**Systemic change as a smarter response …. why prevention is better than cure.**

Death prevention has been long recognised at common law as an important part of the coronial function and yet, preventing death is not identified as an object or purpose in the Northern Territory *Coroner's Act* or in fact in any state or Territory in Australia other than Queensland, where it is an object of the *Coroners Act* 2003 (QLD) to "help to prevent deaths from similar causes happening in the future."[1]

There is however statutory recognition that coroners have the ability to prevent future deaths through the conduct of thorough and rigorous coronial investigations and inquests which provide an opportunity to explore failures that may have led to, contributed to, or resulted in a death. At an inquest, there is the benefit of hindsight and with that, the coroner is able to consider what happened leading up to the death and ask what could have been avoided, what should have occurred but didn't, and what systems or processes failed. By asking these questions the coroner may identify potential remedies, make comment and formulate recommendations with the purpose of the prevention of further deaths occurring in similar circumstances.

The importance of the preventative role of the coroner was highlighted during the *Royal Commission into Aboriginal Deaths in Custody* (RCIADIC)[2] which resulted in 34 recommendations on the coronial process[3], including recommendations on responses to coroner recommendations, reporting and monitoring, and improving the accountability of government agencies.

Recommendation 13 of the RCIADIC stated:

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[1] Coroners Act 2003 (Qld), s3(d).
[2] 1987-1991.
[3] Royal Commission into Aboriginal Deaths in Custody (RCIADIC) (1991).

> That a Coroner inquiring into a death in custody be required to make findings as to the matters which the Coroner is required to investigate and to make such recommendations as are deemed appropriate with a view to preventing further custodial deaths. The Coroner should be empowered, further, to make such recommendations on other matters as he or she deems appropriate.

The importance of the ability of the coroner to make recommendations for preventative purposes, is described by Boronia Halstead in Hugh Selby's '*Inquest Handbook'* as being representative of:

> "…the distillation of the preventative potential of the coronial process. The action taken in response to such recommendations carries the promise of lives saved and injury averted. It should be noted that every single death represents the tip of an iceberg of injuries and other high-risk circumstances. A proactive strategy has the potential to avert not only deaths but alleviate risks to health and safety more generally.[4]

In the Northern Territory, the broad discretionary power of the coroner to make recommendations is found in section 35(2) of the Act which provides that:

> A coroner may make recommendations to the Attorney-General on a matter, including public health or safety or the administration of justice connected with a death or disaster investigated by the coroner.

[4] Boronia Halstead, 'Coroners' Recommendations Following Deaths in Custody', in Selby, H (ed) (1998) *The Inquest Handbook, Federation Press, 186-187.*

Where the death being investigated is a death in custody or is a death which was caused, or contributed to by injuries sustained while that person was in custody the coroner must hold an inquest and must make recommendations.[5]

Where recommendations have been made by the coroner, Northern Territory government agencies are under a statutory responsibility to provide a written response to the Attorney-General responding the recommendations. [6] The Attorney-General must then report to the Legislative Assembly.[7] The report is also provided to the coroner and they are now published on the Coroner's page on the Department of Attorney-General and Justice website for public access (and transparency).

However, the mandatory requirements for agencies to respond to recommendations made by the coroner do not ensure that recommendations are implemented. What is required is that agencies consider recommendations and provide a response as to what action they have taken, or will take with respect to them.[8] It may be the response of the agency that a recommendation is 'not feasible' for example, as was the response of the Department of Infrastructure, Planning and Logistics (DIPL) to a recommendation made by the Territory Coroner, Judge Elisabeth Armitage in the matter of *Nigel Harris,*[9] who died when he was struck by a vehicle that had veered off the track after suffering suspension failure on a sand dune at the Finke Desert Race in 2021.

The governing and sanctioning body for motorsport events throughout Australia is Motor Sports Australia (MSA). MSA was outside of the coroner's jurisdiction, but

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[5] *Coroners Act* 1993 (NT), s26.
[6] *Coroners Act* 1993 (NT), s46B(1).
[7] *Coroners Act* 1993 (NT), s46B(3).
[8] Coroners Act 1993 (NT), s46B(2).
[9] *Inquest into the death of Nigel Roy Harris* p2023] NTLC 13.

recommendations were made to DIPL as the agency responsible for hosting the Finke event and obtaining the necessary approvals.

Following that inquest, it was a recommendation of the coroner that:

> The relevant government department responsible for making recommendations to the Minister prior to the granting of the legal instrument giving approval for the race ensure that adequate spectator safety measures have been implemented prior to the granting of any approvals.

