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NORTHERN TERRITORY OF AUSTRALIA

CORONERS COURT

A 51 of 2019

AN INQUEST INTO THE DEATH

OF KUMANJAYI WALKER

ON 9 NOVEMBER 2019

AT YUENDUMU POLICE STATION

JUDGE ARMITAGE, Coroner

TRANSCRIPT OF PROCEEDINGS

AT ALICE SPRINGS ON 14 OCTOBER 2022

(Continued from 13/10/2022)

Transcribed by:
EPIQ

THE CORONER: Mr Coleridge?

MR COLERIDGE: Good morning, your Honour. The next witness will be Helen Gill. She is present in the body of the court and I call Helen Gill.

THE CORONER: Ms Gill, if you wouldn't mind just coming up to the witness box? Thanks for coming to court to day to give your evidence.

HELEN GILL, affirmed:

XN BY MR COLERIDGE:

MR COLERIDGE: Ms Gill, my name is Patrick Coleridge. I am one of the counsel assisting the coroner. Before I ask you any questions I might just remind you that this isn't a memory test and that it is perfectly acceptable for you to say that you don't remember things. Equally, if I am confusing you you let me know - that is my fault, not yours. If you don't hear something you let me know. If you want to have a look a the documents you've got in front of you, you let me know, okay?---Thank you.

I take it that you've got a couple of documents in front of you?---That's correct.

And those documents are an affidavit that you authored on 6 April 2021?---That's correct.

Your Honour, that's at 9-5 of the brief.

And the second document is an affidavit that you authored on 3 October 2022? ---That's correct.

And that's at 9-5AA. Sorry, that's for the purposes of the record and not (inaudible). Can I just ask you a couple of questions about the annexures to those documents? ---Yes.

So the first affidavit - this is the April 2021 affidavit, at annexure HG2 you've included a time line, is that correct?---That's correct.

And that time line is a time line you prepared from your handwritten notes?---That's correct.

And they were handwritten notes that you started taking on 9 November, is that correct?---That's correct.

2019?---That's correct.

Now, I don't know if I have misunderstood the affidavit but it sounds as though on 10 November you started typing your notes?---That's correct.

So you typed up the notes you had taken by hand the day before?---That's correct.

And started taking new notes on the 10th directly into that document?---That's correct.

So these are contemporaneous notes?---That's correct.

That reflect - or reflective as best you could, your memory of the things that you did and said as you did and said them on the 9 and 10 November?---That's correct.

All right. Now, when you annexed that document to the affidavit of 6 April 2021 did you amend that document in any way?---Not at that annex - not at that time.

At that time, no. So that you hadn't updated it in any way when you annexed it to the first affidavit?---That's correct.

Now the second affidavit - so the affidavit dated 3 October 2022, there is an annexure HG5 which contains an updated timeline?---That's correct.

Now, is the time line as follows - some time before October 2022 you were asked to provide a supplementary affidavit?---That's correct.

And you'd been informed that the coroner was investigating the death of Kumanjayi Walker?---That's correct.

And as a part of that investigation she was investigating decision-making surrounding the withdrawal of health staff from Yuendumu?---That's correct.

And you understood that it was important to provide as much information as you could?---That's correct.

In part because there might be criticisms that there had been deficiencies in health decision-making?---That's correct.

You were aware at the time you updated that timeline that a root cause analysis had been conducted by the Department of Health, is that correct?---I'm not sure if it was completed at the time that I updated my timeline but I was aware that it was being undertaken, yes.

So you were certainly aware that it was being done?---That's correct.

If I put it to you that the root cause analysis was completed on 31 August - or at least that it was circulated to counsel assisting on 31 August and you furnished your second affidavit on 22 October, would it stand to reason that you updated the timeline after the root cause analysis was complete?---It may have been. I have not received that root cause analysis findings though.

Now, I take it that you updated the chronology that you had prepared on 10 November 2019?---That's correct.

And then annexed it to the affidavit of October 2022?---That's correct.

Did you rely on any other contemporaneous notes when updating that timeline? ---No.

Okay, so the updates - and the updates are reflective in blue text?---That's correct.

In that updated timeline. Those updates are entirely reliant on your memory of events, is that correct?---That's correct.

Your memory of events some three years later?---That's correct.

Had you been involved in discussions with the Department of Health - perhaps you hadn't been given the findings, but involved in discussions around the root cause analysis?---I was interviewed.

And had you discussed the decision-making on 9 November from other health staff in the three years in between 9 November and 22 October 2022?---Sorry, could you just repeat that?

Okay. The first date is 9 November 2019?---That's correct.

The second date is 22 October 2022?---Mm mm.

In the interim had you had discussions with other health staff about the decision-making that had been undertaken in November 2019?---Obviously with the root cause analysis. Also within our primary and public health care services for what we could improve on for - and lessons learned from the withdrawal of our staff that weekend.

And those discussions would have included people like David Reeves?---That's correct.

Naomi Heinrich?---Not that I spoke to Naomi, no.

What about clinic staff from Yuendumu who had been in Yuendumu in November 2019?---I don't have any recollection.

Certainly you were aware that there had been a good deal of media attention and the like around both the trial and the Coronial inquest?---That's correct.

And you knew that it was a matter of some significance for the Department of Health?---Absolutely.

Can I just ask you two questions then about the chronology, what it is, and I suppose how sure you are of its contents?---Yes.

The first question I have for you is would you say you are pretty confident that the things that you did write in November 2019 are accurate?---Yes.

Because they are contemporaneous?---I'm not sure of that word, but yes.

You made them at the time?---Yes, yeah, yeah.

But the mere fact that you had to update the timeline in October 2022 suggests that there were things that you didn't put in those notes?---That's correct.

Okay, so you'd accept that there were omissions from those original notes?---Yes.

Given how much later you made the updated timeline, would you accept that there could be other things not included in the blue text that you might have omitted from that timeline?---Yes.

The second question I wanted to ask you concerns the blue editions themselves. You made them some three years after the events?---Yes.

And you were doing your best to recall not just one conversation you'd had on 9 November but perhaps a series of about 50 conversations?---That's correct.

Over two days?---That's correct.

And in that blue text you provide what I might suggest to you is an extraordinary level of detail for someone recalling events three years after the fact?---It was a significant event.

