Kunmanara Kugena (male), Kunmanara Gibson and Kunmanara Minning.

The said Court finds that Kunmanara Kugena (female) aged 39 years, late of the Yalata Community, South Australia died at Ceduna Hospital, Eyre Highway, Ceduna, South Australia on the 27th day of February 2004 as a result of pneumonia, cardiomyopathy, chronic obstructive airways disease and non insulin dependent diabetes mellitus.

The said Court finds that Kunmanara Windlass aged 33 years, late of Town Camp via Ceduna, South Australia died at the Queen Elizabeth Hospital, 28 Woodville Road, Woodville, South Australia on the 17th day of April 2005 as a result of septic shock due to pneumonia.

The said Court finds that Kunmanara Peters aged 36 years, late of the Yalata Community, South Australia died at Ceduna Hospital, Eyre Highway, Ceduna, South Australia on the 3rd day of September 2005 as a result of right lung abscess and right pneumonia.

The said Court finds that Kunmanara Kugena (male) aged 42 years, late of the Yalata Community, South Australia died at Kuhlmann Reserve, Kuhlmann Street, Ceduna, South Australia on the 20th day of November 2005 as a result of lobar pneumonia.

The said Court finds that Kunmanara Gibson aged 38 years, late of the Yalata Community, South Australia died at the area known as 18 Tank, near Ceduna, South Australia on the 14th day of July 2009 as a result of gastrointestinal haemorrhage with contributing alcoholic liver disease.

The said Court finds that Kunmanara Minning aged 41 years, late of the Yalata Community, South Australia died at the area known as 18 Tank, near Ceduna, South Australia on the 5th day of October 2009 as a result of cardiomegaly and alcohol-related seizure activity.

The said Court finds that the circumstances of their deaths were as follows:

1. Introduction and background

1.1. The town of Ceduna lies on the west coast of South Australia. It is situated at a relatively remote location being approximately 400 kilometres from Port Lincoln at the foot of the Lower Eyre Peninsula. Ceduna is situated approximately 500 kilometres from the town of Whyalla on the western side of the Spencer Gulf. The Ceduna and Thevenard conjoined townships have a population said to be between 3,500 and 4,000 people. Various figures have been given in respect of the proportion of Aboriginal people residing in the Ceduna community, but it is accepted that at any given time somewhere between 20% and 30% of the regions' population are indigenous people. Many of the indigenous population reside permanently in Ceduna.

1.2. There are a number of Aboriginal communities to the west of Ceduna. The Yalata community is situated approximately 200 kilometres to the west of Ceduna. The Oak Valley community is situated approximately 300 kilometres north from Yalata. It is said that the people belonging to those communities maintain a traditionally Aboriginal lifestyle. The indigenous populations of these communities belong to the

Southern Pitjantjatjara people, sometimes known as the Anangu people. The evidence varied as to the populations of Yalata and Oak Valley at any given time, but it is fair to say that the populations are counted in hundreds rather than thousands.

1.3. Both of these communities are 'dry', and bans exist in respect of the possession and consumption of alcohol within the confines of either community.

1.4. Although both Yalata and Oak Valley have permanent dwellings established at those locations, there is nevertheless an element of transience in the lifestyle of their residents. For some considerable period of time members of these communities have travelled to Ceduna and have remained there for extended periods of time and for different reasons. These have included climactic factors such as the need to avoid the heat during the summer months. There are cultural reasons that explain the presence of some members of these communities in Ceduna. Some use Ceduna as a meeting place and as a central service centre to access health and other government facilities. But there is overwhelming evidence to suggest that, to their detriment, they also come to Ceduna in order to access the cheap supply of strong alcoholic beverages that are locally available. The alcoholic beverages of choice are said to consist of fortified cask wine such as port, and cheap cask wine of other descriptions. There have been conditions imposed upon the licences of the region's licensed liquor outlets that have been designed to restrict or control the sale or supply of liquor to persons whom the licensee has reasonable grounds to suspect reside at or are travelling to Oak Valley or Yalata Reserve. Other voluntary control measures have related to the times of the day at which fortified wines can be sold and in respect of the number of units of alcohol that can be sold to one person, either on foot or in a vehicle.

1.5. These measures have not been successful in curbing alcohol abuse among the transient indigenous population. Over the years visiting indigenous people appear to have had little or no difficulty acquiring strong alcoholic beverages in casks and, as witnessed by this Court during its site visit in and around Ceduna, this is graphically illustrated by the presence of numerous discarded plastic wine cask bladders and containers littering the ground at a location near Ceduna at which Aboriginal people habitually congregate, camp and drink. It would be wrong to stereotype the entire indigenous population in this region as having drinking problems, but the evidence adduced before the Court establishes that there is without a doubt a severe and intractable culture of excessive alcohol consumption among the transient Aboriginal

population in Ceduna and that this culture is having a negative impact on the wellbeing and functionality of those people. The deaths that are the subject of these concurrently heard Inquests are cases in point.

1.6. Chronic ill health and self neglect is also an issue among these populations. I heard evidence that hospital discharge prior to the completion of treatment and against medical advice is a common trait amongst Aboriginal persons in Ceduna. One possible underlying factor involved in this is that among Anangu people a hospital admission bears a connotation of imminent death, but the onset of alcohol withdrawal and the need to 'self-medicate' with alcohol is suggested as being one of the more prosaic reasons[1].

1.7. As will be seen, there are striking parallels between the deaths that are the subject of these Inquests, and the background against which they occurred, and the situation in this region as it existed 20 to 30 years ago as revealed by the investigations of the Royal Commission into Aboriginal Deaths in Custody in 1990. It was at that time recognised by the Commission that alcohol misuse amongst the Aboriginal community on the west coast in general was a serious problem and that it had played a role in the life and death of an Aboriginal person who had died from natural causes in police custody in Ceduna and whose death was one of the subjects of investigation by the Commission.

1.8. The townships of Ceduna and Thevenard have for some years now been declared a dry zone, meaning that alcohol is forbidden to be consumed in the public areas of those locations. The restriction is enforced. It is universally accepted that the dry zone has appropriately been maintained, but one of its consequences is that transient Aboriginal persons who are minded to drink alcohol to excess do so at locations outside the confines of the Ceduna and Thevenard town areas, which for myriad reasons all adds to their vulnerability. Most notably and relevantly as far as the matters with which this Inquest is concerned, they congregate at a location known as '18 Tank' which is a flat, desolate and pitiless area of land some 2 or 3 kilometres outside of the Ceduna township. It will be borne in mind that the habitués of this location are in the main not locally resident and either do not have access to housing within the townships or, if they do, choose to occupy camping places such as this notwithstanding. They sleep rough at this location at all times of the year and are

[1] Transcript, page 429

vulnerable to the elements. They bring with them their sicknesses and morbidities, all aggravated by continual self neglect and the excessive consumption of locally accessed cheap alcohol. Some of them have perished as a result. That such a situation has continued to develop for so long and still exists despite well intentioned attempts at alleviation is difficult to comprehend. Although it is said that these communities lead a 'traditional' lifestyle, the degradation that alcohol brings to their way of life is manifestly incompatible with the dignity that one would normally accord such a concept. Counsel assisting the Court Ms Amanda Taylor suggested to the Court that the conditions in which these people exist should not exist in today's world and are especially unacceptable in a modern and affluent society such as ours. It is hard to disagree.

1.9. Located in Ceduna is the Wangka Wilurrara Transitional Accommodation Centre (TAC). The Centre is commonly known as the Town Camp. The Town Camp has been in existence since approximately 2004. The land upon which the Town Camp is situated is owned by the Ceduna Council. The land is currently leased to Housing SA which is a division of the Department for Communities and Social Inclusion (as it now is). The Town Camp was originally set up as a joint Housing Trust of SA, ATSIC and Ceduna Council program. It has provided, and continues to provide, a worthwhile service. Its purpose has been to provide a safe campsite for Aboriginal people from Yalata, Oak Valley and other communities when these people come to Ceduna. The Town Camp was originally set up to offer two programs, being a short time stay and a structured integration type arrangement where support workers would assist vulnerable clients. The short stay was originally envisaged to be for a period of two weeks. The second program was a transitional program to assist residents to integrate into the Ceduna community and to provide assistance with accessing health and other services. Its aim was to move the clients through a Safe Tracks program into more permanent housing in Ceduna. The Town Camp is situated on approximately 40,000 square metres of land. It is fully fenced. It is situated on Goode Road, a short distance from the Ceduna township proper. On the site there is an administration block that includes a registration office, communal and homestyle kitchen and dining areas. Residents are not permitted to sleep in that building. The resident accommodation consists of a number of double living units on the site that have a bedroom area at each end with a breezeway containing a fire pit or cooking barbecue between those rooms. Each room is setup to accommodate up to four

people. These rooms are often allocated to families with children. Units can be allocated to single people based on needs that might involve cultural reasons, frailty, vulnerability or other complexities as identified by TAC staff. The units are permanent structures. They are airconditioned and have running water available. Inside there are beds with mattresses and bedding is available to residents as part of the registration process. The second type of resident accommodation at the Town Camp is a variant of a traditional Aboriginal shelter known as a Wiltja. These shelters consist of a circular steel frame that is less than 2 metres high and sits on hard packed earth. It is covered with canvas which is resistant to fire and water. There are approximately 18 Wiltjas erected. Some are erected on an as needs basis. The sheltered sleeping capacity of the entire facility is about 70 people, although some residents choose to camp on the site without formal shelter so that figure might increase. At times 90 people have been camped on the site. This would most likely have occurred during extremes of weather. Residents are charged $6 per night. They are provided with shelter and food.

1.10. The other aims of the Town Camp include the provision of opportunities for residents to access onsite health, community and recreational services and activities and to provide transition to facilitate residents returning either to their communities or to other suitable long term housing. The Town Camp caters for people of Aboriginal and Torres Strait Islander descent. The guideline for the length of time over which people may stay at the Town Camp is 12 weeks, although this can be extended with management approval. Most residents identify themselves as belonging to a regional community.

1.11. Residents are not permitted to drink or possess alcohol within the Town Camp. However, in accordance with current guidelines, if a person comes to the Town Camp seeking accommodation and is intoxicated, they will be allowed entry provided that they are not aggressive or violent. If the person is grossly intoxicated and there are concerns for their wellbeing and welfare, attempts are made to have them seen at the Ceduna sobering up unit which is located at the rear of the Ceduna Hospital. I will describe the sobering up unit in more detail later in these findings. Residents are also expected to comply with codes of behaviour. The salient behavioural feature of the Town Camp is its strict policy of being alcohol free. A breach of the policy might result in exclusion from the Town Camp although, as I understood the evidence, the

period of exclusion is significantly shorter than it was in earlier times of the camp's existence.

1.12. I have already alluded to the existence of the area known as 18 Tank. This area of land is situated to the north east of the Town Camp and is separated by a distance of approximately 2 kilometres. This location also abuts Goode Road. It was said in the evidence that it takes approximately 30 minutes to walk between Town Camp and 18 Tank. The area of land known as 18 Tank is outside the confines of the Ceduna and Thevenard dry area and so drinking of alcoholic beverages takes place there. This site has no facilities, although a trailer with a water tank is from time to time placed there. Recently an emergency telephone has been established at the location. I was told that the number of occupants camping at 18 Tank is heavily influenced by cultural business in the community, such as funerals, and for reasons of personal choice. There are no alcohol restrictions at 18 Tank and it is a location known for rough sleeping and alcohol consumption. In July 2009 an initiative was undertaken in order to induce persons residing at 18 Tank to move to the Town Camp. The initiatives included the provision of free food and accommodation for a period of time. I understood that since that time the Town Camp has been occupied more fully than in the past. Nevertheless, the area known as 18 Tank is still used, for the most part, for the purpose of consumption of alcohol. Staff from the Town Camp from time to time engage with persons situated at 18 Tank offering accommodation services and checking on their wellbeing.

1.13. Aboriginal persons move between 18 Tank and the Town Camp usually on foot. Whereas the Town Camp might be a suitable place for accommodation, its residents might well choose to spend time at 18 Tank for the purposes of drinking. The movement between the two areas was said roughly to coincide with meal times. Intoxicated persons moving on foot between the two locations are vulnerable to the dangers presented by vehicular traffic along Goode Road.

1.14. I have mentioned the sobering up unit situated at the rear of the Ceduna Hospital. This premises, which provides bedding accommodation for five persons, is currently operated by the Ceduna Koonibba Aboriginal Health Service (CKAHS). It is open four nights per week, Monday to Thursday, between the hours of 6pm and 8am. Intoxicated Aboriginal persons might come to the sobering up unit in varying circumstances that might include self-referral, conveyance by way of the Mobile

Assistance Patrol (MAP) which is a bus service, or by way of police involvement. Patients are provided with a bed, their clothes are washed and they are provided with food in the morning. Many of them leave well before 8am. I was told in evidence that a breath alcohol analysis is conducted upon admission and that very frequently breath alcohol concentrations exceed 0.25% which is a substantial, if not gross, level of intoxication. Thus it is that persons may still be under the influence of liquor when they leave the following morning. It is important to note that this sobering up unit, so called, is not a declared sobering up centre for the purposes of the Public Intoxication Act 1984. The unit does not provide any detoxification, withdrawal treatment or alcohol rehabilitation services. I found during the Inquest that the persons who run the unit clearly have a genuine concern for the individuals who come to it and are frustrated that they cannot do more. I will discuss the operations of the Ceduna sobering up unit in more detail in these findings.

1.15. I make it plain that in delivering these findings I imply no criticism of the populace of the towns of Ceduna and Thevenard nor of their governing bodies.

2. The six deaths the subject of the Inquest

2.1. These are concurrent Inquests into the deaths of six Aboriginal persons, each of whom had a connection with the Yalata community or Ceduna or both. Severe alcohol abuse played a part either in the life or the death of these individuals. Although alcohol intoxication was not the anatomical cause of death in any particular case, each of the six persons died at a relatively young age from the effects of comorbidities that either had a demonstrable association with chronic or acute alcohol abuse or were the subject of neglect due to the alcoholic lifestyle of the individual concerned. In each case there was an element of homelessness and rough living associated with their lifestyles at the time of their deaths. As indicated earlier they represent cases in point illustrating the profound dysfunctionality of the communities in which they lived, caused for the most part through alcohol abuse.