The written response to the Attorney-General from the Acting CEO of DIPL was that the proposal was not feasible as it was not possible to "implement all spectator safety measures before obtaining approvals." The response then provided the basis for that position and set out what was proposed in the alternative. Whilst the recommendation in the terms proposed was not adopted by DIPL and the recommended 'overhaul' or systemic change to that process, which had been carefully considered and formulated by the coroner was not accepted on its face, it appears from media reports that there were still safety changes implemented as a result of the coronial investigation and inquest.

If that is correct, then it would appear that the inquest and resulting recommendations had a salutary effect on MSA, which is a positive and worthwhile outcome.

And for the record, despite media reporting – "Fencing the Finke" **was not a recommendation of the coroner.**

It must of course be acknowledged that the response of an agency may be dependent on the resources available to that agency to make the recommended changes. If agencies are not resourced to implement recommendations made by the coroner to prevent future deaths,

then the incredibly important and powerful oversight function of the coroner in making such recommendations, is diminished.

***Deaths in Custody***

It is a mandatory requirement under section 26 of the Act for coroners to investigate and report on the care, supervision and treatment of a person who dies while in custody or whose death was caused or contributed to by injuries sustained while in custody. The coroner must then make recommendations following an inquest, with respect to the prevention of future deaths in similar circumstances as the coroner considers relevant.

Again, as was identified in the RCIADIC, the value of any such recommendations lies in the response of the agencies to which they are directed. That response may not necessarily be an undertaking that a recommendation has been accepted and has been, or will be implemented but as required under the Act, there must be consideration given to it and if a recommendation is not accepted, an explanation provided as to what will be done to address the concerns of the coroner which led to such a recommendation.

There have been many inquests into deaths in custody in the Northern Territory. Too many. As a snapshot, I have selected two matters from 2010 and 2012 which were inquests held by the (then) Territory Coroner, Judge Greg Cavanagh. Both of the deceased were Aboriginal men and both inquests considered Watch House procedures and staff training.

The first of those was *Cedric Trigger*[10] who was arrested by police sometime after midnight on 9 January 2009 and conveyed to the Alice Springs Watch House. Mr Trigger had been arrested following a 000 call to police, advising that a male had climbed over a 2m fence at a local accommodation lodging, was violent and was being was being held by security

[10] *Inquest into the death of Cedric Trigger* [2010] NTMC 036.

guards. Less than two hours later, he was found on the floor of his cell, not breathing and could not be resuscitated. A post mortem examination found that his cause of death was a traumatic subdural haemorrhage resulting from blunt head trauma. During the course of the inquest it was revealed that there had been evidence that Mr Trigger had "duck dived" over the fence and it was found probable that he sustained his fatal head injury when he fell to the ground prior to his arrest. Expert forensic evidence was given that the symptoms of a head injury causing bleeding to the brain could easily be mistaken for significant intoxication as had been the assumption by police officers when Mr Trigger was unable (or unwilling) to walk himself to the cell.

*Terrence Briscoe*[11] died in the Alice Springs Watch House at 11.45pm on 4 January 2012. He had not committed any offence but was being held in the Watch House having been detained around two and a half hours earlier under s128 of the *Police Administration Act* because he was considered to be so intoxicated that it was necessary to take him into 'protective custody.'

He was certainly intoxicated at the time he was detained. He had been drinking throughout the day and, unbeknown to police, when he was placed in the police van for transport to the Watch House, he drank about half of a 700ml bottle of Bundaberg Rum which another detainee also in the van, had secreted in his pants. Mr Briscoe was found deceased at 1.43am during a cell check. That was despite other detained prisoners who had heard him choking and gasping for breath and had tried but failed to get the attention of police stationed in the reception area of the Watch House.

[11] *Inquest into the death of Terrence Briscoe* [2012] NTMC 032.

The inquest found that his level of intoxication was such that it was potentially fatal, the consumption of the rum raising his blood alcohol level by .211% with post mortem tests revealing that at the time of his death he had a blood alcohol reading of .350grams/100ml, which is within the lethal range. After hearing expert evidence during the inquest the coroner found that despite the amount of alcohol consumed being enough to have killed him, the probable cause of death was a combination of acute alcohol intoxication, positional asphyxia and aspiration which obstructed his airways and led to death.

There were multiple issues ventilated in these mandatory inquests. I won't go into the details of each of those for the purposes of this paper but would like to highlight similarities to systemic failures which had been identified in previous inquests and yet despite those learnings, assurances by police and recommendations by the coroner – they had not been implemented, and these subsequent preventable deaths occurred, in similar circumstances.