But you would agree that there is an extraordinary level of detail?---Yes, I would agree.

And I think you've already agreed that the matter had been widely reported in the media in the intervening period?---That's correct.

And you'd had discussions about it with the Department of Health - staff within the Department of Health?---That's correct.

Do you accept that when you were updating that timeline some three years later there is a risk that you may have mis-remembered some of the text in blue?
---There's an obvious risk.

And that that risk is compounded to some extent by the fact that you were also receiving information about the events of 9 November from sources external to yourselves?---I accept that.

Can I move away from the documents themselves?---Mm mm.

And just ask you some introductory questions about who you are and what you do? You are originally from New Zealand. Is that right?---That's correct.

All right. And can I ask you first, let's forget your kind of management background, what's your clinical background?---Yep, so I'm a registered nurse. I have been practising within Australia since 2004 this time. Prior to that, it has been - my nursing background has been in New Zealand from 1995 when I registered a combination of Emergency Department, mental health units and high dependency and intensive care units and education as well. Since arriving in Australia this time, predominately, I worked at - - -

I'll just pause you there?---Yes.

When you say, "this time", was this around 2004?---2004. And 1999, I came over and worked at Cabrini Cardiothoracic Unit in Melbourne.

That's in the south-eastern suburb somewhere?---Yeah, yeah, yep.

But perhaps let's focus on 2012 - - -?---Yep.

- - - which is when I gather you came to the Territory for the first time?---That's correct, I - - -

Can I ask you why you decided to come to the Territory?---I was looking for something different. I never believed that nursing is something that is completed within four walls. I was looking for an opportunity to do more, I guess in a remote rural region and to hopefully provide education and health care that wasn't necessarily restricted to within a structure as such.

What opportunities did you understand the Territory to offer in that regard?---Yeah, sure. So, Indigenous heath. The challenges within health care provision and remote locations. It had – I had had a previous colleague that had worked also in the Territory who was very positive and the opportunities of, you know seeing, I guess, seeing the location and the opportunity arose, so I came over.

So, can you tell us a little bit around your practice, your clinical practice since 2004? I know that you've moved to towards management?---Yep.

But what was the nature of your clinical practice from 2004?---Yep, sure. So, initially, when I arrived, I worked in the Emergency Department here at Alice Springs Hospital. Then I transferred over to remote, which is now known as Primary and Public Health Care. I – initially when I commenced work with them, I was a relieving remote area nurse, so where there was staff on leave or we didn't have people filling positions, I would relocate around those communities. I then - - -

Can I just pause you there?---Yes.

Some of those communities were Warlpiri communities?---That's correct.

Including Yuendumu?---That's correct.

You spent a bit of time in Papunya?---That's correct.

Go on?---And then, I was health centre manager out at the Watarrka Health Clinic which is also known as Kings Canyon. I was there for over a couple of years and then I had a break from primary and public health care and went and worked as an occupational health nurse on the Granites gold mine out on the Tanami, and then returned to primary and public health care in 2010, where I once again relieved in multiple communities and then was based in Ti Tree as the health centre manager. So, over those periods of years, I've been a combination of a remote area nurse, as well as the remote area nurse/health centre manager in those communities.

Now, ultimately, you've kind of – I know that you still do some clinical work?---That's correct.

But you've taken on managerial responsibilities. Is that right?---That's correct.

What is your current role within the Department of Health?---Currently, I'm the quality and safety manager for primary and public health care.

I want to ask you some questions about primary and public health care. I think Dr Reeve gave us a bit of a potted definition of the difference between primary and secondary and tertiary health care, so you can assume a degree of familiarity with that term. But is it fair to say in your view that – and maybe this is one of the things that interests you in Indigenous health, but there is a real disparity in outcomes from a primary health perspective between urban centres and from non-Indigenous communities?---I would agree with that.

And that reflects rates of ill-health in many remote Indigenous communities?---That's correct.

For example, remote and Indigenous communities like Yuendumu have some of the highest rates of chronic disease in Australia?---I accept that.

Things like rheumatic heart disease?---I accept – sorry.

You've just got to verbalise for the record?---Sorry, yes, I accept that.

Other cardiac conditions?---I accept that.

Diabetes?---I accept that.

Other renal or kidney disease?---I accept that.

Respiratory illness?---I accept that.

But also, acute mental health presentations?---That's correct.

For example, it's in remote Indigenous communities in the Territory that we're seeing some of the highest suicide rates in the world amongst young adults?---That's correct.

And in relative terms, high rates of presentation of things like drug-induced psychoses?---That's correct.

So, primary health care isn't just about ensuring that we deal with minor conditions in a long-term sense, it's also about dealing with what can be very acute presentations?---That's correct.

Things that require emergency or urgent responses?---That's correct.

Asthma attacks?---I accept that.

Anaphylaxis?---That's correct.

Heart attack?---That's correct.

Serious injury during fights?---Yes.

Lacerations, stabbings, gunshot wounds and the like?---I accept that.

And equally, people tragically do things like take their lives?---That's correct.

Okay. Now, some of those acute presentations are beyond the skill set of a remote clinic to deal with?---I accept that.

At least, not completely?---But some of them can be dealt with. Is that right?---That's correct.

So, things like anaphylaxis, for example, could be dealt with, with an EPIPEN? ---That's correct.

All right. You said a moment ago that your role was, I think, quality and safety assurance. Is that right?---Quality and safety manager, that's correct.

Is it fair to say that in order to ensure the quality of the health services that the department is providing, you keep statistics?---That's correct.

And you keep those statistics to identify health needs across the Territory?---That's correct.

Including by region?---That's correct.

And in part, that's also to identify service gaps that might be arising?---That's correct.

To allocate resources?---That's correct.

And it's also just important to assure that you maintain the consistency and quality of the health services that you're providing, for example, to a community like Yuendumu?---That's correct.

Does the Department of Health keep performance indicators - - -?---We do.

- - - for individual clinics?---That's correct.

So, these would be stats that would enable you to monitor how one clinic in one location is performing as against another clinic?---That's correct.

Would there be stats that would enable you to monitor rates of compliance with regular Echo screening of patients with rheumatic heart disease?---That's not part of our – one of our key performance indicators.