2.2. As part of these Inquests I also enquired as to whether in an individual case procedures or requirements as they had existed at the Ceduna Town Camp or at other service providers may have contributed to or otherwise have formed part of the circumstances of the death.

2.3. In certain circumstances in traditional Aboriginal culture it is customary to avoid using the first name of a deceased Aboriginal person. Accordingly, I shall refer to each deceased person as Kunmanara.

2.4. The circumstances of the death of Kunmanara Kugena (female)

Kunmanara Kugena, a woman of 39 years of age, died on 27 February 2004 at the Ceduna Hospital. The cause of death as noted on her death certificate is pneumonia for three days, cardiomyopathy for two years, chronic obstructive airways disease for three years and diabetes for five years. I find that to have been the cause of her death.

2.5. Kunmanara Kugena was born on the Anangu Pitjantjatjara Yankunytjatjara (APY) Lands in the far north west of the State and she grew up in camps. In her earlier years she had been a heavy binge drinker, as was her partner who also had a serious drinking problem. In their earlier years they would both sleep rough on a regular basis. In her later years Kunmanara Kugena became too ill to drink and was too unwell to sleep out.

2.6. Kunmanara Kugena suffered airway disease from early childhood. Recurrent chest infections developed into bronchiactesis. She also had a long history of cigarette smoking until breathing difficulties forced her to cease in the year 2000. Treatment for chronic obstructive airways disease required the use of bronchodilators and steroid puffers. She was diagnosed with non insulin dependent diabetes at the age of 25. In 2003 she was diagnosed with an enlarged right ventricle of the heart and cardiomyopathy. As a result of these conditions, Kunmanara Kugena had an extensive treatment history as both an admitted patient and an outpatient dating back to 1984. Her history of alcohol abuse in the mid to late 1990s resulted in her becoming a client of the Ceduna sobering up unit. Records also indicate that she was irresponsible with self-medicating procedures and that she regularly absconded from hospital treatment.

2.7. Most recently prior to her death Kunmanara Kugena had been staying at the Ceduna Town Camp. Prior to that she had been staying with her partner at what is known as the A1 Cabins in Ceduna. Those cabins were used by the Ceduna Hospital Step Down Unit when the Unit proper was full. While Kunmanara Kugena was staying in the Town Camp it was noticed that she had extreme shortness of breath. She was using oxygen and steroid puffers but neither provided any significant alleviation of

her symptoms. On the morning of 26 February 2004 she was taken from the Town Camp by ambulance to the Ceduna Hospital Accident and Emergency Department. She arrived at approximately 8:05am. At 8:25am she was diagnosed with bilateral pneumonia. She was admitted to acute care at the hospital. Her condition steadily deteriorated throughout the day and evening. At 11:55pm that night Kunmanara Kugena suffered a cardiac arrest and at 12:47am on 27 February 2004 she was pronounced life extinct.

2.8. Kunmanara Kugena's death was investigated by police. I have had the benefit of a thorough report regarding the circumstances of her death compiled by Sergeant Dave Walker of SAPOL. At the time he compiled his report he was a Brevet Sergeant with the Ceduna Criminal Investigation Branch[2]. I accept the analysis set out in Sergeant Walker's report.

2.9. An examination of the Ceduna District Health Services and the CKAHS files[3] reveals that Kunmanara Kugena suffered from several life threatening comorbidities. She had a number of admissions to the Ceduna Hospital. In July 2003 Kunmanara Kugena was admitted to the Ceduna Hospital with a diagnosis of cor pulmonale which is a serious condition involving a degree of heart failure, but she absconded after three days. One day later she re-presented with pneumonia. There were a number of admissions in July, August, September, October and December of 2003 involving cor pulmonale and chest infections. In January 2004 she was admitted with a principal diagnosis of cardiomyopathy, chronic obstructive airways disease and a serious chest infection. She discharged herself on this occasion against the advice of clinicians. There was a further admission later in January with infective exacerbation of chronic obstructive airways disease.

2.10. Her final admission was the one I have described on 26 and 27 of February 2004 when she died. There were many attendances in 2003 at the CKAHS Clinic with various symptoms of a respiratory nature.

2.11. Although Kunmanara Kugena rarely consumed alcohol in the last six years of her life, she had been brought by police to the Ceduna sobering up unit on a number of occasions in the 1990s with moderate to high blood alcohol concentrations.

---

[2] Exhibit C0a
[3] Exhibits C59, C59a, C59b and C61

2.12. A Mr Zane Gunter[4], who is a registered nurse and family relative of the deceased was, at the time of Kunmanara Kugena's death the Manager of the Town Camp. He was present at the camp on the day Kunmanara Kugena was taken to hospital prior to her death. In his statement Mr Gunter described Kunmanara Kugena as being a traditional Aboriginal person who, in company with her life companion, lived a transient lifestyle for most of her youth. This was so despite the fact that she suffered from life threatening illnesses from an early age. In due course her progressive illnesses were such that she did not sleep rough during the later stages of her life. She had acknowledged earlier in her life that if she drank alcohol she would end up in hospital.

2.13. There is no suggestion that Kunmanara Kugena's death was contributed to by exclusion from any services in or around Ceduna.

2.14. <u>The circumstances of the death of Kunmanara Windlass (male)</u>

Kunmanara Windlass was 33 years of age when he died on 17 April 2005. He was a member of the Yalata Aboriginal community. He died of septic shock and pneumonia at the Queen Elizabeth Hospital. I find that to have been his cause of death.

2.15. Medical records reveal that Kunmanara Windlass[5] suffered from previous bouts of pneumonia, was an alcoholic and had cirrhosis of the liver. He had been admitted to hospital with pneumonia on two occasions prior to the occasion of his death. Kunmanara Windlass tended to be non-compliant with taking medication and would abscond or discharge himself from hospital before completing treatment. Kunmanara Windlass also experienced police attention during his life. He had been repeatedly arrested for being intoxicated and causing disturbances. He attended hospital regularly with injuries caused from fighting with others, from walking on glass, from burns, abscesses and the like. Most recently, in March of 2005, Kunmanara Windlass had attended at the Ceduna Hospital on two occasions with pneumonia and chronic liver disease with difficulty breathing. There was blood present in his sputum. He discharged himself against medical advice after three days despite an offer from medical staff that he have a few hours leave per day. Four days later he was again at the Ceduna Hospital with shortness of breath and again he self discharged before completion of treatment for pneumonia.

---

[4] Exhibit C54a
[5] Exhibit C64, C66, C67, C68 and C69

2.16. That alcohol had a significant impact on Kunmanara Windlass' life is evidenced by arrests for behavioural offences and apprehensions under the Public Intoxication Act over the years. In July 2004 he had been apprehended for breach of bail for drinking alcohol within 200 metres of the Town Camp. In September 2004 he was seen to be causing problems in Ceduna due to intoxication, as a result of which he was taken to the sobering up unit. In September 2004 he was arrested for driving under the influence in Ceduna with a blood alcohol reading of 0.313%. It was said in respect of Kunmanara Windlass that he was in the habit of camping alone. He was a petrol sniffer as well as an abuser of alcohol and was constantly ill. It is said that he would sooner sit outside in the rain and drink alcohol than seek shelter in the Town Camp[6]. Evidently Kunmanara Windlass was camping, possibly for as long as three weeks, prior to his death in scrub near the Town Camp.

2.17. The report of the Investigating Officer, Senior Constable Roberts from the Ceduna Criminal Investigation Branch[7], suggests that restrictions placed on the availability of alcohol within the Yalata and Oak Valley communities has had the effect of alcoholics moving to towns such as Ceduna to acquire liquor. It is suggested that Kunmanara Windlass' case exemplifies this. Mr Gunter, to whom I have already referred, also suggested that Kunmanara Windlass was a chronic alcoholic who would drink himself into a stupor and would fall where he was drinking and pass out.

2.18. Kunmanara Windlass was a user of the sobering up unit in Ceduna at times between 1999 and 2004. Most recently prior to his death he had attended at the sobering up unit in the early hours of the morning of 15 April 2005 but was unable to be accommodated because the unit was already full with five clients.

2.19. As far as Kunmanara Windlass' residence from time to time at the Town Camp is concerned, he stayed there on occasions between June 2004 and March 2005. Records suggest that he resided in breezeways and attended for meals. In the weeks leading up to his death he resided at the Town Camp either in a tent or in a breezeway. On 6 April 2005 Kunmanara Windlass was refused entry into the Town Camp for three weeks because he was caught with a cask of wine in his left sleeve and, when asked to leave, he refused. It is said that the police attended and located him lying near a tent where he was arrested under the Public Intoxication Act and

[6] Statement of Edwin Joseph O'Loughlin, Exhibit C13
[7] Exhibit C14

lodged in the Ceduna police station cells. On 12 April 2005 he was again seen at the Town Camp but was walking out when police attended.

2.20. It appears that it was from that point onwards that Kunmanara Windlass slept rough in the scrub near the Town Camp, although he was reported to have his own bush and blanket. He was sighted in Ceduna on the foreshore and at that time his blanket was wet as it was raining. In many ways Kunmanara Windlass' circumstances of rough sleeping were the product of his alcoholism insofar as the reason for his exclusion from the Town Camp on 6 April 2005 was due to alcohol related issues, as was a further incident as described on 12 April 2005. Kunmanara Windlass' most recent brush with the law was on the evening 14 April 2005 when he was apprehended under the Public Intoxication Act and in the first instance taken to the police cells. He would later present at the sobering up unit which, as seen, was then full with five clients.

2.21. Information obtained from the Ceduna office of the Commonwealth Bureau of Meteorology indicates that the weather in Ceduna in the days preceding Kunmanara Windlass' death was mild to cold with temperatures around 20°C or less.

2.22. On the day that Kunmanara Windlass presented on the final occasion to the Ceduna Hospital, namely 15 April 2005, he had been seen at the sobering up unit with a wet blanket wrapped around himself and, although he could not be accommodated, he had been offered food but would not eat it. He had gone to the Ceduna township foreshore where he sat on the lawn for some time. He presented at the Ceduna Hospital at about 8:20 that evening. The MAP bus had dropped him off at Accident and Emergency. He stated to the nursing staff that he had been lying down all day 'feeling crook and coughing up blood'. He looked pale, had rapid breathing and pulse with a moist cough and had traces of blood stained vomit and coughed up blood stained sputum. He was commenced on intravenous antibiotics. His condition deteriorated and he was retrieved to the Queen Elizabeth Hospital in Adelaide the following day. There he received respiratory and inotrope support for significant lactic acidosis. He passed away after continuing to deteriorate. His time of death was 9:45am on 17 April 2005.

2.23. It is pointed out in the report of Senior Constable Roberts[8] that notwithstanding Kunmanara Windlass' exclusion from the Town Camp from 6 April 2005 onwards, he would have had sleeping facilities available to him at premises in Ceduna, at least in the shed of that premises. It is believed that Kunmanara Windlass had stayed at that premises in the past and stayed there for two nights in the weeks prior to his death. The conclusion of the Investigating Officer, Senior Constable Roberts, is that regardless of what accommodation assistance that could have been provided to Kunmanara Windlass by the Town Camp, he would have elected to camp rough in any event. In short, there is no suggestion that the procedures followed by the staff of the Town Camp contributed to his death. That said, there seems little doubt that Kunmanara Windlass' lifestyle, dominated as it was by severe and frequent intoxication and the neglect of his own health, was a substantial contributor to his death.

2.24. <u>The circumstances of the death of Kunmanara Peters (male)</u>

Kunmanara Peters was 36 years of age when he died on 3 September 2005 at the Ceduna Hospital. The cause of death as expressed on Kunmanara Peters' death certificate is right lung abscess for three days and pneumonia for two weeks. I find that to be the cause of death.

2.25. Kunmanara Peters was a member of the Yalata Aboriginal community and, like many people from that community, he led a relatively transient lifestyle and regularly moved between Yalata and Ceduna.

2.26. Kunmanara Peters had a long history of ill health with repeated bouts of right upper lobar pneumonia in 1998, 2000, 2003 and 2004. He was diagnosed with non insulin dependent diabetes in 1998. Medical records[9] show that he has history of discharging himself from hospital against medical advice and was non-compliant with medication. He suffered from alcoholism. Kunmanara Peters' significant alcohol problem was noted at the Ceduna Hospital in January 2000 and July 2000. In addition, he was noted to be an alcoholic in March 2003 when he was admitted to the Ceduna Hospital from the sobering up unit with right sided chest pain and blood stained sputum, having been drinking alcohol for two to three days. In December 2004 staff of the CKAHS Clinic attended at the Town Camp where Kunmanara Peters complained of

[8] Exhibit C14
[9] Exhibits C30f, C74, C75, C76 and C78

sore feet and stated that he had left his medication back in Yalata two weeks previously. He had been drinking alcohol since arriving in Ceduna. Kunmanara Peters had utilised the services of the sobering up unit in January 2005. He had presented there on a night in February 2005 only to be turned away because of lack of availability of beds. Apparently he refused to leave on that occasion. On 12 February 2005 he attended the unit.

2.27. Records indicate that Kunmanara Peters stayed at the Town Camp at times between September 2004 and August 2005. He would stay in or near a tent or hut or a mattress near a fire in breezeways between huts. He occasionally ate meals provided by Town Camp staff. At one point he booked in to stay at the Town Camp short term, having been camping in the scrub at 18 Tank, but apparently he elected not to stay there for the entire two weeks that he was booked in for. On 4 January 2005 it is recorded that Kunmanara Peters broke camp rules by smashing an electric frying pan and throwing coals on other residents and their blankets. He was excluded from the Town Camp for a week on this occasion. Evidently he trespassed on 6 January 2005. On 10 June 2005 it was noted that Kunmanara Peters was sleeping by a fire with other persons in the middle of the night. At one point it was noted that, despite heavy rain, Kunmanara Peters continued to do this. On 13 June 2005 it is recorded that during the evening Kunmanara Peters was drunk, sitting out the front of the Town Camp. In July 2005 there are records suggesting that Kunmanara Peters stayed at the Town Camp mainly utilising breezeways between units. There are similar notations for August 2005. In particular, on 30 August 2005 which was only a few days prior to his death, he was listed as residing in the breezeway between units 9 and 10 at the Town Camp.