When *Cedric Trigger* was taken into custody, he had fallen out of the police van at the police station before being dragged and placed in a holding cell without a risk assessment, for over an hour.

It was revealed at the inquest that there had been a failure to comply with the Watch House Standard Operating Procedures (SOP's) which are part of the Custody Manual. One specific issue explored at inquest, was that the important role of having a designated watch house keeper as required was not complied with and no one had assumed the role on that night. In the absence of a Watch Commander, the watch house keeper is responsible for the safe custody and care of persons in custody and risk assessment. In that inquest, the coroner found that the allocation of a specific person as the watch house keeper had been a practice not observed for some time, despite the inquests of *Gardner (1997) and Ross (1998)* which

had also been inquests into Alice Springs Watch House deaths some ten years earlier, and had resulted in the Alice Springs Watch House Standard Operating Procedures being amended to “define and emphasise the role of the watch house keeper…” . The coroner noted that the circumstances of the *Gardner* and *Ross* inquests had highlighted the onerous responsibilities of police who take hundreds of people into “protective custody” each year and yet, the situation had not changed (despite his recommendations).

Although the same system had failed in *Trigger*, the coroner accepted the evidence from senior police that the role of watch house keeper had since been formalised and changes had been made to ensure that on each shift there was a designated officer in that role and that persons in custody who would not, or could not walk would not be dragged into cells but instead taken to hospital if in such a state, and that risk assessments would occur much sooner. On that basis, the coroner did not make any recommendations on Watch House procedures stating that “…it is not necessary to do that when I am confident that measures have already been put in place to address these matters.”

Two years later, in the 2012 inquest of *Kwementyaye Briscoe* however, where there had again been failures in Watch House procedure, the coroner expressed his dismay at the similarities between the deaths of Cedric Trigger and Kwementyaye Briscoe.

He had this to say:

> “It is astonishing to me that 14 years after the introduction of *Standard Operating Procedures* in the Alice Springs Watch House and only 18 months after an inquest into the death of Cedric Trigger, nearly every police witness called before me

> admitted that prior to Kwementyaye's death they were ignorant about the contents, in some case the existence, of those SOP's."[12]

Similarities included, that a person in police custody had been dragged to a cell having not been able to walk, the absence of a rostered Watch House Keeper and the failure to conduct a timely and appropriate risk assessment.

In his findings the coroner made specific reference to previous recommendations having not been implemented. He said:

> "This inquest has highlighted the failure to ensure that recommendations arising out of previous inquests result in long term, sustainable change. As a result, the Commissioner himself has undertaken to review any recommendations related to custodial issues that flow from inquiries conducted by the Coroner or Ombudsmen. A register has been created to track recommendations and the Commissioner will receive a relevant briefing every six months."[13]

This time, the coroner made recommendations.

Sadly though, deaths in custody continue to occur despite improvements to Watch House procedures and risk assessments including the introduction of nurses into Watch Houses following the death of Kwementyaye Briscoe, as acknowledged by the coroner in his findings for *Briscoe*.[14]

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[12] *Inquest into the death of Terrence Briscoe* [2012] NTMC 032, [184].
[13] Ibid, [221].
[14] [2012] NTMC 032.

For further examples of the types of recommendations made by the coroner, I have selected two very recent inquests held by the Territory Coroner Judge Armitage, which demonstrate the types of issues that can be addressed through recommendations for systemic change. Whether or not the recommendations made in each of these inquests will be adopted is yet to be seen but in both, the assurances by the institutional witnesses who appeared from the government agencies involved were that as a result of these deaths they have learned, that they had proactively made changes ahead of the inquest and that in essence, they have become 'smarter' by acknowledging failures and reviewing and improving the systems that failed these young people, in the hope of preventing future deaths in similar circumstances.

***Mandatory Inquest into the death of Xysz[15] (Ngalarina)***

On 19 January 2022, Ngalarina was admitted to the Royal Darwin Hospital (RDH) for 14 days as an involuntary patient under s39 of the *Mental Health and Related Services Act*. Ngalarina had a history of volatile substance abuse and upon admission, it was the impression of the on call Psychiatry Registrar that they were having a behavioural disturbance in that context, with a differential diagnosis of a relapse of schizoaffective disorder.

At 11.30pm on 31 January 2022, the 22 year old was found unresponsive in a bathroom in a general ward in RDH with an empty can of aerosol deodorant next to them which had been purchased earlier that day from the RDH pharmacy. The cause of death was sudden death associated with volatile substance inhalation (butane and propane).