Would there be other statistics that you keep that would allow you to monitor it on a clinic by clinic basis or not?---Not off the top of my head.

What about statistics that would allow you to monitor rates of chronic disease screening?---Yes.

Rates of staff turnover?---Yes, that's not key performance indicator, but yes.

But the statistic – the data - - -?---We would have that. Yes.

Yes. What about data that would allow you to monitor or measure the number of referrals from an individual clinic to a general visiting physician per capita?---That's not one of our key performance indicators.

(Inaudible) be more statistical data to allow you to measure it?---They would be able to obtain that.

Are there other important metrics or measures or KPIs that you use to measure the performance of one clinic as against another?---No, just our normal NT KPIs.

Are those KPIs publicly available somewhere?---I believe so.

Could you list the KPIs for her Honour? I don't know how lengthy they are; if there are 100 or so of them, perhaps - - -

THE CORONER: Mr Hutton is standing up behind you.

MR COLERIDGE: Sorry.

MR HUTTON: But they are lengthy, your Honour, and they're a Northern Territory wide KPI's that's set with the Commonwealth government, AMSANT and other parties. We – we can certainly provide those - - -

MR COLERIDGE: I won't – I won't ask you to specify what they are?---There are a number of them.

Can I just ask you this though, as a part of quality assurance, would you also be monitoring complaints that are made about individual clinics?---That's correct.

All right. From 2019, are you aware – sorry. Are you aware of any particular complaints about Yuendumu Health Clinic, about the treatment or insensitivity towards Warlpiri people in Yuendumu?---Not that I can recollect.

Do you know how residents would make a complaint?---There's a number of ways, so there is through the health centre itself, through the health advisory group. There is – we have a consumer engagement survey that is completed within all of the communities by our local Aboriginal Employment Officers within Alice Springs here that travel out to communities. That's giving options, and part of that survey is about the satisfaction that they are receiving. Do they feel that they've been heard? So we get feedback that way.

Can I just (inaudible)? And sorry, go on?---And also we have the Northern Territory Consumer Feedback form, that they can submit. They can also call the Health Commission. And there's other avenues that way.

This might be something you're able to answer on your feet, equally it might not, but do you have a sense of how Yuendumu Health Clinic is comparing to other health clinics in the Northern Territory on those KPIs?---Not without reviewing them, no I'm sorry I don't.

But that's something that could be done?---Absolutely, yeah.

I want to ask you some questions now about temporary withdrawal of service?---Yes.

Now asked you some questions about how critical primary health care was, particularly in remote communities, but you'd agree, wouldn't you, that it's as a result of the significance of primary health care that temporary withdrawal of service is such a serious decision?---That's correct.

It can have real implications for a population, is that right?---That's correct.

And those health implications can include avoidable hospitalisations?---That's correct.

And preventable deaths?---That's correct.

And that's why I take it, that the decision needs to be made at a relatively high managerial level?---That's correct.

The executive level?---That's correct.

When making decisions about temporary withdrawal, you make a risk assessment, you'd agree?---I agree.

Now, you're effectively balancing a number of things when you do this?---That's correct.

One of those things is level of risk to staff?---That's correct.

And on the other hand, you're balancing level of risk to community?---That's correct.

The health implications?---That's correct.

Now do you accept that these are balanced in the sense that the higher the degree of risk to the community, the greater the degree of risk to your health staff needs to be, before you could decide to pull them out of a community?---Sorry, could you repeat that?

I might give a more practical example?---Yeah.

If a community was very, very healthy, it might be easier to justify the decision to withdraw staff on the basis of their safety, than if the community was very, very unwell, would you agree?---I would agree, but – yes, I would agree.

Am I also right that these risks – or the level of risk on either side of the ledger, it isn't static, it can change over time?---Very much so.

And so when assessing risk, and balancing risk, you need to reassess things if the data changes?---That's correct.

Okay. Finally, and as the temporary withdrawal of service guideline states, risk assessments needs to be documented?---That's correct.

And you'd be well aware that that was one of the deficiencies identified in this case? ---Yes.

And there are perhaps two reasons that these decisions need to be documented, if I could put the first to you. It's that it ensures accountability and historical record? ---That's correct.

But equally, and I think this is a word that Mr Mullins used yesterday, it ensures that processes are followed?---I accept that.

Where there are check lists, it ensures that you check each box?---I accept that.

For example, it ensures the people who need to be notified of decision making are notified of decision making?---That's correct.

Can I ask you questions now about that first side of the ledger, which is your assessment of the degree of risk to staff? You say in your second affidavit, that a significant consideration is the views of the staff members themselves - - - ?---That's correct.

- - - would you agree? And your evidence is that you need to take these views seriously?---That's correct.

Even though they might be what we call subjective?---Mm mm.

And that's because staff well-being is important?---That's correct.

But also because they're on the ground, correct?---That's correct.

They know the context?---That's correct.

You don't know as much of the context?---That's correct.

You've also given evidence that staff have a tendency to under-report safety concerns?---In my affidavit I have, yes.

But what follows from that in your opinion, it seems, is that when staff come to you and say we're worried about this, you've really got to listen?---That's correct.

Because a lot of the time they might be worried, but say nothing?---That's correct.

So there mere fact that they're saying something, is an indication in itself, of the seriousness of the problem?---That's correct.

You then say that you need to balance the subjective assessment against an objective consideration of the relevant circumstances?---That's correct.

Now, some of those circumstances, some information, is information given to you by staff would you agree?---I would agree.

But an important part of making an objective assessment is seeking out other information, would you agree?---That's correct.

And in the remote community context, that can mean liaising with other stakeholders?---That's correct.

A very significant stakeholder, when the issue is staff safety, is the police?---That's correct.

They are often best placed to provide information about levels of crime in a particular community?---That's correct.

In this case, it was suggested to you by Cass Holland I think, that there were – there was an influx of ganja into the community?---That's correct.

And police would be best placed to tell you something about that, you might think? ---That's correct.

But in addition to telling you something about crime, they can provide you critical information, about things that they can do, to mitigate risk?---That's correct.

They might have arrested an offender who was responsible for the break-ins, correct?---Correct.

They might be planning to conduct high visibility patrols on the streets of Yuendumu, for example?---That's correct.

They might have planned a community meeting to address increasing rates of crime?---Yes, that's correct.