2.28. On 17 August 2005 Kunmanara Peters was arrested by police at the Town Camp for an alleged assault near the Town Camp. He was refused bail. While in police custody he complained of a headache and was taken to Ceduna Hospital for treatment that evening. He was seen to have a cough, fever and a headache. He was diagnosed as having a lower respiratory infection and was prescribed an antibiotic. He was medically assessed as being fit for police custody and was returned to the Ceduna cells. On 18 August 2005 he was transferred into Correctional Services custody and remained at the Port Augusta Prison until 29 August 2005. That day he was transported back to the Ceduna police station and appeared in the Ceduna Magistrates

Court on 30 August 2005 where he pleaded guilty to assault and was released with an order that he perform 80 hours of community service. Kunmanara Peters, as seen, is recorded on the Town Camp records as staying in the breezeway between units 9 and 10 on the evening of 30 August 2005. However, the records also show that at 4am on 31 August 2005 Kunmanara Peters was outside the gate wanting to come in but was refused entry. It is not known how and when Kunmanara Peters had left the Town Camp, or the circumstances of his returning and his refusal to be let in.

2.29. At approximately 6:50pm on 1 September 2005, police were tasked to a male person lying on the footpath outside a shop on Poynton Street, Ceduna. This person was Kunmanara Peters. He was very intoxicated and was apprehended by police under the Public Intoxication Act. He was taken directly to the Ceduna sobering up unit where he was accepted. Evidently Kunmanara Peters was at one point unable to stand due to his state of his intoxication. He had a shower and was fed. I do not understand that Kunmanara Peters was at any time taken to the Ceduna police station pursuant to the Public Intoxication Act. At approximately 12:30am on 2 September 2005, Kunmanara Peters insisted on leaving the sobering up unit and did so with a male friend by the name of Martin Gibson[10]. There were no means by which he could be detained there. At the time of leaving, Kunmanara Peters' clothes had not completely dried following their washing upon his arrival at the unit. After leaving the sobering up unit Kunmanara Peters and his friend separated and Kunmanara Peters walked towards the Ceduna foreshore area. Weather conditions that night were cold and windy. The Bureau of Meteorology statistics show that between 30 August and 1 September 2005, temperatures in Ceduna were approximately 10°C or less.

2.30. On the morning of 2 September 2005 Mr Gibson found Kunmanara Peters on the lawn foreshore area without any bedding. He complained of being sick and of having a pain in his chest. At approximately 11:15am Kunmanara Peters was driven to the Ceduna Hospital by a cousin. He was there admitted and diagnosed as suffering from right lobar pneumonia. He was treated by Dr Larty[11]. He said that he had been drinking alcohol for two days and had been sleeping outside in the cold. He was administered intravenous antibiotics over the next two days. On 3 September 2005 his condition deteriorated. He suddenly convulsed and became unresponsive. Attempts to revive him were unsuccessful and he was certified deceased at 5pm.

[10] Exhibit C15
[11] Exhibit C16

2.31. It is difficult to avoid the conclusion that Kunmanara Peters' severe deterioration leading towards his death was contributed to by his exposure to the elements in the period from the early hours of the morning of 31 August 2005 to his being taken to the Ceduna Hospital at 11:15am on 2 September 2005. The fact that he insisted upon leaving the sobering up unit shortly after midnight in wet clothes would not have assisted in this regard. I am in no way critical of the staff of the sobering up unit as I fully accept that Kunmanara Peters was insistent upon leaving the unit, notwithstanding the time of night, the dampness of his clothes and what apparently was no access to proper accommodation. The staff of the unit had neither the physical means nor the lawful authority to keep him there.

2.32. Kunmanara Peters' plight emphasises the need for sobering up facilities to have the capacity and authority to detain persons apprehended under the Public Intoxication Act until such time as those persons are able to make proper judgments in relation to their own welfare. The Ceduna sobering up unit was only a defacto facility, not declared under the Public Intoxication Act as a place in which persons incapable of looking after themselves because of intoxication could lawfully be detained. There is some uncertainty as to whether this has always been properly understood. One thing is certain and that is that the facility has not possessed the means to detain people or to prevent them from leaving. I am not critical of Ceduna police for conveying Kunmanara Peters to the sobering up unit, as opposed to the police cells, in the first instance. The officers were not to know what lay ahead in terms of Kunmanara Peters' poor exercise of judgment, and taking him to the sobering up unit was in any case the most compassionate thing to do.

2.33. <u>The circumstances of the death of Kunmanara Kugena (male)</u>

Kunmanara Kugena was 43 years old when he died on 20 November 2005. Kunmanara Kugena actually died at a rough camping area in Kuhlmann Reserve at Ceduna. His cause of death was lobar pneumonia.

2.34. Kunmanara Kugena was a resident at Yalata with his partner, Ms Audrey Peters[12].

2.35. Kunmanara Kugena was first diagnosed with pneumococcal pneumonia in 1983 when he was admitted to hospital coughing up blood. He was admitted to hospital several

[12] Exhibit C31

more times with pneumonia in the course of his life and the records[13] indicate that he too was a reluctant patient and would abscond from time to time. There are two examples of this. Firstly, in January 2003 he attended at the Ceduna Hospital one evening with a lacerated finger that he said he had sustained whilst breaking up a fight that morning. The laceration was deep and dirty and clearly required immediate attention. Kunmanara Kugena indicated that he had not come into the hospital prior to this time because he had been drinking. Indeed, a blood alcohol examination revealed a level of 0.335%. On this occasion Kunmanara Kugena disappeared before treatment could be administered. Secondly, on 11 December 2004 he had presented at hospital with his partner. He was coughing and had a chest infection and fever. Kunmanara Kugena became anxious when advised that he would need to stay in hospital for observation and antibiotic treatment and he then absconded.

2.36. In October 1999 blood tests had revealed that Kunmanara Kugena had chronic liver disease. He apparently then embarked on a program of detoxification that involved him regularly attending a clinic. On this occasion there is an indication that he may have remained alcohol free for at least one month.

2.37. Information derived during the police investigation of this matter indicated that Kunmanara Kugena and his partner preferred to camp outside and rarely stayed inside buildings. There are records of several attendances by Kunmanara Kugena and his partner at the Town Camp in the year 2005. For the most part the accommodation utilised consisted of wiltjas, tents and open breezeways. There is one particular entry for 10 June 2005 that suggests that he stayed in a breezeway that night with three other persons on a very cold and wet evening. There is a similar entry for the night of 13 June 2005 and on this night it is recorded that he and his partner were fighting and that he was intoxicated.

2.38. The evidence from Town Camp records[14] suggests that difficulty was encountered in respect of Kunmanara Kugena's behaviour from time to time. There was an exclusion in April 2005 for jumping the fence, following which he was located on the premises notwithstanding his exclusion. There was a further exclusion in July 2005 for a supposed period of six weeks during to slamming a door on a worker's hand and throwing rocks at a vehicle and worker. However, following this there are a number

[13] Exhibits C71 and C73
[14] Exhibit C70

of instances of his attendance at the Town Camp in July and August. The day following his exclusion he was apprehended by police at Town Camp for allegedly causing trouble as he had nowhere to sleep and was grossly intoxicated. Yet on 26 July 2005 he is recorded as actually staying in a breezeway at the Town Camp. On 9 August 2005 Kunmanara Kugena was arrested for assaulting his partner while they were sitting around a fire outside of the Town Camp. On another occasion in August 2005 there was a notation regarding his having jumped the gate. There was a further period of exclusion in October 2005 that ended on 7 November 2005. On that day Kunmanara Kugena is recorded as having stayed in a breezeway with three other residents.

2.39. On the evening of 9 November 2005 a fight occurred outside the gate of the Town camp. It allegedly involved Kunmanara Kugena, his partner and others. As a result of this disturbance Kunmanara Kugena and his partner were excluded from the camp. Kunmanara Kugena was arrested by police later that night when he was found asleep in a breezeway notwithstanding his exclusion. He is recorded as having been moderately to grossly affected by alcohol. The following morning he was released from police custody on bail with a condition that he reside at Yalata.

2.40. Information obtained from Kunmanara Kugena's partner indicates that from that point onwards to the date of his death, 11 days later, he camped rough in scrub near the perimeter of the Town Camp. During this time his health steadily declined, he was having difficulty breathing and was not eating. Ms Peters tried to encourage him to see a doctor but he refused, stating that he just wanted to go home to Yalata. On the night of his death Ms Peters slept next to him in order to keep him warm. In the early hours of the morning it was apparent that Kunmanara Kugena was unable to breathe properly or stand. Kunmanara Kugena was described by other witnesses as having difficulty breathing and at one point shook as if he was having a fit. An ambulance was called for, although there was some difficulty describing the location. Kunmanara Kugena died at the scene and was certified life extinct at the Ceduna Hospital later that day.

2.41. On the night of Kunmanara Kugena's death the minimum air temperature was 9.1°C. The maximum air temperature was 21.7°C. There was no rain.

2.42. There is an indication in the evidence that Kunmanara Kugena preferred to sleep outside in the fresh air, regardless of the weather conditions and regardless of whether he was at Town Camp or not. Mr Zane Gunter, the previous Manager of the Town Camp, stated that Kunmanara Kugena was an habitual binge drinker and regularly abused alcohol. According to Ceduna Health Service records, he suffered from alcoholic withdrawal and was admitted to hospital. Mr Gunter suggests that Kunmanara Kugena was subject to Aboriginal Tribal Law which commands men to sleep outside to be at one with the Land. The investigating police officer, Senior Constable First Class Mary Octoman of the Port Lincoln Criminal Investigation Branch, reached the following conclusion:

> 'Kunmanara Kugena's habit and desire to sleep outside throughout his life probably exacerbated his recurrent pneumonia. This, combined with his aversion to medical treatment, almost certainly hastened his death. I believe that health workers, community members and Kunmanara Kugena's family all tried to encourage him to seek medical assistance and to change his harmful lifestyle. Their attempts were not successful at altering Kunmanara Kugena's decisions.
>
> From the evidence at hand, I do not believe the procedures followed by the Transitional Accommodation Programme staff contributed to Kunmanara Kugena's death. I believe that regardless of what accommodation and assistance could have been provided to Kunmanara Kugena, he would have elected to camp rough and continue with his chosen way of life. Kunmanara Kugena's own decisions in relation to his health and lifestyle ultimately led to the circumstances of his death.' [15]

The conclusion expressed by Senior Constable First Class Octoman would appear to be a reasonable one.

2.43. <u>The circumstances of the death of Kunmanara Gibson (female)</u>

It will be noted so far that the deaths of the first four deceased persons with whom this Inquest is concerned occurred in 2004 and 2005. Lest those matters be regarded as having historical significance only, the pattern of involvement of alcohol and chronic neglect of health in the lives and deaths of transient Aboriginal persons in the Ceduna area is in more recent times demonstrable in respect of the death of Kunmanara Gibson, and indeed Kunmanara Minning, whose death I will deal with in the next section.

[15] Exhibit C41a, page 18

2.44. Kunmanara Gibson was 38 years of age when she died on 14 July 2009. The cause of her death at a pathology review was found to be gastrointestinal haemorrhage with contributing alcoholic liver disease. I find that to have been the cause of her death.

2.45. Kunmanara Gibson stayed at the Town Camp when in Ceduna from the Yalata community. The last occasion on which she utilised the Town Camp for accommodation was 6 June 2009. On this occasion she was brought to the Ceduna Hospital with first and second degree burns to her legs which had not been treated for some days and which by that time were malodorous.

2.46. Kunmanara Gibson was again admitted to the Ceduna Hospital on 15 June 2009 and presented with chronic vomiting after prolonged alcohol use. She was tachycardic with a blood pressure of 80 and a haemoglobin of 45, both of which are extraordinarily low. She was immediately transfused with two units of blood and retrieved to the Queen Elizabeth Hospital. Examinations were performed in an attempt to identify the source of the bleeding. She was admitted to the Intensive Care Unit where she was intubated and treated for alcohol withdrawal among other things including an ear infection and a chronic ruptured right eardrum. Kunmanara Gibson stabilised and was moved to a ward where she continued to improve. At one point, however, she had to be detained in order to complete intravenous antibiotic therapy.

2.47. On 25 June 2009 Kunmanara Gibson was discharged from the Queen Elizabeth Hospital to the Ceduna Hospital's Step Down Unit. Kunmanara Gibson then discharged herself against medical advice. From that point it appears that Kunmanara Brown slept rough at 18 Tank. There is no evidence that she presented at the Town Camp in the period leading to her death. Nor has any reason been identified to explain why she would not have done so. By 5 July 2009 Kunmanara Gibson had become increasingly unwell. The people with whom she had been camping at 18 Tank went to the Town Camp and asked that an ambulance be called. She was taken to the Ceduna Hospital where she was admitted. She presented with an alcohol reading of 0.27%. She was intoxicated, experiencing dehydration and had anaemia. Kunmanara Gibson was admitted and was provided with intravenous antibiotics and a plan for a several day admission. However, she refused to stay and left the following morning. It appears that she continued to sleep rough at 18 Tank for several days during which it was cold and raining and inevitably muddy. On the night before her death she reported that she felt unwell and went to lay down. The next morning she

arose, sat next to a fire and was reported to be crying and upset and in a lot of pain. Witnesses went to her tent and it was evident that Kunmanara Gibson had been incontinent. An ambulance was obtained but unfortunately she died enroute to hospital.

2.48. There is no suggestion that Kunmanara Gibson had been denied any services that might have alleviated her situation.