In the period between admission and passing away, Ngalarina was moved between the mental health inpatient units – Cowdy Ward, Joan Ridley Unit (JRU) and the Youth

[15] Inquest into the death of *Xysz Tacdilwaazy@Josh Ngalarina @ Mayinaj* [2024] NTLC 3.

inpatient Unit (YIP) and also a general ward. The moves made were for a number of reasons including outbreaks of COVID-19 in the mental health inpatient units but also due to improvements in Ngalarina's mental health which meant that they were progressing towards being discharged at the end of the 14 days and, having been clinically assessed it was considered that they could safely be transitioned to lower acuity environments.

One of the issues for the inquest was that of 'outliers'. Outliers are mental health patients who require mental health inpatient services, but due to a shortage of beds in the appropriate inpatient unit are placed in the emergency department or a general ward. In this case, it was Ward 3A, which is the general orthopaedic ward where, as we learned at the inquest, outliers were often sent despite Ward 3A staff not being trained in caring for mental health patients.

Although Ngalarina was in a general ward, they were still an involuntary patient and under security guard to prevent escape from the ward and to prevent harm to self or others. One of the issues was that security guards were not informed of Nglaraina's mental health status or the relevant risks, including volatile substance abuse. It was while under security guard escort that Ngalarina purchased aerosol deodorant from the RDH pharmacy.

A glaring absence of clear policies and procedures, handover processes and appropriate training for the non-mental health staff who care for mental health patients in general wards was explored in detail at the inquest. It was acknowledged by the Department of Health (Health) that those were either lacking or inadequate, and had contributed to this preventable death. By the time of the inquest much work had been done to improve those processes and the coroner heard evidence that the work was ongoing. Given the 'prompt and diligent' response of Health to the death of Ngalarina which included the review and

revision of policies and procedures, the introduction of new training programs for VSA and mental health patient care, the coroner did not make any recommendations concerning staff training or outlier polices.

However, one lingering concern held by the coroner was the availability of aerosols in general wards. In the institutional response, Health advised that following Ngalarina's death, aerosol deodorant had been removed from the shelves in the RDH pharmacy, but the view of the coroner was that it was not enough to ensure that aerosols were not accessible in the general wards.

To ameliorate that risk, the coroner made the following recommendation:

**I recommend** that the Department of Health consider extending the ban on aerosol cans to apply hospital wide and, where that is not possible, for example on medical grounds, they be kept safely secured.

These findings were handed down on 5 April 2024 and the written response of the Chief Executive Officer for Health to the Attorney-General is required within 3 months.[16]

***Discretionary Inquest into the death of Grace***[17]

This was the death of a 13 year old girl, who died on 28 January 2022 from a self-inflicted gunshot wound to her chest. The weapon used was a .308 Winchester rifle which belonged to her father. The rifle and ammunition had been stored in an unlocked cupboard in her parents' bedroom, in suburban Darwin. Grace had a younger brother who also lived at the home and also had access to the unsecured weapon.

[16] *Coroners Act 1993 (NT),* s46A.
[17] *Inquest into the death of Grace* [2023] NTLC 7.

In September 2021, Grace disclosed to her school counsellor that she had thought about suicide. It was the third time she had been to see this counsellor, having previously self-referred. Their first two sessions were in June 2021 and they had discussed friendship and peer group issues not considered by the counsellor as uncommon for female students in year 7.

There was nothing uncovered in the investigation into Grace's death to indicate that anyone else knew that she was having suicidal thoughts but after she had passed away, her private notebooks revealed drawings and writings dating back to 2019 which revealed that secretly, Grace was suffering and had suicidal thoughts.

There were two institutions involved in this inquest, the Department of Education (Education) and NT Police (Police). There were a number of issues explored, including the missed opportunities by Education to identify the risk of suicide and engage in any safety planning due to the lack of adequate policies and guidelines around suicidal disclosures. There were also questions about missed opportunities in the collection of forensic evidence, ballistics expertise and some of the decision making in the investigation conducted by NT Police.

***Police***

Although ultimately found by the coroner not to have resulted in any significant failings in the outcome of the investigation into Grace's death, there were issues identified in the police investigation which, it was acknowledged by Police at the inquest, should have been done differently.

Broadly, the issues identified were:

- the failure to have a Forensic Pathologist attend at the scene or to provide expertise and guidance in the collection or preservation of forensic evidence
- the lack of gunshot residue (GSR) on Grace's hands or feet
- the failure to take Grace's fingerprints
- storage of firearms and ammunition, regulation and compliance with the *Firearms Act 1997* and the decision by police not to charge Grace's father for his failures under the Act
- lack of expertise within NT Police to reconstruct a firearms crime and scene ballistics expertise generally

In relation to the majority of these, whilst they were acknowledged as shortcomings in the investigation for which the coroner made recommendations[18] to inform and improve future investigations, she was satisfied that there was no third party involvement in Grace's death and made findings to that effect. However in a different scenario, that may not have been the conclusion. It was acknowledged by NT Police that there had been significant learning opportunities to improve investigation practices and many of those improvements were demonstrated through the institutional response.