You'd agree that all of those things are potentially protective, in the sense that they might reduce risk?---That's correct.

And so it is essential that you know what they're doing, before a decision about withdrawing is made, would you agree?---I agree.

Another stakeholder, and one I think that you note in at least your second affidavit, is – or are elders within community?---That's correct.

And I'm using the word "elders" as a little bit of a loose catch all for you know, senior Aboriginal people?---Yes.

And that's important first, just because it's their community?---That's correct.

You're providing the service to them?---Mm mm.

So it's respectful?---I accept that.

But also, because they can be a really important source of information about what's happening in community, would you agree?---I agree.

You might find out, for example, that there's a big funeral on?---I agree.

You might find out that families from one camp are fighting with another camp, would you agree?---I agree.

You might find out that a kid who is responsible for some break-ins, had been taken by family to Papunya?---I would agree.

So, the things that you learn from elders are also potentially very significant to the risk assessment. Would you agree?---I agree.

I want to ask you some questions now about 9 November 2019. I'm going to skip through some of the chronology quickly. We have your affidavits, which are obviously very detailed. And they're a part of the evidence. So I'll focus on a couple of individual steps in the decision making. Nine o'clock you received the first notification from Janine (inaudible) is that right?---That's correct.

You're very welcome to go to the - - - ?---Timeline.

- - - first or second chronology, up to you?---Yep.

In any event, she's received a call from Cass Holland, and Cass Holland had told her about the break-in at Vanessa Watts' house?---That's correct.

And Cass Holland effectively asked about covering for Watts, because Watts was so fatigued?---That's correct.

All right. Now at 9.08, you then notified David Reeve, correct?---That's correct.

Now your next call was at about 9.12, so the conversation with Reeve could only have been three or four minutes long?---That's correct.

And as I understand it, you were just information sharing at that stage?---That's correct.

At 9.12, you then had a conversation with Cass Holland?---That's correct.

And she then relays to you some information about what's going on?---That's correct.

She says that staff are feeling unsafe?---Mm mm.

I want to suggest to you that she doesn't say that staff want to be removed?---That is correct.

That's correct?---That's correct.

She's just raising a concern about safety?---That's correct.

And she's looking for support?---That's correct.

Ms Gill, did you tell her at that time, that the way the Department would support health staff in Yuendumu was by removing them from Yuendumu?---That's incorrect.

Okay. At 9.20, you then had a conversation with Fiona Cameron?---That's correct.

And you provided her with an update?---That's correct.

Based on what you'd been told by Janine Bridge?---That's correct.

And Cass Holland?---That's correct.

You told her that the nurses weren't feeling safe?---No, that's not correct.

You didn't tell her that?---Not at that stage.

Did you have any discussions about the withdrawal of nurses from Yuendumu?
---I had the discussion, at that stage, with Fiona Cameron, regarding Vanessa Watts, if that – that there had been, as discussed with Cassie Holland and documented in my timeline, if there was any other secured accommodation that Vanessa could have been moved into if there was damage or we were un – unable to secure her accommodation. If there was anywhere else within Yuendumu that we could securely accommodate her. And if there wasn't, because she kept referring to her as feeling spooked, then we would possibly withdraw her to Alice Springs.

So in so far as there was discussion about withdrawal, your evidence is that it was limited to Vanessa Watts?---That's correct.

All right. Are you sure that you couldn't have discussed the possibility of withdrawing the entirety of the health clinic at that time?---That's correct, I - - -

You're sure?---I did not discuss that at that stage.

At 9.30, so this is about 10 minutes after your conversation with Cameron started?
---Mm mm.

You then had a second conversation with Cass Holland, do you agree?---That's correct.

Now, your notes say that you just asked Cass Holland for Luana Symonds number?
---That's correct.

Is it possible that during the course of that conversation, you said to Cass Holland, look, if clinic staff are unsafe, we're going to pull you out?---No.

It's not possible?---That's not the discussion that we had.

Would you accept, given what you've said about the possibility that there might be omissions from these notes, would you accept that it's possible, that a conversation of that kind occurred?---It's possible, but that's not my recollection of that telephone call.

Indeed, it's possible that something of that kind was said, in either of the conversation at 9.12 with Cass Holland, or the conversation at 9.30, isn't it? ---It's possible, but that's not my recollection.

I want to take you to some evidence, in fairness to you, some of the other evidence in the case. The first evidence I'll take you to is the evidence of Ms Holland herself.

Your Honour, for the record, this is Ms Holland's slightly informal statement, at 9-6 of the brief at page 1.

Now, you don't have a copy of this. So if I'm reading too quickly, you let me know?---Okay.

But in effect, and this is in the middle of the page, Ms Holland says "I made the phone call to the manager on-call and described the previous night's events." Now the manager on-call at that time was Janine Bridges?---That's correct.

"I explained that those concerned did not want Luana informed, as she was already stressed"?---That's correct.

Luana was in Alice Springs?---That's correct.

"Janine advised that she would need to notify the executive on-call, Helen Gill"? ---That's correct.

The next paragraph reads, "Helen rang me back after she'd escalated the information to Fiona Cameron. Helen advised that Luana would be told. Helen then requested that I visit the group of nurses personally, to deliver the message that if they felt unsafe, they would be accommodated in Alice"?---That's not my recollection.

No. Does it cause you to doubt your recollection at all, noting what you've said about your notes, that Ms Holland's recollection appears to be that you told her that, at around about 9.30?---I'm – I feel that that's difficult, because this is my recollection, and that is Cassie's recollection. And so we have to respect both of them.

Of course. Now, Ms Holland goes on to say that she was then accompanied by John Alton to go on and visit some of the elders and speak to them about what was to occur in community. I'm not asking you to comment on that. I'm just providing you that information by way of context. The next piece of evidence that I want to take you to is the evidence of Janine Rewaka. Now she gave a statutory declaration to the Coroner on 26 June 2020. And she was one of the nursing staff on the ground in Yuendumu that day?---That's correct.

Okay. You may or may not be aware, that she annexed to her statutory declaration a set of handwritten notes?---Mm mm.

And gave evidence in the stat dec that she'd written those notes on 12 November 2019. So that's three days after the events?---Okay.