2.49. The circumstances of the death of Kunmanara Minning (male)

Kunmanara Minning was 41 years of age when he died on 5 October 2009. A post-mortem examination was conducted in respect of his remains by Dr John Gilbert, a forensic pathologist at Forensic Science South Australia[16]. Dr Gilbert has reported the cause of death as being cardiomegaly and alcohol-related seizure activity. I find that to have been the cause of Kunmanara Minning's death.

2.50. Kunmanara Minning had a past history of petrol sniffing, alcohol abuse and burns. He also had a history recorded at the Ceduna Hospital of alcohol related seizures for which he had been prescribed an anticonvulsant[17].

2.51. Kunmanara Minning had lived for the most part in Yalata with his partner and her sister. He had been a regular visitor at Town Camp in Ceduna where he had stayed five times since January 2009 for periods averaging about a week. He was registered at the Town Camp from 25 September 2009. He decided to stay in Ceduna until after the October long weekend of 3 to 5 October 2009, but there were five nights during that period that he did not return to Town Camp, including the nights of 4 and 5 October 2009. Rather, he camped at 18 Tank. Kunmanara Minning's partner stated[18] that they would drink two to three casks of port between them each day. She stated that Kunmanara Minning did not bring his anticonvulsant medication from Yalata as he did not think they would be staying in Ceduna as long as they did. She suggested that he go to the Ceduna Hospital to obtain medication but he did not do so.

2.52. On 5 October 2009 his partner thought that Kunmanara Minning looked unwell during the day. He had been drinking from a cask of port. During that evening he went to sleep on a mattress with his partner and at approximately 9:45pm she awoke

[16] Exhibit C49a
[17] Exhibit C83 and C83a
[18] Exhibit C48

to find him having a fit. She turned him from his back onto his right side and noticed that he was not breathing when the fitting had ceased. Another resident of the camp drove into Ceduna to alert the police and ambulance. Resuscitation was attempted by ambulance officers until the arrival of the local medical practitioner who certified life extinct.

2.53. Analysis of a specimen of blood obtained at autopsy reportedly showed a low blood alcohol concentration of 0.038%[19].

2.54. Dr Gilbert reports that Kunmanara Minning's death occurred in the context of the seizure on a background of previous alcohol related seizures. Many sudden deaths in epilepsy are believed to be mediated by cardiac arrhythmias and that Kunmanara Minning's cardiac enlargement may have predisposed cardiac arrhythmias in the context of a seizure. An external examination of Kunmanara Minning's body revealed that he bore extensive burn scarring around the neck and over the anterior aspect of his chest. Other areas of apparent burn scarring were noted over the medial aspect of the left upper arm and over both shins.

2.55. No reason has been identified as to why Kunmanara Minning did not reside at the Town Camp at the time of his death; the same applies in respect of Kunmanara Gibson. One can only surmise that the preference for accommodation at 18 Tank was borne out of a desire to drink having regard to the fact that Town Camp bans drinking on the premises.

2.56. There is no suggestion that Kunmanara Minning was denied any services that might have alleviated his situation.

3. Two further relevant deaths

3.1. The evidence also revealed that a further relevant death had occurred in respect of Kunmanara Windlass, a female Aboriginal person who was aged 53 years at the time of her death on 1 July 2009. This matter was reported to the State Coroner at the time of her death. The statement of Ms Irene Adair[20], who is the Housing SA Regional Manager of the Eyre and Western Region, and as such has overarching responsibility for the Town Camp in Ceduna, reveals that Kunmanara Windlass had been a regular

[19] Exhibit C50a
[20] Exhibit C90

resident of the Town Camp during 2009. In July 2009 Ms Adair became aware through Town Camp staff that Kunmanara Windlass had passed away in the Ceduna Hospital on 1 July 2009 from complications related to septicaemia. It appears that Kunmanara Windlass had travelled from the Yalata community and had been staying at 18 Tank prior to her hospital admission. She had not been at the Town Camp prior to her admission to hospital.

3.2. A post-mortem examination of Kunmanara Windlass was conducted by Dr Carl Winskog, a forensic pathologist at Forensic Science South Australia[21]. The post-mortem report reveals that Kunmanara Windlass had presented on 22 June 2009 with clinical radiological evidence of pneumonia and possible sepsis. She was tachycardic and admitted with a low grade fever. She received antibiotics but discharged herself prior to full treatment. She was brought back to the hospital three days later when treatment was resumed. Clinical improvement was achieved, but the patient deteriorated rapidly with increased respiratory rate and anxiety but without pain or fever. She complained of headache. She had a cardiac arrest on 1 July 2009 from which she could not be resuscitated. She

3.3. Kunmanara Windlass had a history of end stage cardiomyopathy and alcohol abuse, malnutrition, chronic lung infections and chronic suppurative lung disease. Dr Winskog expressed her cause of death as being haemorrhagic pericarditis and acute ischaemic heart disease, sepsis and pneumonia. He explains in his report that the haemorrhagic pericarditis may have been the result of a sepsis. He notes that Kunmanara Windlass had left the hospital during active treatment for pneumonia with earlier clinical signs of bacteraemia. Premature cessation of antibiotic treatment will result in regrowth of bacteria and a colonisation of bacteria in blood with sepsis. This is also more likely to happen in an individual with a previous history of sepsis, as in this case.

3.4. Although this death does not form the subject of a coronial Inquest, it is an obvious further case in point of alcohol having a negative and adverse involvement in the life and death of a person in the Ceduna area, occurring in very similar circumstances to the deaths of others. There is no suggestion that Kunmanara Windlass was denied any services that might have alleviated her situation.

[21] Exhibit C90c

3.5. The final death that is of relevance concerns the death of an Aboriginal male person aged 38 years on 4 March 2011. The male person was struck by a vehicle on Goode Road at Ceduna. Goode Road is the thoroughfare between the Town Camp and 18 Tank, separated by a distance of about 2 kilometres. On this occasion it appears that the Aboriginal male person had been run over by a car and had received multiple fatal injuries. An ambulance arrived on the scene at about 9:56pm and police arrived shortly afterwards. The toxicology results for the deceased reveal that he had been severely intoxicated at the time of his death. The evidence suggests that on 3 March 2011 the deceased had gone to 18 Tank with several other people from the Town Camp. They had gone there in the morning of that day. They were all drinking at 18 Tank and went from 18 Tank to the Town Camp just before 6pm. There the man had a supper of vegetables and chicken. A fair inference is that the man was struck by a vehicle when he was on foot travelling between the two locations. The evidence also suggested that there had been other incidents involving road traffic and Aboriginal persons moving between one location and the other. In any event, the male's death in March of this year would appear to provide further evidence of the devastating effects of alcohol on this indigenous community.

4. The current position in Ceduna

4.1. Mr Robert Spaan is an Operations Manager with Housing SA and is the Operations Onsite Manager of the Town Camp. He has held that position for just over two years. It struck me during his evidence before the Court that Mr Spaan was an insightful individual who had a firm grasp of the situation as it now exists in the Ceduna area. Mr Spaan explained that the Town Camp was established in late 2004 in recognition of the fact that there were a number of people coming down from remote areas, particularly Yalata and Oak Valley, who required accommodation as an alternative to sleeping rough. Mr Spaan explains some of the reasons why there is this transitional migration that includes the need to escape extreme temperatures inland and the securing of services that are available in Ceduna such as the hospital and other health services. Mr Spaan believes that currently there are approximately 100 to 200 people at Yalata and another 80 at Oak Valley.

4.2. Mr Spaan explained the current regulations in relation to drink on site. There is no consumption of alcohol permitted on site and residents are not permitted to bring alcohol onto the site. Alcohol located within the site it is destroyed. The person in

possession of the alcohol is warned and if the person is a repeat offender they may be excluded for a period of 24 hours. This represents a departure from procedures that existed some years ago which saw residents being excluded from the facility for extended periods of several days for alcohol or other behaviour based reasons.

4.3. Mr Spaan told the Court of the existence of drinking to heavy intoxication outside of the Town Camp and the behavioural problems that this engenders.

4.4. Mr Spaan also told the Court that a certain number of people elect to sleep rough such that at any given time, depending on the weather, there may be up to 40 or 50 people registered with the Town Camp with half of those electing to sleep elsewhere.

4.5. If residents are intoxicated they are still allowed to come on site, provided their behaviour is appropriate and they are not posing a risk to other residents. The facility accommodates approximately 80 people with an average occupancy over the last 12 months of approximately 33 persons per night. Mr Spaan told the Court that residents may be registered for periods of up to three months but that they might not necessarily stay at the facility for the whole of that period of time.

4.6. Mr Spaan also described the situation at 18 Tank to the north of the Town Camp. He acknowledged that the site was chosen for sleeping in the open because it was outside the town limits and that this enabled the occupants to drink alcohol. There are other reasons why persons might choose to occupy that location, but Mr Spaan acknowledged that primarily the bulk of the people who occupy that location go there to drink[22].

4.7. Mr Spaan suggested that it might not be appropriate to view these Aboriginal people as homeless having regard to the fact that they would not characterise themselves in that light owing to their nomadic and traditional lifestyles such that 'the bit of dirt that they're sleeping on that night is home'[23]. However, Mr Spaan acknowledged that the motivating factor involved in indigenous people coming to Ceduna from places such as Yalata is the availability of alcohol in Ceduna. Mr Spaan said:

> 'Most of our clients are addicted in some way or another to alcohol.' [24]

[22] Transcript, page 47
[23] Transcript, page 49
[24] Transcript, page 51

He suggested that local alcohol accords and alcohol management plans have not been successful. Mr Spaan suggests that the accord 'needs more teeth'[25]. The observations of the Court during the view at 18 Tank very much bears out the scenario that solid drinking of cheap cask alcohol takes place at 18 Tank.

4.8. Mr Spaan described 18 Tank in these terms:

> '18 Tank is an area of land which is crisscrossed with tracks and there's huge amounts of rubbish, there's no toilet facilities and people stay there for days. So it's an extremely unhealthy environment. People go there with young children as well and things like that and if there's drinking there's no controls, you know late at night there's fires randomly going. It can be a very unsafe environment for people and particularly no controls around intoxication or those sorts of things. So yeah, it's difficult to know exactly what to do. You've got traditionally people camped out but the level of intoxication and danger now means it should be reviewed.' [26]

4.9. Mr Spaan was aware of Ceduna Council policy that persons who came from Yalata or Oak Valley for short stays should be encouraged to go home. This still remains the view of Council.

4.10. Mr Spaan told me of the fact that persons who regularly live at the Town Camp may have alcohol related brain damage or liver disease or gastrointestinal illnesses as a result of drinking for many years. As well there is an incidence of diabetes.

4.11. Mr Spaan told the Court that on most nights there would probably be 20 or 30 severely intoxicated people within Ceduna. At times police are required to take those people away. Mr Spaan also told the Court that in his experience people drink solidly for up to five days at a time, after which they can become delusional and start to hallucinate. He suggested that approximately eight people might reach that stage of severe intoxication. His impression was that there would be between five and eight people of that kind in and around the Town Camp every week.

4.12. According to Mr Spaan, the location of 18 Tank adds to the vulnerability of the persons who attend there. It makes it difficult for ambulance and police to locate these persons, especially at night. Mr Spaan in this context also referred to the death on Goode Road in March of 2011, presumably due to the darkness and the intoxication of the person involved.

---

[25] Transcript, page 53
[26] Transcript, page 63

4.13. In Mr Spaan's experience the drinks of choice for Aboriginal persons who get to a serious stage of intoxication by the end of the week are Stanley Port, Fruity Lexia and Fruity Gordo.

4.14. The current position in Ceduna was also explained to the Court by Sergeant Peter Murray of SAPOL. Sergeant Murray is the general duty supervisor, otherwise known as the patrol sergeant, in Ceduna. He has been stationed there since October 2007. He provided a statement to the Inquest[27]. Sergeant Murray also gave oral evidence during the Inquest. Sergeant Murray spoke of the incidence of police being called out either to the Town Camp or 18 Tank and suggested that there would be a need to attend either place approximately once per day. Generally police attendances related to disturbances or reports of violent behaviour and sometimes reports of intoxicated people. Sergeant Murray suggested that a fair estimate of the average number of people at 18 Tank at various times of the year would be anywhere between 20 or 30.

4.15. Sergeant Murray also spoke of the dangerous movement of pedestrian traffic between 18 Tank and the Town Camp. He suggested that the people involved tended to be intoxicated because of the drinking that takes place specifically at 18 Tank. This movement roughly coincides with Town Camp meal times, which can involve intoxicated persons walking during periods of lower visibility such as sundown. And they invariably walk along the roadway itself.

4.16. Sergeant Murray opined that the most significant issue as far as policing in Ceduna is concerned is the alcohol abuse that exists among the indigenous and non-indigenous population. The transience of the indigenous population meant that the alcohol abuse in their case was much more visible.

4.17. Sergeant Murray recognised, as did others who gave evidence in the Inquest almost unanimously, that people come to Ceduna because of the easy availability of alcohol that was freely available to Aboriginal people in Ceduna, and in particular by way of cheap port in casks.

4.18. Sergeant Murray spoke of the use of the Public Intoxication Act 1984. He suggested that the Ceduna sobering up unit would be the first option considered for the depositing of intoxicated persons, but that frequently police were not able to take

[27] Exhibit C93

intoxicated people to that facility because it was either full or not open. Otherwise, in practical terms, there would be no other place to take these people apart from the police cells. When they are taken to the police cells they are subjected to a breath analysis test and they may be held, depending upon their degree of intoxication, for several hours.

4.19. The Court concludes that the current situation in Ceduna is no different from what it was at the time of the deaths with which these Inquests are concerned.

4.20. The Court also concludes that the Town Camp serves a worthwhile purpose in that it keeps those housed inside it reasonably safe and in any case much safer than if they were at places like 18 Tank.

5. The Ceduna sobering up unit

5.1. The Ceduna sobering up unit has been operated by CKAHS which, until 1 July 2011, was an entity of Country Health South Australia, a South Australian Government agency. As of that date CKAHS is a registered organisation under the Office of Indigenous Corporations under the Corporations and Aboriginal and Torres Strait Islander Act 2006 (C/w). The Chief Executive Officer of the CKAHS is Ms Kerry Colbung who provided a statement[28] to the Inquest and gave oral evidence. The current operations of the sobering up unit were explained by Ms Colbung in her evidence and also in the evidence of Ms Tanya Darke, who is the Program Manager of CKAHS.