[18] **I recommend** that NT Police embed in appropriate general orders clear direction as to the circumstances in which it is mandatory to immediately notify the forensic pathologist of a death and provide an opportunity for their attendance at a scene, in person or via videolink; **I recommend** that NT Police amend the appropriate general orders to identify deaths in which it is mandatory for Police to attend autopsies and, guidance as to any discretion (if any); **I recommend** that NT Police amend the appropriate general orders or other applicable policy to address fingerprinting for forensic purposes including for comparative purposes; **I recommend** that NT Police review the information provided to police members about decisions on prosecution and update relevant information or training to reflect the Internal Broadcast "Prosecution Opinion files – Coronial Investigations involving unsecure firearms: dated 1 December 2022.

With regard to the lack of forensic expertise in firearms deaths however, the coroner expressed concern about that still being the case in 2022, given the assurances given by Police to the (then) Territory Coroner, Judge Cavenagh, in the 2018 inquest of *Matthew Rosewarne,*[19] that an independent review commissioned by police would review the adequacy of skills, experience and training, expertise and supervision in crime scene, fingerprints and firearms units within NT Police.

On the basis of those assurances, Judge Cavenagh had not made any formal recommendations in 2018, expressing confidence that the review and additional training would occur. However, as noted by the coroner in her findings in *Grace,* six years on, the Northern Territory remains without the necessary expertise in this area. The coroner said

> "…like Judge Cavenagh, I too am asked to be reassured that an agency wide review of Police which was commenced by the Northern Territory Government in 2023 will specifically report on forensic capabilities, identify gaps and future priorities. However, even with that assurance, I am concerned that reviews achieve nothing without implementation and steadfast commitment (even in spite of new competing priorities)."

On this occasion, the 'assurance' of systemic change was not enough and the coroner went on to make a **recommendation** that:

> NT Police establish and maintain internal expertise in firearm crime scene reconstruction and ballistics or have and maintain availability of appropriate external expertise.

[19] Inquest into the death of *Matthew Rosewarne* [2018] NTLC 024.

***Education***

In *Grace,* the other government department in the spotlight was the Department of Education. In particular, the failure of the school counsellor to appropriately respond to Grace's disclosure of suicidal ideation.

What was revealed through the coronial investigation and subsequent inquest, was that at the time of Grace's disclosure in 2021 (and her death in January 2022), the school operated under a *Student Wellbeing and Positive Behaviour Policy* which was an inadequate framework to ensure appropriate information sharing or to manage the risk in circumstances such as Grace's. There was nothing formal in place at the time to guide staff on self-harm or suicidal disclosures.

On 13 September 2021, following Grace's disclosure to the school counsellor that she had thought about suicide, a risk assessment was carried out by the counsellor in which Grace was assessed as 'low risk', meaning that there was no active follow up or safety planning. The record keeping of the school counsellor was poor, and contemporaneous school records of the three sessions with Grace were not made. Instead, they were entered months later based on handwritten notes which had then been destroyed, and without any independent recollection of the sessions. The record keeping was inadequate and unsatisfactory.

At the time of the inquest, the Department had made significant improvements to the '*Whole of School Approach*' to student wellbeing and whilst the coroner referred to the reforms which had been made as 'encouraging and positive' it was her view that there was still further work to be done.

It was **recommended** that:

> the Department of Education ensure that there is appropriate policy, guidelines and training in all schools incorporating best practice following any disclosure of suicidality or suicidal thoughts by a student, including but not limited to, risk assessment, safety planning, follow up or referrals and communication to appropriate persons. Consideration should be given as to whether a policy similar to the NSW *Management of Suicidality in Students* policy should be adopted.

In the inquests of *Xysz* and *Grace*, it was apparent that the deaths of those young people had a profound effect on the institutions involved which had failed them. To their credit, in the institutional responses each of the departments identified and accepted responsibility for the failures in their systems and processes, and gave undertakings to make changes to reduce or prevent the risk of future deaths in similar circumstances.

Ultimately, it is smarter for government departments and agencies to commit to systemic change. Coronial investigations, inquests and recommendations are a powerful tool and attract wide reaching media interest and public attention placing the spotlight squarely on those responsible. With the addition of departmental 'buy in' and commitment to continuous systemic improvement and reform, future deaths may be prevented.