I just want to read to you what she says happened. She says, "The next morning", so this is the morning after the break-ins, the morning of the ninth. "I was sitting outside when Cassandra Holland and John Alton pulled up in the clinic ambulance. I went over to talk with them. Cassandra informed me that she'd taken this matter higher up to the managers, Helen Gill, who wanted to evacuate us for our safety." Now, you'd agree that it sounds very much like Cass Holland was telling her, Helen Gill has told us that if we're feeling unsafe, we're out?---That's implied in what you've read, yes.

And that evidence, which is – was as good as Ms Rewaka's memory three days after the events, appears to be consistent with Ms Holland's memory of her conversation with you. You'd agree?---That – appears that way.

And perhaps if I can just take you to Ms Cameron's evidence, or some of Ms Cameron's evidence. I won't go there. Ms Gill, I'm not suggested that you had a made a final decision at 9.30 in the morning. But could I suggest to you that it's possible that you had said to the nursing staff, look, if you guys are feeling unsafe, what's on the table is withdrawal?---My recollection of my telephone call, at that time that you've bought me to thus far, is with Cassie Holland. And that the discussion was – excuse me, in regards to the security of Vanessa Watts' house. It was in regards to if there was no other way to provide her a safe and secure accommodation, and that she requested to be, or would like to be, we could withdraw Vanessa, and bring her into town for the weekend. At that stage, the discussion was only regarding Vanessa. But that we needed to ask how the other staff were feeling.

Given that you were going to – you contemplated it at that time, so that's at 9.30 or thereabouts in the morning on 9 November, that you would ask staff how they were feeling?---Yep.

Could it have been suggested if – that if they were feeling bad and unsafe, the option would have been to withdraw them as well, like Ms Watts?---That's a possibility.

Okay. I mean that would make sense, given that what you contemplated for Ms Watts was withdraw - - - ?---Mm mm.

- - - correct?---That's correct.

And so if other staff members felt unsafe, it's likely that what you would have contemplated doing for them, would have been withdrawing them as well?---It was a possibility, yes.

I want to ask you some questions, just quickly, about the conversation you had with Luana Symonds at 11.15 am?---Yes.

Now, Luana was in Alice Springs, correct?---That's correct.

Now, she said to you that "All staff are requesting to withdraw" is that right?
---That's correct.

Did you ask her "Which staff"?---No, I did not.

Did you think it was important that you speak to the staff who wanted to leave at that time?---Yes.

And you did that at 11:40?---That's correct.

I want to be careful about the timeline here though. At 11:15 am you had not yet spoken with any member of the police force?---That's correct.

You hadn't spoken to any of the Indigenous staff?---That's' correct.

You hadn't spoken to any of the elders?---That's' correct.

Any of the other stakeholders?---That's correct.

And indeed, the only staff on the ground in Yuendumu you had spoken directly to was Cass Holland, correct?---At that stage that's correct.

All right. You hadn't even spoken with Vanessa Ross?---That's correct.

Or any of the other nurses whose houses had been broken into?---That's correct.

At 11.35 am you then got on the phone to Fiona Cameron, correct?---Mm mm. That's correct.

And you second affidavit, page 32, you say, "Well, I notified her of the request of Yuendumu clinic staff to all be removed from community?---That's correct.

And Fiona Cameron said that she'd notify Reeve - David Reeve?---That's correct.

Now, you then had a telephone call at 11:40, correct?---That's correct.

That was the conference call with all of the staff?---That's correct.

And your next call was at 11:50 when Fiona contacted you and said, "David has made the decision, you're approved for withdrawal?---That's correct.

So the information on which David Reeve approved the withdrawal was the information you provided to Fiona Cameron at 11:35 am?---I believe that as you have noted, that by omission I probably - I believe that I have mis-documented there

where I have contacted Fiona after the telephone call. It is not documented in my timeline though.

Okay. Now, the times in the timeline you extracted - or at least your evidence is that you extracted those times from your phone, correct?---That's correct and my notes.

And you're assuming, some three years later, that there must have been an error in this timeline?---That's correct.

Would you agree that he best evidence of the timeline is the timeline?---That's correct.

That you made as the events were occurring?---That's correct.

Would you agree that it's probable that you called Fiona at 11:35 and then called the clinic staff at 11:40?---That's correct.

It's probable then, isn't it, that the information that was relayed to David Cameron (sic) is the information you provided Fiona at 11.35, correct?---That's possible, yes.

And that was information that didn't take into account the views of the various stakeholders I've just taken you to?---That's correct.

You'd agree that David Reeve's risk assessment was as good as the information he had, correct?---That's correct.

You've also agreed that information from stakeholders like police, elders, Education, the views of staff members, are critical to making an accurate risk assessment? ---That's correct.

But he didn't have any of that information, did he?---Not to my knowledge.

And any information that had been relayed to David Reeve was information that was almost a fourth-hand account of what the nurses wanted, would you agree? ---I agree.

Perhaps I will dis-aggregate that for you. A nurse had spoken to Luana Symonds about the views of the entire clinic, is that right?---I believe so.

Luana Symonds had related that information to you?---That's correct.

You relayed that information to Fiona Cameron?---That's correct.

And Fiona Cameron relayed that information to David Reeve?---That's correct.

I want to ask you some questions now about your 11:40 am conference. Now, at that conference at least all of the non-Indigenous staff who were present in

Yuendumu gathered - I forget which house it was - can you remember?---At Janine's I believe.

And you'd agree that all of the non-Indigenous staff were gathered together so that you could have a conversation with them?---That's correct.

And the staff were telling you things about what was happening?---That's correct.

And they were telling you things about what they wanted you to do?---That's correct.

At par 76 of your first or second affidavit - perhaps I will put it to you and if you agree you agree, if you don't we can go to the documents, but would you agree that this is when you first found out about the additional break-ins?---I would agree with that, yes.

And given the evidence you have given about the probable time line, this isn't information that David Reeve is likely to have had when he made his decision at around about 11:40 or 11:50, correct?

MR MCMAHON: Your Honour - and Mr Reeve has put on - for himself put on evidence as to the information that was before him at the time he made the decision.

MR COLERIDGE: And that evidence might be accepted and equally it might not.

MR MCMAHON: Well, is that a fair proposition for this witness?