5.2. The CKAHS took control of the sobering up unit in 2004. Prior to that the unit had been managed by the Ceduna Hospital. The unit is located directly behind the Ceduna Hospital, although it does not form part of the hospital. Its hours of operation have varied over the years but as at the time of the Inquest it operated from Monday to Thursday between the hours of 6pm through to 8am. The operating hours are based on funding considerations, but the operating hours are designed to reflect the peak drinking hours during a typical week in Ceduna.

5.3. The unit has five beds and is staffed by two people. The unit deals with heavily intoxicated people. It is a service for the whole community but the majority of its

[28] Exhibit C91

clients are Anangu people. Persons utilising the sobering up unit are not necessarily at dangerous levels of intoxication that might require medical intervention.

5.4. The unit has a MAP bus service linked to it that operates Monday to Thursday between the hours of 6pm and midnight. MAP is utilised as a resource to convey intoxicated clients either to the unit or to an alternative safe place. The unit also accepts self-referrals and referrals through SAPOL, the Town Camp and the Ceduna Hospital.

5.5. Ms Colbung told me that the unit currently receives a mixture of funding from Drug and Alcohol Services South Australia (DASSA) and from Country Health SA.

5.6. In her evidence Ms Colbung assured the Court that there is a clear need for the sobering up unit to continue to exist in the community[29]. The Court agrees, but with serious modification that I will later explain.

5.7. In her evidence Ms Colbung explained that the service has what she described as a 'recidivist' client base among the Aboriginal community. In other words, there is repeat custom. At times it can be something of a revolving door. She stated that the clients are usually very intoxicated with blood alcohol levels mostly greater than 0.25%. The highest recorded breath alcohol level was around 0.4%. A breath analysis is conducted upon admission to the facility. Many of the clients are either chronic alcoholics or persons who have come into the community to engage in binge drinking.

5.8. Ms Colbung explained to the Court that if more funding was available, the facility would ideally be open all nights, or at least on a six days per week basis if possible. She suggested in evidence that there is a 'huge gap in the service'[30] that they deliver; she was unable to say what happened when severely intoxicated people were at large on nights when the unit was not open.

5.9. The sobering up unit does not offer a clinical service. Specifically, the unit does not provide detoxification services, although the evidence from Mr Andrew Lane who is the Executive Officer, Director of Nursing of the Ceduna Hospital assured the Court that the hospital itself provided detoxification services and withdrawal therapy. I deal

[29] Transcript, page 254
[30] Transcript, page 263

with that issue separately in these findings. What the sobering up unit does provide is ongoing monitoring and supervision overnight. A bed is provided as is food, and the client's clothing is washed and dried. Sweet drinks are provided in the morning. On occasions there are cases where an ambulance has to be called to transport clients from the sobering up unit at the rear of the hospital to the Accident and Emergency Department at the front of the hospital and there have been occasions when, disappointingly according to Ms Colbung, such clients have then been discharged from the hospital without further supervision. There was a great deal of evidence given during the course of the Inquest about the interaction between the sobering up unit and the hospital and in respect of the passage of persons between one facility and the other. The interaction was not always described as favourable but it would be idle to attempt to identify or apportion any fault in this regard. To my mind the matter is in any case rectifiable. I return to this issue.

5.10. As far as the use of the facility is concerned, Ms Colbung stated to the Court that Mr Spaan's evidence to the effect that there were between 20 and 30 severely intoxicated people within Ceduna on a given night was reasonably accurate. She also said that the estimate that between 5 and 8 people per week might be in a state of hallucination and exhibit delusional behaviour at the end of a drinking week was also accurate. Indeed, the opening times of the sobering up unit were intended to reflect that pattern. The five beds at the facility were inadequate to cope with the numbers involved, although other evidence suggested that the facility was not always full. However, very frequently the unit is full within the first half hour of its opening. In the winter months the facility experiences an increase in use as it acts as a shelter for rough sleepers.

5.11. Ms Colbung confirmed that Anangu people 'in the grip of the grog'[31] very frequently have comorbidities of a serious kind.

5.12. I was told during the course of the evidence that many people who have been accommodated in the sobering up unit leave well in advance of the closing time of 8am. There is an hiatus between the closing time of 8am and the opening of the Emergency Department of the hospital at 9am. This makes it difficult for clients to be referred from one facility to the other, specifically for the purpose of detoxification.

[31] Transcript, page 291

The other consequence of the early closing time is that clients are very frequently discharged when they have not fully sobered up. Hence the revolving door.

5.13. Ms Colbung agreed that the facility required the ability to remain open for longer, and in particular for a maximum of 18 hours which is the figure stated in the Public Intoxication Act 1984 over which declared sobering up centres may lawfully hold patients. There was unanimous agreement during the Inquest that this need exists.

5.14. Ms Tanya Darke confirmed that there is a high degree of repeat business for the Ceduna sobering up unit. Her experience is that the number of people who are released with no alcohol in their system, as measured by breath analysis upon release, is minimal. She agreed that it was desirable that the unit have the ability to hold people long enough to reduce their blood alcohol level to zero.

5.15. Mr Andrew Lane is a qualified registered nurse whose current role is as the Executive Officer, Director of Nursing at the Ceduna District Health Service which incorporates the Ceduna Hospital. Mr Lane also commented upon the adequacy of the Ceduna sobering up unit. He suggested that five beds, which is the current capacity, is inadequate and that in his view around 15 beds would be required. He also suggested that a better arrangement than what exists at the moment would be if the sobering up unit was in closer proximity to the Ceduna Hospital Emergency Department having regard to the fact that the unit is at the rear of the hospital. It is not unheard of for ambulances to have to convey people from the sobering up unit to the Emergency Department, albeit only a short geographical distance. Mr Lane also suggested that there is certainly a need for a new facility that provides not only greater capacity, but that was also more culturally appropriate.

5.16. I have alluded to the fact that the Ceduna sobering up unit is not a declared sobering up centre pursuant to the Public Intoxication Act 1984. Nor is it a place approved by the Minister for the purposes of that Act. The letter of Mr David Swan who is the Chief Executive of SA Health[32] makes that clear. Indeed, according to Mr Swan's letter, the only placed declared to be a sobering up centre for the purposes of the Public Intoxication Act is the Waranilla Clinic in Adelaide which currently does not function and is not being used as a sobering up centre. That means that within the entire State there is no sobering up centre that is declared under the Public

[32] Exhibit C100

Intoxication Act and which has the lawful authority to detain persons apprehended under the Act.

5.17. Section 7 of the Public Intoxication Act 1984 authorises a member of the police force who has reasonable grounds to believe that a person who is in a public place is under the influence of a drug or alcohol, and that by reason of that fact the person is unable to take proper care of himself, to apprehend that person[33]. Where a member of the police force has apprehended such a person, he is obliged to take that person to one of four different types of place. Those places are (a) the place of residence if any at which the apprehended person is permanently or temporarily residing, (b) a place for the time being approved by the Minister for Health for the purposes of the Act (of which there are none so approved), (c) to a police station or (d) to a sobering up centre declared under the Act for admission as a patient[34].

5.18. Under this legislation, if the apprehended person is taken to either option (a) or (b), the person must be released from custody. If the apprehended person is taken to either option (c) or (d), the person may be detained under compulsion for a maximum of 10 hours or 18 hours depending on whether they are taken to a police station or a declared sobering up centre. There is no obligation upon police to seek out medical treatment for the apprehended person, although the Act authorises the discharge of a person for this purpose where necessary[35].

5.19. Where a person apprehended under the Act is taken to a police station, the officer in charge of that station is authorised to detain that person. However, the officer in charge is obliged, before the expiration of the period of 10 hours from the time of apprehension, to discharge the person from detention if in his opinion the person has so recovered from the effects of the drug or alcohol as to be able to take care of himself. If the officer does not hold the opinion that the person is able to take care of himself, the officer must cause the person to be transferred to a sobering up centre for admission as a patient[36]. Under this legislation, a declared sobering up centre may detain a person for a maximum of 18 hours.[37].

[33] Section 7(1)(a) and (b)
[34] Section 7(3)
[35] Section 7(11)
[36] Section 7(4)
[37] Section 7(5)

5.20. It will be seen from this analysis that detention for a period of 18 hours may only be imposed where the apprehended person is taken to a sobering up centre that is declared as such under the Act. Otherwise, the maximum period of time over which an intoxicated person may be detained in a police station is 10 hours.

5.21. There are no declared operational sobering up centres in the State of South Australia. In particular, the Ceduna sobering up unit is not a declared facility. This state of affairs has a number of awkward consequences. Firstly, the only place in which an intoxicated person can compulsorily be detained is in a police station, and for a limited period of 10 hours. Secondly, the obligation upon police to cause a person to be transferred to a sobering up centre where the officer in charge of a police station does not form the opinion that the person has so recovered from the effects of the drug or alcohol as to be able to take care of himself, cannot be obeyed. This difficulty is most acute when at the expiration of the period of 10 hours the officer in charge of the station cannot in all conscience hold an opinion that the person has sufficiently recovered from the effects of alcohol. In these circumstances the person would have to be released. In theory such a person might be re-apprehended if he or she were to go to a public place, but this hardly seems to be a satisfactory way of going about things. Thirdly, the practice of taking apprehended persons directly to the Ceduna sobering up unit is not authorised by law, although I would hasten to add that notwithstanding this lack of lawful authority, it is possibly the most humane and sensible thing to do if it is open and not full. As well, it might be argued that the practice falls within the spirit of section 7(9) of the Act which permits police to discharge a person who is detained in a police station into the care of a friend. Nevertheless, the fact remains that the practice of taking an apprehended person directly to the Ceduna sobering up unit as it now exists is not authorised by law. Finally, and specifically in relation to the position as it stands in Ceduna, the sobering up unit does not have any lawful authority to detain persons taken to that facility or to otherwise compel them to remain. Kunmanara Peters' case exemplifies this dilemma.

5.22. All of this means that whatever the position may be in other centres of the State of South Australia, there is a clear need for a sobering up centre in Ceduna that is declared under the Public Intoxication Act 1984 as a sobering up centre, and one which therefore has the power and authority to compel apprehended persons to remain for a maximum period of 18 hours. There is a need to promote better and more

effective interaction between the Ceduna sobering up unit and the services provided by Ceduna Hospital such as detoxification and alcohol withdrawal therapy. I intend to make a recommendations at the end of these findings accordingly.

6. Services provided by the Ceduna Hospital

6.1. Evidence on this topic was given by Mr Andrew Lane to whom I have already referred. Mr Lane has worked in nursing in the Ceduna region since 1990. For a two year period he was the manager of the sobering up unit in Ceduna. He has acted as the Director of the CKAHS. Mr Lane told me that the Ceduna Hospital provides alcohol withdrawal and detoxification therapy. He told me that in the 2009-2010 financial year, 26 persons undertook such therapy of which 20 were identified as Aboriginal. Year to date figures to May 2011 revealed that 14 persons had undertaken alcohol withdrawal and detoxification therapy of which 7 were identified as indigenous. Mr Lane produced the Ceduna District Health Services 'Alcohol and Drug Withdrawal, Referral and Admission' admission policy[38]. This policy was developed and agreed upon by the CKAHS and DASSA. He also produced the treatment procedure document relating to alcohol and drug withdrawal for the Ceduna District Health Service[39]. This policy and treatment procedure appears to have been developed in 2008 and 2009.

6.2. Mr Lane gave some evidence about the interaction between the hospital and the Ceduna sobering up unit. He told me that the hospital's current policy was such that if a person was severely intoxicated they should be admitted to hospital for observation. Otherwise, if a person was assessed as being intoxicated but nevertheless able to maintain their own airway, able to walk unaided, able to think rationally and not put themselves in danger, then that would not be grounds of admission to the Ceduna Hospital. Notwithstanding this, in the view of the Court there is a need for greater interaction between the sobering up unit and services provided by the hospital so that persons accommodated in the sobering up unit might then be provided with detox and withdrawal therapy services as opposed to them merely walking out the revolving door.

6.3. Mr Lane spoke of Aboriginal patients habitually discharging themselves from the hospital before the completion of treatment for acute illnesses and it was he who

[38] Exhibit C92, AL2
[39] Exhibit C92, AL3

suggested that the onset of alcohol withdrawal might have a role to play in this regard. Mr Lane told the Court of certain initiatives that have rendered the hospital's services as being more culturally appropriate for Aboriginal people, but it is clear that the phenomenon of premature discharge remains an issue.

6.4. Mr Lane made it clear that the Ceduna Hospital does not provide alcohol rehabilitation services, although hospital staff have and will refer clients to DASSA and Mr Lane made specific reference to the presently to be established day centre in Ceduna.

7. The evidence of Dr David Scrimgeour AM

7.1. Dr Scrimgeour is a medical practitioner and is a Public Health Medical Officer with the Aboriginal Health Council of South Australia. The Aboriginal Health Council is the peak body representing all Aboriginal community controlled health services and Aboriginal community substance misuse services in South Australia. That includes Aboriginal community controlled health services that exist in the far west of South Australia, including the CKAHS in Ceduna, the Tullawon Health Services at Yalata and the Oak Valley Health Service at Oak Valley. Dr Scrimgeour's role over the last three years has been to provide public health advice and support to the Aboriginal Health Council and to its member services. Being a general practitioner with post graduate qualifications in public health, Dr Scrimgeour regularly visits these services, providing both public health support and some clinical support as well. His role includes the examination of public health issues that impact on Aboriginal health services and to assist those services in the development of strategies to ensure that the services manage health problems both from an individual perspective and a population health perspective.