THE CORONER: I think - - -

MR COLERIDGE: It's a matter for submissions, your Honour. I am happy to move on, for sure.

Your account of that meeting is that staff were asking to leave, is that correct?---That's correct.

I want to be careful here. Were staff saying, "We're unsafe and we want support" or were they saying, "We're unsafe and we want to go"?---So the initial conversation was - the initial part of the conversation, all staff - there was one spokesperson at that stage and that was Janine - and the statement from her was that all staff had chosen to request to be withdrawn. They did not feel safe in the community.

So you understood it to be the view of all staff members that they wanted to go?---All non-Indigenous staff members present at that meeting, that's correct.

Were you aware that Michaela Starbuck, one of the most junior nurses in this cohort, has given evidence that though she felt unsafe, she wasn't necessarily saying, "We're asking you to withdraw us". Were you aware of that?---No.

Were you aware that Ms Starbuck's evidence appears to be that they wanted support and they feel like management then made the decision to withdraw them but didn't offer them an alternative?---No, I didn't know that.

Were you aware that her evidence was that when the community was ultimately told that the staff wanted to leave, that she felt like she had been made a scapegoat? ---No, I did not.

Equally, Ms Holland's evidence was that she did not want to leave?---That's correct.

Is your recollection that she expressed that view to you during the meeting?---So near the end of the meeting Ms Holland actually made the statement that she wanted to stay in community, that she termed it "locked-in", that she wouldn't go outside of her house, so that community were unaware that she was there. I - we talked that through and I made the decision that that was not an option to (a) stay in community on her own, due to safety concerns and also to - with our RAN staff safety policies and guidelines we don't have one staff member within communities, it's unsafe to attend, it's against our safety guidelines.

Equally, John Alton, one reading of his evidence - it's not for you to say what his evidence is, her Honour will decide that, but one reading of his evidence is that he suggested that something like a community meeting might be held. Do you have any recollection of that?---That was not discussed with me, no.

But that in the end, "they" - management in town - said "No"?---That's his evidence.

Do you have any recollection of that being the dynamic in that conversation, that members of the clinic staff on the ground were saying, "Look, we want support but the support doesn't necessarily need to be withdrawal"?---That was not the conversation that I recollect.

In the root cause analysis it is suggested that options to keep health workers in Yuendumu were considered but not pursued by primary health care management because they did not sufficiently mitigate the risks posed to the identified safety concerns" that that is one of the findings of the root cause analysis?---I haven't thoroughly read through the root cause analysis.

But certainly, you are - or you were, in that context, PHC manager, is that correct? ---I was, I accept that.

What options did you consider?---So the consideration was obviously initially when the conversations commenced, was about if there were other secure accommodation for those that required, or where we were unable to provide secure accommodation to them within community. Obviously, the other things that we look – we considered was what other support we could provide via Yuelumu to health staff.

Can I just clarify there, when you say what other support you could provide via Yuelumu? Is that the notion of the Yuelumu nurses covering the clinical needs of Yuendumu, or were they going to support the nurses in Yuendumu in some other way?---It was certainly if we were required at that stage to withdraw staff, where one of the things that you take into consideration is that if that is the event that happens, then how will we provide emergency provision to that community, and - - -

So I want to leave that part of the risk assessment to one side. What I'm really asking you about at the moment is, whether you considered alternative ways of reducing the risk to the safety of Yuendumu Clinic staff - - - ?---Yep.

- - - to an acceptable level?---Yep. There was – no.

So for example, no consideration was given to the possibility of additional staff from Alice Springs coming into Yuendumu?---That's correct.

And no consideration was given to having a community meeting, or something of the like?---That's correct.

All right. I want to ask you some questions about the presence, or absence, of Indigenous staff from this meeting at 11.40. Certainly they were not present at that meeting?---That's correct.

Were you aware of who the Indigenous staff were in Yuendumu at that time?---Yes, but I wasn't aware if they were in community on the day.

Did you ask anyone a question about that?---No I didn't. I - - -

Did you ask anyone at the 11.40 meeting to go and fetch the Indigenous staff members?---I requested that they go and have the discussion. I didn't ask anyone to fetch anyone.

You requested that they have a discussion after the 11.40 meeting?---It was discussed at the 11.40 meeting, that they have the discussion with the Indigenous house staff.

But I just want to clarify the purpose of the 11.40 meeting. And the purpose of the 11.40 meeting was in effect, to get everyone together and to make a decision about what the clinic wanted to do?---That's correct.

Okay. And the clinic is made up of staff of more than one race?---That's correct.

And the only staff present at that meeting were members of the non-Indigenous race?---That's correct.

All right. Why didn't you say, okay, somebody go get Jamison or Mary or Nola, and get them here?---It's an oversight.

But didn't they need to feel a part of this decision making?---That's correct.

Didn't they need to feel like the decision hadn't been made in their absence, and they'd just been notified about it after the fact?---I accept that.

These Indigenous staff members were Aboriginal members of the community of Yuendumu?---That's correct.

And the decision you were making, collectively, but in their absence, affected the community of which they were members?---I accept that.

But they were also professionals, weren't they?---That's correct.

And their input as professionals should be valued by the Department, do you agree?---I agree.

And you might think that they had important input, as Indigenous professionals, to provide to this decision making process at 11.40, would you agree?---I accept that.

Do you think that it's – or would you agree that it's essential that if decisions are to be made about the working conditions of a mixed race work force, that systems be in place to ensure that management does not just consider the views of one race, when making a decision?---That's correct. I accept that.

Are you familiar with the concept of systemic racism?---No.

Would you agree that in addition to situations where people are deliberately or consciously racist, and I am not suggesting that this was one such occasion, but would you agree that there might be situations where institutions or systems fail to provide equal opportunities to people of different races?---I accept that there are some.

And one of those opportunities in the work force, is the opportunity to provide input when significant decisions are being made about you as an employee?---Sure.

And about your community?---I accept that.

Now would you accept that not by design, but in its outcome, the process for making that decision at 11.40, on 9 November 2019, operated in a way that included all of the non-Indigenous staff, but did not include any of the Indigenous staff?---I accept that.

And do you agree that the outcome of that process was, that the non – sorry, the Indigenous staff members were discriminated against?---Not intentionally, no. I don't accept that.