7.2. Aside from Dr Scrimgeour's current role, he has over 30 years experience working as a general practitioner and public health physician in Aboriginal health, including in remote Aboriginal communities. For example, from 2001 to 2007 he was the Medical Director of Tullawon Health Services at Yalata community. In that position, as well as in his current position, he has become familiar with the circumstances of the Aboriginal communities of the Far West of South Australia and with the complexity of the health problems and health care needs of the people from these communities. In addition to that, it is clear from the material Dr Scrimgeour produced to the Court

that he was aware of the circumstances surrounding the movement of Yalata and Oak Valley residents from those locations to Ceduna.

7.3. Dr Scrimgeour studied the briefs in relation to the circumstances surrounding the deaths of the six individuals who are the subject of these Inquests. He provided a report by way of letter to the Court[40] and he gave oral evidence to the Court as well.

7.4. Dr Scrimgeour told me in evidence that a strong connection could be drawn between the deaths under Inquest and the issue of alcohol addiction and sleeping rough. He said as follows:

> 'I think there's a range of ways in which alcohol interacts with those chronic diseases. But one way is that the chronic diseases themselves make people more susceptible to life-threatening events. People have severe chronic obstructive airways diseases, as a couple of these people did. They're more prone to developing pneumonia. If you develop pneumonia when you're sleeping rough and highly intoxicated the chances of getting to treatment rather than dying because of pneumonia are low. But it's also the fact that all of these chronic diseases are potentially treatable diseases and many of these people were on medications for their chronic illnesses. But because of the chaotic lifestyle of sleeping rough and drinking heavily almost certainly these medications weren't being taken, so the chronic diseases become more and more out of control. The more out of control they are, the more susceptible they are to having a fatal myocardial infarction for example or developing a fatal pneumonia or developing some other problem which can ultimately kill them. So although the cause of death on a death certificate, the immediate cause of death may not have been the alcohol, it is that whole lifestyle around sleeping rough, drinking alcohol, which meant that this individual person died from this condition whereas somebody else with all the same conditions, without the alcohol addiction, may not have died.' [41]

I accept that analysis of the situation. The deaths that are the subject of these Inquests typify what Dr Scrimgeour is describing.

7.5. Dr Scrimgeour added that although these people had contact with health care facilities, and that alcohol addiction had been identified, there was no evidence that any of them had ever been offered, or if offered, had received meaningful treatment for their addiction. This scenario was not surprising to Dr Scrimgeour as the opportunities for treatment for alcohol addiction in the Far West of South Australia are basically non-existent, despite the fact that it has been known for many years that alcohol is a major contributor to morbidity and mortality in that region in respect of indigenous people. Dr Scrimgeour observed that while the alcohol addiction in

[40] Exhibit C87a
[41] Transcript, page 147

respect of the six individuals remained untreated, prescribing medications for the other health problems was largely a waste of time and all of the chronic conditions remained uncontrolled.

7.6. Dr Scrimgeour suggested that the alcohol abuse amongst the indigenous population in this region should be regarded more as a health problem, such that if appropriate treatment facilities were available, the deaths of the six individuals may have been prevented.

7.7. To my mind the observations made by Dr Scrimgeour are powerful ones. His observations are based on the evidence that exists in respect of the circumstances of the deaths of the six individuals with which this Inquest is concerned. His observations are supported by other evidence in the case and in particular by Mr Andrew Lane, the Executive Officer, Director of Nursing at the Ceduna Hospital.

7.8. In his report, Dr Scrimgeour lists five recommendations for change that I herein set out.

> 'I would recommend that Ceduna Hospital develop an agreement with the Ceduna Sobering Up Shelter to ensure that medically supervised detoxification is available to people referred from the Sobering-Up Shelter when required.
>
> I would recommend the development of a strategy for the management of alcohol addiction in the Ceduna area, involving all health services including the hospital. Such a strategy should include a plan about who should be notified if a patient with a known alcohol problem discharges himself or herself against medical advice, to maximise the chances of ongoing medical and social support.
>
> I would recommend that appropriate and sufficiently-resourced alcohol rehabilitation facilities be established within the vicinity of Ceduna, Yalata and Oak Valley as a priority.
>
> I would recommend that ongoing counselling services be available to support the management of alcohol addiction.
>
> I would recommend that ongoing training and support be provided to general practitioners and other primary health care personnel in Ceduna, particularly at Ceduna Koonibba Aboriginal Health Service, to up-skill them in the medical management of alcohol addiction. ' [42]

[42] Exhibit C87a, page 4

8. The need for rehabilitation services

8.1. It will be seen from Dr Scrimgeour's report and his evidence that he is a strong advocate of the establishment of alcohol rehabilitation facilities within the far west coast region. This view was shared by a number of other interested entities.

8.2. The question of rehabilitation is to be regarded as distinct from that involving detoxification and withdrawal therapy. Detoxification might require approximately one week. Dr Scrimgeour explained that, depending upon the individual circumstances in Ceduna, the process of detox might involve hospitalisation or, in the alternative, supervised monitored withdrawal in the home setting. It might also occur in community facilities such as the sobering up unit. Withdrawal could also administered, or at least be given appropriate therapy, within the Town Camp unless that person was at risk of severe withdrawal symptoms. On the other hand, effective rehabilitation would involve continued residential therapy after detoxification.

8.3. The need for rehabilitation in respect of the treatment for alcoholism in this region was identified many years ago in 1990 in the course of the Royal Commission into Aboriginal Deaths in Custody. It is referred to specifically within the 'Report of the Inquiry into the death of the woman who died at Ceduna on 18 February 1983' delivered by Commissioner Elliott Johnston QC on 3 October 1990. The woman who was the subject of that aspect of the Commission's inquiry was an Aboriginal woman of approximately 30 years of age at the time of her death. The deceased ultimately died in custodial circumstances due to a cardiac arrhythmia, but the circumstances of her life were remarkably similar to those of the persons who are the subject of these Inquests. The woman in question had suffered from chronic and persistent illness throughout her life and she was a chronic alcoholic. Her poor health was clearly associated with her lifestyle and social and environmental conditions. The woman had an aversion to hospitals and regularly discharged herself before treatment could be completed. She had been convicted on approximately 50 occasions, predominantly on charges of being drunk in a public place. Her alcoholism had to be viewed against what was described as the horrendous social background in which she and her family lived. The woman died in the cells of the police station at Ceduna. The Commission found that there was no doubt that many of the deceased's health problems had been

associated with her chronic abuse of alcohol. A number of attempts had been made over the years by various health agencies to assist her in curbing her drinking habits, including trips to the alcohol rehabilitation farm at Baroota, south of Port Augusta. I will mention that facility in another context later. The deceased and her family were traditional Pitjantjatjara people who had been moved to the Lutheran Mission at Yalata in the early 1950s. She grew up at Yalata during her childhood, although she had travelled extensively with her family within traditional Pitjantjatjara lands. At around the time of her death the deceased woman had lived with her husband at a halfway camp west of the township of Ceduna, many of the residents of which came from Yalata. The camp bore certain parallels with the area that would become known as 18 Tank insofar as alcohol abuse, poor sanitation and hygiene dominated the lives of camp dwellers.

8.4. The Commissioner recorded[43] that in February 1983, the time of the deceased's death, there were no facilities in the Ceduna area for the treatment or rehabilitation of alcoholics, although the Commissioner also noted that early in the year 1990, the year of the report, the sobering up unit had been opened in Ceduna as a shelter for intoxicated persons. The Commissioner also noted that the deceased had died as a young woman and although her health may have been exceptionally bad, it was clear that the Aboriginal people on the west coast of South Australia endured a much lower standard of health compared to the non-Aboriginal population and perhaps other Aboriginal people in South Australia. The Commissioner also identified that alcohol misuse amongst the Aboriginal community on the west coast in general was a serious problem. This prompted the Commissioner to observe that during the deceased's lifetime there had been few, if any, services for alcoholics in Ceduna and, whereas a sobering up unit had since been established, a facility of that kind by necessity focussed on immediate care rather than on detoxification and rehabilitation and could not be expected to have a significant effect on reducing the prevalence of alcoholism in the community it served. The Commissioner recorded that as of 1990 there were no detoxification or rehabilitation facilities in Ceduna for alcoholics and that members of the community requiring such treatment were obliged to attend clinics some distance from Ceduna. I observe that the position regarding detoxification is different

[43] Paragraph 2.2 of the Report

now as detoxification and withdrawal treatment is currently available in the Ceduna Hospital. However, as far as rehabilitation facilities for alcoholics are concerned, the Interim Report of the Royal Commission into Aboriginal Deaths in Custody indicated the need for the establishment of detoxification and rehabilitation facilities for the care of intoxicated persons and culturally appropriate facilities for the treatment of alcoholism. The Commissioner said as follows:

> 'These matters are of vital importance given the prevalence of this condition in the Aboriginal community and the high proportion of Aboriginal people who are held in custody in this State, as elsewhere, on alcohol related offences. This matter requires more extensive investigation.'

8.5. It will thus be recognised that as long ago as 1990 the need for localised rehabilitation services for alcoholics and intoxicated persons was identified in very strong terms and identified in the context of community circumstances that are almost identical to those that exist today. And yet, nothing has been undertaken so far in respect of the establishment of rehabilitation services on the west coast.

8.6. I also note from the Royal Commission's Report that at one point in history Yalata possessed a 'wet canteen' which operated until 1982 and that alcohol misuse and its resulting violence and social disruption at Yalata had been a significant feature of the daily lives of members of that community. This had been one of the reasons why in 1985 a permanent camp had been established at Oak Valley on the Maralinga Lands where the consumption of alcohol was discouraged by members of that community. Oak Valley had become an alternative for Yalata people, free from the alcohol and violence which had been all too common in Yalata. I mention this not only because of its historical significance, but also because in some quarters it is now suggested that the time has come to consider re-introducing a strictly controlled liquor outlet available to residents of Yalata.

8.7. The need for local rehabilitation facilities was also identified by other witnesses and represented entities in the course of the Inquest. Mr Christopher Charles, counsel for the Yalata Community Incorporated, strongly advocated the need for local alcohol rehabilitation facilities to be made available to the Aboriginal communities on the west coast. Ms Irene Adair is the Regional Manager for Housing SA in respect of the area of the State that encompasses the Eyre Peninsula and the west coast. She is familiar with the operations of the Town Camp, having overarching responsibility for

that facility. Ms Adair in fact conducted the Court's site visit in respect of the Town Camp at Ceduna. Ms Adair also gave evidence to the Inquest and demonstrated an intimate knowledge of matters as they pertain to the abuse of alcohol amongst the Aboriginal community in and around Ceduna. Ms Adair is a member of the Senior Officers Group that is a group of local stakeholders that has assembled a Ceduna Alcohol Management Plan dated November 2010. The interested stakeholders include South Australian Government organisation, non-government organisations, liquor licensees, various communities, including indigenous communities and health services. Ms Adair told me that it has been of some considerable concern to the Senior Officers Group that rehabilitation services are not available locally. Discussions at Senior Officers Group meetings have taken place as to whether rehabilitation services that might exist elsewhere in the State, particularly in the Riverland or in Adelaide, was a suitable response to the difficulties posed by the circumstances as they exist on the west coast. The consensus is that it is not a suitable response. I note that the Ceduna Alcohol Management Plan that appears to be in draft format at the time of Inquest contains a strong recommendation that a residential rehabilitation centre in the Ceduna region for alcohol and other substances should be established[44]. I also observe that the same document advocates funding for increased capacity, standards and opening hours of the local sobering up unit[45].

8.8. Ms Kerry Colbung, the Chief Executive Officer of CKAHS Incorporated, in her well considered evidence given to the Court, spoke of the preferred view of the Aboriginal community that there be a rehabilitation facility located in the Ceduna area. The perceived advantage of having a local rehabilitation facility is that rehabilitating individuals can have greater access to loved ones and family when they are close to home. On the other hand Ms Colbung recognised that it might be useful for Aboriginal people from the Ceduna area to engage with other Aboriginal people from other areas from across the State. Ms Colbung was aware of possible plans that the Commonwealth Government were pursuing in respect of the establishment of a rehabilitation facility at Port Augusta. Ms Colbung told the Court that she believed that such a facility was supposed to service the whole north western region of the State, although the CKAHS so far had not been engaged in any consultations about the establishment of the facility. I pause here to observe that the Commonwealth

[44] Action 4.1.1.1
[45] Action 4.1.1.2

Government did inform the Court during the course of the Inquest of the Port Augusta facility plans, the details of which I will mention below.

8.9. Ms Tanya Darke, the Program Manager of CKAHS, gave evidence, amongst other things, concerning the success or otherwise of placements or attempted placements of Aboriginal clients to the Kalparrin rehabilitation service in Murray Bridge, a location as remote as one might imagine from the west coast of the State. She told the Court that since late 2007 and early 2008, a total of 14 clients had been directly referred to that facility through the CKAHS Drug and Alcohol Field Officer. Of those 14 clients that were referred, all of them were accepted into Kalparrin but six of those persons in the event declined to attend for various reasons. One of those persons was having difficulties with his partner and so did not want to leave the local community to go to rehabilitation. Some of the clients ended up back on drinking binges and made poor decisions when intoxicated. They simply changed their minds about rehab. This difficulty is occasioned by the fact that once the clients were accepted for referral to the Murray Bridge rehabilitation facility, it could take up to five working days for transport and travel arrangements to be put in place. Ms Darke told me that they check on these persons throughout that period in an endeavour to ensure that they are sober or at least in detox, but sometimes they will simply 'take off and start drinking'[46]. Thus it is if persons ultimately decide not to go to the facility, there is nothing that can be done to compel them to do so. Ms Darke also told of experiences prior to the year 2008 when they would work with DASSA and actually physically put people on the bus to Murray Bridge and pay for them to do so, but where the clients alighted at Port Augusta and chose either to go out drinking there or to find family there. In cases where there is a referral to the Murray Bridge facility which is actually taken up, the Drug and Alcohol Field Officer physically drives them to the facility. Ms Darke also described another negative circumstance in respect of referral to the Murray Bridge facility and that is simply the tyranny of distance. People do not like to travel or go all the way there alone. She suggested it is a discomforting feeling for these people to be leaving their country and to be going to a different place where they do not know anybody. As far as the eight cases were concerned in which the clients did make it to Murray Bridge, Ms Darke told me that two of those eight people were a couple but, unfortunately, remained at the Kalparrin facility for only one week because the male partner was expelled from the facility for continuous fighting. Ms

[46] Transcript, page 326

Darke believed that the female person was back in Ceduna drinking again. There was one other male person who, in March 2009, attended the Kalparrin facility and is still there. This is regarded as a positive outcome. In fact, Ms Darke suggested that it was really the only positive outcome of the 14 cases. She suggested that the majority were still known to be drinking. To use the expression of Mr Todd Golding, counsel for the Minister for Families and Communities and Minister for Health (SA), there is an argument to say that the referral to the Murray Bridge rehabilitation facility has been a failure. This is no adverse reflection on the dedication of the Ceduna and Koonibba Aboriginal Health Service. It simply illustrates that there will be difficulties associated with locating a rehabilitation service that is remote from the communities whom it is meant to serve. The Court is of the view that there is a powerful argument available that alcoholics on the west coast need to be rehabilitated rather than exiled.