The outcome was – the outcome was that they did not enjoy the same opportunities of the non-Indigenous staff, do you agree that?---I agree that they weren't included in there, but I don't agree that I was racist in that manner.

I'm not saying that you were racist?---Mm mm.

But the outcome of the decision is that only the members of one race didn't enjoy the opportunity of providing - - -

MR MCMAHON: Your Honour - - -

MR COLERIDGE: - - - of providing input - - -

MR MCMAHON: I object, your Honour. That's not the evidence. The evidence is that Luana Symonds was involved in the telephone call. She is not the same race as everyone else. Dr Rosser is Indigenous. She was also in the telephone call. The propositions that are being expressed, do not reflect the evidence.

MR COLERIDGE: Okay, I'll qualify it, your Honour.

Do you agree that no member, Indigenous member of the local Warlpiri Community was included in - - - ?---I accept that.

The – I want to ask you some questions about the request that you made of your staff during the 11.40 meeting. That they meet with elders and traditional owners, police, teachers, and for Yuendumu Old Person's Program?---That's correct.

Now can I just ask you to have a look at the second chronology, which is at page 32 of your second affidavit?---Mm mm.

Now towards the bottom of the page, the second last bullet point reads, "I requested that local community members be notified of the temporary reduction of the services and that all emergencies will be covered by Yuelumu Health Centre. In particular, I requested that staff speak with the elders and traditional owners, police, teachers, Yuendumu Old Person's Program." Do you agree?---I agree.

All right. The first thing I want to ask you about that is this. What you were asking them to do was notify them, correct?---That is the terminology I used.

Of a decision that had been made?---Of a potential decision to be made.

And certainly, by the time you got off that call, the 11.40 call, you got a call at 11.50, and you were notified that the decision had been made?---That's correct.

So unless they smack out of the house, and in the next 60 seconds or so, consulted with the local elders, they were notifying them the decision had been made. Would you agree?---I'd agree.

They weren't consulting with them?---I wasn't present during their conversations, but I would agree with you.

The second question I want to ask you about that is this. You'd agree that that line is in blue text?---That's correct.

And that means that it was not present in your first chronology?---That's correct.

And you would agree, that it is not in your first affidavit?---I agree.

So I take it that this is one of those things that you inserted into the chronology some three years after events?---I accept that.

Without the assistance of notes?---I accept that.

Were you aware, at the time you put together this affidavit in October of 2022, that questions of race and racism might arise in the inquest?---There was potential.

Is it possible that records something that you think you might have done or that you wished you'd done, but that you're not sure that you did do?---No.

It's not possible?---Sorry, it is possible.

Okay. I want to ask you some questions now about the Yuelamu nurses and what was to happen with Yuelamu. Now, there's the 11:50 call with Cameron. She tells you the decision's been made. Correct?---That's correct.

And then you have a 12:10 conversation with David Reeve. Correct?---That's correct.

Now, in both conversations, you were told that management above you wanted two nurses to cover Yuelamu. Correct?---That's correct.

All right. And you then got on the phone with Janine Rewaka at 12:10 and you said, "Look management want two staff to go to Yuelamu."?---That's correct.

Okay. You would agree that the next telephone call was at 12:36 pm?---That's correct.

And during that call, you were notified by Janine Rewaka that no staff were willing to go to Yuelamu?---That's correct.

Right. I want to ask you about three things here. The first is, your evidence is that you were never made aware that John Alton was in fact willing to go to Yuelamu? ---That's correct.

Okay. So, the information that you were given was, in fact, incorrect?---I can only go on the information that I've been given.

But if we assume for the moment that John Alton did volunteer to go to Yuelamu, and if we assume that you weren't told that?---Yes, that's correct.

Yes?---Yep.

And it would stand to reason that the information you then relayed to Fiona Cameron was also incorrect?---That's correct.

Okay. So, there was a communication breakdown here?---Possibly.

Possibly. Now, the second thing I want to ask you is about the timing. You asked Janine to discuss this option at 12:10?---That's correct.

And the notification you receive is at 12:36 pm?---That's correct.

So, 26 minutes have elapsed. You would agree?---Yes.

At most, depending on how long your conversation with Janine was at 12:10? ---Mm mm.

Would you agree that's a remarkably short amount of time to allow two individuals who might be feeling fearful to decide whether they were going to uplift their lives and move to a remote Indigenous community two hours down the road?---I'm sorry, I don't understand what you're referring to.

Effectively, what you were asking Janine to do is ask the other nurses, is anyone happy to go to Yuelamu?---That's correct.

That was a relatively big decision for them, wasn't it?---I would accept that.

And at most there were 26 minutes within which all of the staff members could decide whether they were willing to make that decision?---I didn't put a timeframe on the time that they gave their decision.

I'm not suggesting that you did, I'm just asking about the time that actually elapsed? ---That's correct.

Okay. Now, I want to read to you from some of John Alton's evidence.

This is at 91, your Honour.

His evidence is,

> "Another thing was that – who was it, someone asked would two of us go to Yuelamu to re-enforce the staff there so that we could cover the clinic from Yuelamu and I volunteered, but no one else. But to be honest, I don't think there was a lot of – not much time given to people to – ah – think about it, or

not everyone, I think, was there."

Would you accept that really, more time should have been allowed to make this important decision about who was going to go to Yuelamu?---As I stated, there was no timeframe put on from my request. The timeframe that we can obviously see here is the timeframe from when I made the call to when I received the return call from Janine.

Certainly. But in that return phone call from Janine, did you say, okay, go get out there and have some more conversations, mull it over?---No, I didn't.

So, you just accepted as conclusive what she told you at 12:36?---That's correct.

The third thing I want to ask you about is – well, it's this. Look, would you agree that ensuring that Yuelamu was adequately staffed was very important on 9 November? ---That's correct.

It was a very important part of ensuring that the withdrawal was safe for the community of Yuendumu?---That's correct.

But it was also important to ensure that the withdrawal was safe for Yuelamu, wasn't it?---That's correct.

Because the Yuelamu Clinic ended up servicing the needs of two communities? ---That's correct.

Indeed, as we know, before Lorraine Walcott and Heather Zanker left Yuelamu, as one of them was preparing the ambulance, the other one was treating a sick child. Were you aware of that?---I was aware of that.