8.10. In this regard Dr Scrimgeour noted in his report[47] that currently there were no alcohol rehabilitation facilities within hundreds of kilometres of Ceduna. He recognised that it was occasionally possible to arrange for people to travel to Kalparrin near Murray Bridge for residential rehabilitation, but that those arrangements can be very difficult. Ms Darke's evidence confirms this. For this reason his recommendation is that any rehabilitation service should be based within the vicinity of Ceduna, Yalata and Oak Valley as a priority.

8.11. The Court received into evidence a letter from Ms Christine Steele who is the South Australian State Manager of the Commonwealth Department of Health and Ageing. The Commonwealth Government was invited during the course of the Inquest to place material before the Court that was relevant to the issues with which these Inquests are concerned[48]. I also received into evidence an affidavit of Ms Simone Cormack who is the Acting Executive Director of the DASSA[49]. DASSA is responsible for providing a statewide health services that addresses alcohol, tobacco, pharmaceutical and illicit drug issues across the State. DASSA was invited to place material before the Court in respect of the proposed non-residential rehabilitation day centre for Ceduna. The letter of Ms Steele and the affidavit of Ms Cormack describe the imminent establishment of a day centre in Ceduna that is said, in the affidavit of Ms Cormack, to be due for completion at the end of November 2011. Ms Cormack states that the

[47] Exhibit C87a, page 3
[48] Exhibit C97
[49] Exhibit C96

day centre will assist with providing Aboriginal and Torres Strait Islander people with substance misuse issues a level of physical, emotional and spiritual health. The day centre will be responsible for the provision of culturally appropriate services and programs designed to assist people manage substance misuse and the issues arising from misuse. It will also provide vocational, recreational and cultural activities and provide links to sobering up services and MAP services. The initiative is partially funded through the Commonwealth Department of Health and Ageing as indicated in both the affidavit of Ms Cormack and the letter of Ms Steele. It is clear that the day centre is an exceptionally worthwhile initiative in Ceduna. However, the establishment of the day centre is not said to obviate the need for long term rehabilitation in the region. The letter of Ms Steele addresses this issue. It informs that funding has been approved to establish a drug and alcohol residential rehabilitation facility in the north of South Australia. Port Augusta has been selected as the preferred location for the residential rehabilitation centre for reasons including the fact that it is a central transport hub for the region, it is accessible for staff, patients and visitors, it is a superior location for ease of staff recruitment and retention for the centre and it has better availability of land for the centre and staff housing. The service provider in respect of the facility is expected to establish and maintain links with key stakeholder groups and health and social services in the far north and western region. It is proposed that once the new facility is operational it will offer up to 12 beds and cater for Aboriginal and Torres Strait Islander people with patterns of alcohol and substance misuse in the Port Augusta, Whyalla, Ceduna and Coober Pedy areas. The facility will focus on non-medicated detoxification and residential rehabilitation. Ms Steele's letter explains that it is anticipated the facility will be open in the 2012-2013 financial year.

8.12. Mr Christopher Charles, counsel on behalf of the Yalata Community Incorporated, submitted that the evidence overwhelmingly suggests that there is a need for local rehabilitation facilities to be worked out at a local level between the various communities concerned. Mr Charles submitted that, notwithstanding the proposal to establish a rehabilitation facility at Port Augusta, the west coast region requires its own rehabilitation facility and, in particular, at a remote location to be determined by the Yalata, Oak Valley and Ceduna communities. He points out that such a facility would be in keeping with Dr Scrimgeour's recommendation and, having regard to the fact that such a facility might be placed on traditional country, might better provide a

place where an alcohol free sobering up centre could be maintained and operated at a local level. In Mr Charles' submission, Aboriginal people have a very clear understanding of what is meant and required by way of rehabilitation, namely at a place totally away from the availability of alcohol and where there are cultural activities and employment opportunities but, most importantly, a place where the person can be maintained 'in a grog free environment for a long time'. Mr Charles urges the Court to make a recommendation in accordance with that submission and suggests that for the last 20 years this has been the predominant and correct view on the west coast.

8.13. I allowed Mr Charles to take the unusual step of providing an affidavit to the Court regarding certain matters, notwithstanding that he was also counsel involved in the Inquests. The affidavit refers to the existence of a rehabilitation farm at Baroota, some 60 to 70 kilometres south of Port Augusta that existed in the 1980s[50]. Mr Charles related experiences where Aboriginal persons were, as part of Court ordered bonds imposes in respect of the commission of offences, required to undergo rehabilitation at this facility. Mr Charles asserts that this system worked well and provided a seamless process of transfer between the Court and alcohol rehabilitation. Of course, the observation needs to be made that the success of the rehabilitation measures at Baroota has to be examined in the context of the fact that the rehabilitation was coercive. In his affidavit Mr Charles refers to recommendation 287 of the Royal Commission into Aboriginal Deaths in Custody to the effect that the Commonwealth States and Territories give higher priority to the provision of alcohol and other drug prevention, intervention and treatment programs for Aboriginal people which are functionally accessible to potential clients and are staffed by suitably trained workers, particularly Aboriginal workers.

8.14. It appears from the letter of Ms Steele that Port Augusta has been selected as the location for a rehabilitation facility purely on pragmatic grounds alone insofar as Port Augusta would be more geographically suitable from the point of view of staffing and transport arrangements. There is obvious force in the observation that a facility closer to the traditional communities would be better placed having regard to the probability that attendance at a residential rehabilitation facility in Port Augusta would be on a

[50] Exhibit C101

voluntary basis only and that the temptation to resort to off campus alcohol abuse in a centre such as Port Augusta would be ever present.

8.15. If the facility is to be placed at Port Augusta, it is the view of the Court that consideration would need to be given to the imposition of involuntary treatment of persons with a severe substance dependence, if only as a treatment of last resort. I observe that in both New South Wales and in Victoria there are legislative regimes in place that are designed to impose such involuntary treatment. I refer here to the Drug and Alcohol Treatment Act 2007 (NSW) and the Severe Substance Dependence Treatment Act 2010 (VIC). These legislative models have not been without their critics and I note that Dr Scrimgeour for one is not favourably disposed towards the idea of coercive or mandatory measures unless the patient had a complicated psychiatric overlay that might in any case require mandatory detention under the Mental Health Act 2009. His view is that if the issue is one of managing alcohol abuse and addiction, it should involve voluntary treatment[51]. Dr Scrimgeour did acknowledge that he was not familiar enough with the material in relation to legislative coercive measures as they exist in other States to allow him to authoritatively comment on it, but he also recognised that there would, in some circumstances, be good reasons to explain why such legislation might be of use. In all, Dr Scrimgeour was of the view that coercive measures were something that one would not pursue initially; he said:

> 'I think there's enough that is not happening in Ceduna that could be happening without having to look at such extreme measures. My experience is, I might say, that many people are very happy to have some respite from the alcohol so it's not a situation where in the majority of cases it does require coercion.' [52]

Dr Scrimgeour was there referring to the fact that in his experience where treatment is offered, many seemingly incorrigible alcoholics will grasp the opportunity for treatment. Dr Scrimgeour suggested that in this context many people are very happy to access residential rehabilitation if it is available at an appropriate location. He maintained several times during his evidence that there is nothing of the kind in the Ceduna area and that he believed that residential rehabilitation was needed somewhere on the west coast. He suggested that there is evidence to show that appropriate services, particularly when they are developed locally and under the

[51] Transcript, page 141
[52] Transcript, page 143

control of local Aboriginal organisations, have given rise to favourable outcomes relating to alcohol addiction as a chronic and relapsing disorder. As far as the question of relapse is concerned, Dr Scrimgeour told the Court that this is an obvious difficulty but that there are many Aboriginal people who are ex-drinkers. He suggested that people who had formerly been in the '*grip of the grog*' do give up the grog and stay off the grog[53]. He suggested that people do stay off alcohol for many years and often permanently after being seemingly incorrigible alcoholics. He said:

> 'There's enough cases around like that including over in the West Coast to suggest that it's not something where we should just give up and say it's all too difficult.' [54]

He said that leaving the situation as it is represents an unacceptable solution. He said:

> 'It would just lead to more deaths like the ones that have been considered at this Inquest.'[55]

9. The availability of alcohol

9.1. Historical and current information regarding the availability of alcohol to transient Aboriginal communities in and around Ceduna is explained in material provided by Mr Eugene Milograd who is the Assistant Commissioner, Legal of the Office of the Liquor and Gambling Commissioner (now Consumer and Business Services). Mr Milograd has provided two statements, verified by affidavit[56], as well a report dated June 2011 prepared by the Office of the Liquor and Gambling Commissioner concerning liquor sales within the Ceduna region[57]. A number of other documents relating to voluntary accords and licence conditions are also annexed to Mr Milograd's material.

9.2. Mr Milograd explains that under the Aboriginal Lands Trust it is unlawful to possess or consume alcohol on the land of the Yalata and Oak Valley Communities. The Office of the Liquor and Gambling Commissioner recognises, however, that it is known that residents of these communities will travel to Ceduna to obtain alcohol that is either consumed in and around Ceduna or possibly smuggled back to the prohibited areas.

---

[53] Transcript, page 146
[54] Transcript, page 146
[55] Transcript, page 146
[56] Exhibits C56a and C56g
[57] Exhibit C56h

9.3. In 2002 an informal agreement was put in place regarding takeaway alcohol sales in the town of Ceduna. The accord, driven by certain stakeholders within Ceduna including the District Council and ATSIC, restricted the sale of fortified wines from the Ceduna Community Hotel, Ceduna Wine Cellars which is a licensed takeout facility and the Thevenard Hotel. Under the agreement fortified wines could not be sold before 4pm. After 4pm only one unit of fortified wine could be purchased per person or per vehicle, per day. After 7pm it could only be purchased in a vehicle, that is, not to any persons on foot. The agreement was to operate for four months between November 2002 and February 2003. The measure was put in place to make it difficult for individuals to purchase that type of liquor and take it to the outlying Aboriginal communities.

9.4. Following this measure, in 2003 the substance misuse accord was established to run from 1 December 2003 for a period of three years. This accord was similar to the 2002 agreement, but it sought to prohibit both takeaway and on site sales of fortified wines before 4pm and prohibit the sale of takeaway cask wine before 4pm. Takeaway sales after 4pm were restricted to the purchase of one unit of fortified wine or one cask of wine to be no larger than two litres. The majority of licensees signed the 2003 accord. The accord ran until December 2006. Mr Milograd explains in his statement[58] that at the expiration of the accord its measures were found to have become wanting. He explains that over the three years of the accord's life, subtle ways had been found to circumvent the agreement which was not binding in any case. He also explains in his statement[59] that it also became evident from interaction with Ceduna police and from other local information that over the three year period people seeking liquor would modify their purchasing habits to enable them to do so. They would buy alcohol at different times and possibly make arrangements for others to purchase it for them.

9.5. Since the 1990s, several licensees in the region have had conditions imposed upon their licenses including this:

> 'There shall be no sale or supply of liquor for carry off the premises other than low alcohol beer as defined in the regulations under the Liquor Licensing Act 1997 (now defined as 3.5% alcohol), to any person whom the licensee has reasonable grounds to

[58] Exhibit C56a
[59] Exhibit C56g

> suspect resides at or is travelling to Maralinga Tjarutja land as declared in the schedule of the Maralinga Tjarutja Land Rights Act 1984 or the land owned by the Aboriginal Lands Trust and known as the Yalata Reserve, defined herein as the lands referred to in Certificate of Title, Register Book Volume 5834, Folio 851.' [60]

The imposed conditions also contain stipulations as to what might constitute reasonable grounds to suspect, the need for appropriate photographic identification or proof of residential address, definition of residence and so on. As at the time of the Inquest these conditions are still on foot.

9.6. The salient features of the report of the Office of the Liquor and Gambling Commissioner into liquor sales within the Ceduna region[61], which examines statistics of alcohol sales and suspicious sales within the region between July and November 2010, is that there is a disturbing trend that Stanley brand two litre port was by far the most popular takeaway alcohol purchased and that, despite a high volume of alcohol sales within the analysis period, the level of sales recorded as being 'suspicious' was considerably low. In total, less than 25% of Stanley port sales were actually recorded as being suspicious, meaning attracting suspicion that the alcohol was to be consumed by residents of the dry Aboriginal communities or would be transported to those locations. The report highlights that, as was established in other evidence, the most popularly purchased products were the Stanley port and 5 litre wine casks, for the most part being Fruity Gordo. The sale of light beer was believed to have been very low and this hardly comes as a surprise.

9.7. Other conclusions from the Office of the Liquor and Gambling Commissioner report included that individuals are purchasing large quantities of alcohol from multiple premises within a very short timeframe and that a regime of the recording of suspicious transactions has worked only to a limited degree.

9.8. In my view the overall conclusion available from this material is that accords and the imposition of licensing conditions have been consistently circumvented and in essence do not work. I repeat my earlier observation that members of the transient Aboriginal community continue to consume cheap, strong alcoholic beverages to detrimental excess as evidenced, amongst other things, by the huge number of empty

[60] Exhibit C56d
[61] Exhibit C56h

bladders and casks left at the 18 Tank location. Furthermore, dry areas in the Ceduna township itself only serve to force drinkers to the outskirts of town, such as locations as 18 Tank. Dry areas do not curb drinking. They simply relocate it.

9.9. There is in existence a Ceduna Alcohol Management Plan 2010-2013 dated November 2010[62]. The plan describes a number of suggested strategies in respect of alcohol management in the district. The plan identifies an overall strategy in respect of the regulation of alcohol distribution and supply, namely to 'advocate for and support appropriate liquor restrictions for the local community'[63]. Included among suggested action is that work be undertaken with indigenous communities in Ceduna, Yalata and Oak Valley to identify and advocate for appropriate liquor restrictions. As well, one proposed action is to investigate the concept of an off-community, highly regulated and licensed 'wet' canteen near Yalata that encourages responsible, social alcohol consumption in a safe environment, near community, as an alternative to binge drinking in Ceduna.

9.10. I have carefully read the detailed and helpful statement verified by affidavit[64]of Mr Trevor Smart who is the Chief Executive Officer of the District Council of Ceduna. Among other recommendations, Mr Smart poses the question as to whether alcohol should be made available to the peoples of Yalata and Oak Valley, and for those communities to address issues associated with responsible alcohol consumption, health and wellbeing and associated issues. He asks:

> 'Why should community such as Ceduna have to deal with the inadequacies and dysfunctionality of remote Aboriginal communities such as Yalata and Oak Valley?' [65]

Mr Smart has indicated in his statement that Council will be pursuing the reintroduction of regulated access to alcohol in or adjacent to the Yalata community. Mr Smart is of the firm view, which is borne out by the evidence in this case, that all initiatives to address alcohol misuse by transient Aboriginal people have only had limited success due to the lack of success of 'prohibition'[66]. Mr Smart suggests that a well managed and regulated introduction of alcohol into the community will provide an educative and supportive approach to consuming alcohol. He advocates the

[62] Exhibit C98a
[63] Exhibit C98a, page 12
[64] Exhibits C58 and C58a
[65] Exhibit C58a, page 7
[66] Exhibit C58a, page 10

implementation of a 'wet' Town Camp in Yalata. Mr Smart makes the following observation:

> 'As it stands now, we are all condoning (State Government included) many slow deaths through the abuse of alcohol, by ensuring that people need to move from their place of residence to access alcohol, that they sleep rough in inappropriate conditions, that they increase their chances of road accidents, that they disintegrate their family unit through disconnection from the community.' [67]

There is obvious validity in much of that observation, but there was insufficient evidence placed before the Court to enable any conclusion to be drawn about the appropriateness of a regulated 'wet' facility in Yalata. One might assume that availability of alcohol near Yalata would act as a disincentive for some members of that community to travel to Ceduna to access alcohol, but whether it would act as a positive strategy overall is a matter for debate. As seen in the RCIADIC report to which I have referred, alcohol availability within the Yalata community historically has been associated with unhappy outcomes.

9.11. What does seem clear is that in Ceduna strong, cheap alcohol is readily available to transient indigenous people. The conclusion seems to be clear that further restrictions that can actually be enforced need to be implemented in that particular location.

9.12. I note that Dr Scrimgeour both in his letter and in his evidence suggests that there needs to be greater emphasis on alcohol supply reduction. Dr Scrimgeour said as follows:

> '… if we can reduce the actual amount of alcohol that people drink by changing the kind of alcohol that's available from highly concentrated alcohol to drinks with a lower concentration of alcohol, that can help to reduce the alcohol-related harm. And you know, there are strategies in place in various parts of Australia to bring in those kind of policies and in places like Alice Springs it has been shown to reduce, for example, the number of admissions to hospital for alcohol-related harm and so forth.' [68]

10. Recommendations

10.1. Pursuant to Section 25(2) of the Coroners Act 2003 I am empowered to make recommendations that in the opinion of the Court might prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the Inquest.

---

[67] Exhibit C58a, page 11
[68] Transcript, pages 164-165

10.2. Taking all of the evidence into account as well as counsel's submissions, I make the following recommendations which I direct to the following entities:

- South Australian Minister for Health;
- Chief Executive Officer of the Department of Health;
- Chief Executive Officer of Housing SA;
- Regional Manager for Housing SA in relation to the Eyre and Western area;
- Executive Director of Drug and Alcohol Services, South Australia;
- Executive Officer, Director of Nursing of the Ceduna Hospital;
- Chief Executive Officer of the Ceduna Koonibba Aboriginal Health Service;
- Members and delegates of the Ceduna Senior Officers Group;
- Officer in Charge, SAPOL Far North Local Service Area;
- Commissioner for the Office of the Liquor and Gambling;
- Manager of the Indigenous Coordination Centre, Ceduna (Australian Government);
- State Manager (SA) of the Commonwealth Department of Health and Ageing;
- South Australian Minister for Aboriginal Affairs and Reconciliation;
- Federal Minister for Health and Ageing;
- Federal Minister for Indigenous Health.

1) That the Commonwealth, State and relevant local Governments recognise that chronic ill health and alcohol abuse poses a serious threat to the wellbeing and functionality of traditional Aboriginal communities and that it poses specific threats to the health and longevity of the individual members of those communities;

2) That the Commonwealth, State and relevant local Governments recognise that the threat to the health, wellbeing and functionality of the members of these Aboriginal communities is a reflection of the extreme social disadvantage that occurs within those communities;

3) That the Commonwealth, State and relevant local Governments recognise that in the Ceduna township and environs there has been, and still is, an ongoing need to reduce the supply of alcoholic liquor to transient Aboriginal populations;

4) That the Commonwealth, State and relevant local Governments recognise that in the Ceduna region there is a need to strengthen and promote amongst the

Aboriginal community primary healthcare, housing opportunities, education, literacy and employment;

5) That the Commonwealth, State and relevant local Governments recognise that there is a need amongst the transitional Aboriginal communities, and the members of those communities, to have meaning in their lives such as might be provided by full employment and the pursuit of recreational and educational activities so as to provide those members of the community with a disincentive to abuse substances, particularly alcohol, and to prevent and minimise the incidence of relapse among rehabilitated individuals;

6) That the Commonwealth, State and relevant local governments remind themselves of the Recommendations of the Royal Commission into Aboriginal Deaths in Custody relating to the abuse of alcohol and other drugs (set out in Appendix A herein), many of which continue to have current relevance;

7) I make the following specific recommendations:

   a) That the Wangka Wilurrara Transitional Accommodation Centre in Ceduna, otherwise known as the Town Camp, continue to be maintained as an accommodation centre for transient Aboriginal persons. I further recommend that strict enforcement in relation to the possession and consumption of alcoholic beverages on site be maintained;

   b) That the Yalata and Oak Valley communities for the time being continue to be dry and that the possession and consumption of alcohol in those communities continue to be prohibited;

   c) That supply of alcohol to members of transient Aboriginal communities in Ceduna be reduced by employing one or both of the following strategies:

      i) Prohibiting within the region the sale of certain identified kinds of alcohol including fortified wines such as port in casks, as well as cask wine;

      ii) That greater resources and effort be provided to address the supply and sale of alcohol to transient Aboriginal people in Ceduna and remote communities of Yalata and Oak Valley;

   d) That a declared sobering up centre pursuant to the Public Intoxication Act 1984 be established in Ceduna such that:

i) The declared sobering up centre is sufficiently resourced to accommodate at least 15 individuals;

ii) That it be situated in close proximity to the Accident and Emergency Department of the Ceduna Hospital and preferably be housed within the same building;

iii) That it be staffed and be situated so as to promote efficient interaction between the staff of the sobering up centre and the clinical staff of the Ceduna Hospital, and in particular to better promote and facilitate the detoxification and withdrawal treatment of persons attending the sobering up centre either voluntarily or those under apprehension pursuant to the Public Intoxication Act 1984;

iv) That the sobering up centre be sufficiently staffed and resourced so that it can remain open and receive patients at all times;

v) That it have the capability as required under the Public Intoxication Act 1984 to detain patients in a secure and therapeutic environment for the statutory period of time stipulated under the Public Intoxication Act 1984, namely 18 hours;

vi) That the sobering up centre be regarded by police as the option of first resort upon apprehending a person pursuant to section 7(3) of the Public Intoxication Act 1984 where detention of the person is believed to be necessary and desirable;

e) That the Executive Director, Director of Nursing of the Ceduna Hospital continues to develop strategies that engender within the hospital a culturally appropriate environment with a view to inducing Aboriginal patients to remain in hospital until such time as their treatment has been completed;

f) That the recommendations made by Dr David Scrimgeour AM, as set out within these findings, be implemented, namely:

> 'I would recommend that Ceduna Hospital develop an agreement with the Ceduna Sobering Up Shelter to ensure that medically supervised detoxification is available to people referred from the Sobering-Up Shelter when required.
>
> I would recommend the development of a strategy for the management of alcohol addiction in the Ceduna area, involving all health services including the hospital. Such a strategy should include a plan about who should be notified if a patient with a known alcohol problem discharges himself or herself against medical advice, to maximise the chances of ongoing medical and social support.

> I would recommend that appropriate and sufficiently-resourced alcohol rehabilitation facilities be established within the vicinity of Ceduna, Yalata and Oak Valley as a priority.
>
> I would recommend that ongoing counselling services be available to support the management of alcohol addiction.
>
> I would recommend that ongoing training and support be provided to general practitioners and other primary health care personnel in Ceduna, particularly at Ceduna Koonibba Aboriginal Health Service, to up-skill them in the medical management of alcohol addiction. ' [69]

g) That an alcohol rehabilitation centre or facility be established that possesses the following elements, namely:

   i) That it be established at a location on the west coast;

   ii) That it be situated sufficiently close to the Aboriginal communities who would utilise it on the west coast;

   iii) That the rehabilitation centre, wherever situated, engages with and is culturally sensitive to members of the Aboriginal community;

   iv) That it be situated well away from licensed establishments and other sources of alcohol;

h) That the South Australian legislature consider enacting legislation that would provide for the mandatory detention and treatment of persons with severe substance dependence, particularly if an alcohol rehabilitation facility were to be situated at Port Augusta or at some other location in close proximity to licensed premises or other suppliers of alcoholic beverages.

Key Words: Sleeping Rough

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 4th day of November, 2011.

Deputy State Coroner

[69] Exhibit C87a, page 4

Appendix A

Recommendations from the Report of the Royal Commission into Aboriginal Deaths in Custody

Coping With Alcohol and other Drugs: Strategies for Change

272 That governments review the level of resources allocated to the function of ensuring that the holden of liquor licences meet their legal obligations (in particular laws relating to serving intoxicated persons), and allocate additional resources if needed. (4:281)

273 That consideration be given to legislating for the appointment of community workers who would have the power to inspect licensed premises to ensure that licensees comply with the applicable legislation and licence conditions. (4:282)

274 That governments consider whether there is too great an availability of liquor, including too many licensed premises, and the desirability of reducing the number of licensed premises in some localities, such as Alice Springs, where concentrations of Aboriginal people are found. (4:282)

275 That the Northern Territory Government review its liquor legislation in the light of the size of the Aboriginal population of the Territory and its needs, and include in such a review the desirability of appointing at least one Aboriginal person to be a member of the Northern Territory Liquor Commission. (4:282)

276 That consideration be given to the desirability of legislating to provide for a local option as to liquor sales trading hours, particularly in localities where there are high concentrations of Aboriginal people. (4:282)

277 That legal provision be available in all jurisdictions to enable individuals, organisations and communities to object to the granting, renewal or continuance of liquor licences, and that Aboriginal organisations be provided with the resources to facilitate this. (4:282)

278 That legislation and resources be available in all jurisdictions to enable communities which wish to do so to control effectively the availability of alcoholic beverages. The controls could cover such matters as whether liquor will be available at all, and if so, the types of beverages, quantities sold to individuals and hours of trading. (4:283)

279 That the law be reviewed to strengthen provisions to eliminate the practices of 'sly grogging'. (4:283)

280 That ATSIC and other organisations be encouraged to provide resources to help Aboriginal communities identify and resolve difficulties in relation to the impact of beer canteens the communities. (4:283)

281 That Aboriginal communities that seek assistance in regulating the operation of beer canteens in their communities be provided with funds so as to enable effective regulation, especially where a range of social, entertainment and other community amenities are incorporated into the project. (4:283)

282 That media campaigns and other health promotion strategies targeted at Aboriginal people at the local and regional levels include Aboriginal involvement at all stages of development to ensure that the messages are appropriate. (4:284)

283 That the possibility of establishing early intervention programs in Aboriginal health services and in hospitals and community health centres with a high proportion of Aboriginal patients be investigated. This would include the training needs of staff in intervention techniques. (4:290)

284 That Aboriginal organisations consider adopting alcohol-free workplace policies and be encouraged and given supper to develop employee assistance programs. (4:290)

285 That Aboriginal organisations and Councils (including ATSIC) be encouraged to give consideration to the further implementation of programs to employ multipurpose Aboriginal drug and alcohol community workers, and that appropriate assistance is sought in the training of Aboriginal people to fill such roles. (4:290)

286 That the Commonwealth Government. in conjunction with the States and Territories Governments and non-government agencies, act to co-ordinate more effectively the policies, resources and programs in the area of petrol sniffing. (4:293)

287 That the Commonwealth, States and Territories give higher priority to the provision of alcohol and other drug prevention, intervention and treatment programs for Aboriginal people which are functionally accessible to potential clients and are staffed by suitably trained workers, particularly Aboriginal workers. These programs should operate in a manner such that they result in greater empowerment of Aboriginal people, not higher levels of dependence on external funding bodies. (4:297)

288 That all workers, both Aboriginal and non-Aboriginal, involved in providing alcohol and other drug programs to Aboriginal people, receive adequate training. Priority training needs include:

a. Relevant cross-cultural awareness and communication training for non-Aboriginal workers such as health and welfare staff who provide services to Aboriginal people;

b. Skills training for Aboriginal alcohol and other drug treatment workers, particularly those who have recovered from alcohol problems themselves but have no formal training in the area. (4:297)