And so, there was a real risk, wasn't there, that there'd be concurrent health needs? ---I accept that.

And the nurses could only be in one place at one time?---I accept that.

Okay. We are also aware – I'll leave that. To your knowledge, there'd been no recent reports of break ins in Yuelamu?---To my knowledge.

Was there accommodation in your Yuelamu that could have housed the Yuendumu nurses?---Yes, there was. There were two houses.

And this was an emergency, in a sense?---Yes.

Why didn't you direct two of the nurses to go to Yuelamu?---The – what I had – the information I had received was that all staff stated that they felt unsafe. That was a reasonable priority for myself to ensure that they remained or were made to feel safe. And so, given staff to state that they feel unsafe, obviously traumatised in some way on some level. So, by giving them a directive that says, "you have to", to

an already traumatised person, that – I'm sorry, but that was not a thought process of mine to give the directive.

Okay. I want to pick that apart a little bit?---Sure.

The trauma, if it be trauma, arose in a particular context. Would you agree? ---I agree.

And that context was a series of break ins from 6 November to 9 November in Yuendumu?---That's correct.

And removing them from Yuendumu, in a very significant sense, remove them from the context. Correct?---That's correct.

Did you have any discussions with staff about whether they would have felt safe in Yuelamu?---No, that was the – I didn't have those discussions. I requested, as per what I was asked to request, was if two staff would go to Yuelamu.

Okay. Is your evidence that Janine actually told you why the staff didn't want to go to Yuelamu?---No.

Indeed, at par 90 of your second affidavit, you said Janine did not tell me, but that you anticipated that it was because staff were not feeling safe in Yuendumu? ---That's correct.

And would have been concerned about the prospect of being required to travel into the community at night?---That's correct.

When you say, "the community", you're talking about Yuendumu?---That's correct.

So, back into Yuendumu?---That's correct.

All right. Did you have any questions about the staff feeling unsafe, just walking around the streets?---No, that was not part of what we were managing on the day.

No, indeed. What you were managing was the fact that staff felt unsafe in their houses due to break ins?---That's correct.

You also anticipated – perhaps I'll put it this way. There'd been no assaults on staff or anything like that?---Not to my knowledge.

There'd been no reports of unrest or fighting in the community?---Not to my knowledge.

What reason would they have to fear merely travelling into Yuendumu?---It's difficult to travel into any community afterhours at night for emergency situations.

Was your concern about travel or safety once they reached Yuendumu?---It was for

both, yep.

And that was despite the fact that, at par 102 of your affidavit, you said that it was standard practise in these circumstances for nurses to be escorted by police? ---That's been misconstrued. If the – we do a pre-risk assessment when - prior to going on any call-outs afterhours. If, according to the triage, that the person – the nurse that's taking over phone, if they are entering into community, not into the health centre to review a patient but actually into community to do the assessment - an emergency first assessment - primary assessment - in the community or going to a - dependent on what has been triaged, if it's a possible suicide or a possible death in community, then sometimes if there's unrest or anyone triages with a lot of noise then we do - part of our assessment is that we contact the police to ask them if they are able to assist us at the scene. So it's not an escort to the health centre, it's actually our process and our protocols to have that if we are attending a situation that we have triaged as unsafe, possibly unsafe for us, within the community itself.

So if they were concerned - let's say they travel from Yuelamu to Yuendumu health centre?---Yes.

And then they need to go into the community to treat someone in their home? ---That's correct.

It would be open to them to ask for a police escort?---That's correct.

Did you have any reason to think that the health staff would be at risk - I'm not talking about travelling, but be at risk from the community itself merely by travelling from Yuelamu of the Yuendumu health clinic?---No.

Questions now about your conversations with the Yuelamu nurses themselves. At 12:48 you have a conversation with Lorraine Wolcott?---That's correct.

And Ms Wolcott expressed to you that she was concerned about the proposal that Yuelamu cover Yuendumu?---That's correct.

There are a couple of different dimensions to her concern, is that right?---That's correct.

One was the fact that the level of fatigue in that health clinic was also quite high? ---That's correct.

Because they had been up all night - or at least they had been up a bit?---They'd been awake overnight, that's correct.

And you then had a conversation with Heather Zanker, is that correct?---That's correct.

And that conversation is set out at paragraph 55 of your first affidavit I think? ---Sorry, of the first or the second.

The first, I'm sorry?---Yep.

So, following your conversation with Lorraine in which she expressed her concerns, you were then advised by Janine Bridge that Heather Zanker also wanted to discuss arrangements because she had concerns of her own?---That's correct.

So in fact Heather was reaching out to you to express concerns?---That's correct.

One of those concerns was fatigue?---That's correct.

One of those concerns was safety?---That's correct.

Now, you've given quite a bit of evidence about the need to listen to staff, haven't you?---That's correct.

Your evidence was that they tend to under-report safety concerns?---That's' correct.

To be stoic?---That's correct.

These nurses were telling you, "Don't do this"?---Mm mm.

That's a yes?---That's your interpretation, yes.

Well, they were telling you that they were concerned about this?---They are concerned, yes.

And that they were reluctant to do this?---That's correct.

Didn't that give you pause for thought?---Obviously.

Do you think it was appropriate - well, perhaps I can return to the evidence that you gave about your reluctance to send the Yuendumu nurses to Yuelamu because they might have been traumatised. Do you think that the opposite might have been true? That these - - -?---I accept that.

That these incredibly fatigued nurses, who were expressing their reluctance, might not have wanted to go to Yuendumu?---I accept that.

And might have felt pressured to do so in the circumstances?---I accept that.

Did you think to advise Fiona or David of the level of fatigue in Yuelamu?---Not at that time.

You're aware that David Reeve's assessment of the level of risk depended on the ability of the Yuelamu clinic to service Yuendumu?---That's correct.

But he wasn't informed about the level of fatigue?---That's - not at that stage, no.

No. Was he ever informed about the reluctance of Heather Zanker and Lorraine Wolcott to travel?---Yes.

At what point in time?---If I can refer to my timeline. So at - so I notified Fiona Cameron at 2 pm of the concerns raised with me from Lorraine and Heather.

That is the text in blue, is that right?---So, yes, that's correct.

And it says, "I updated them on the above documented telephone calls"? ---That's correct.

But beyond that it's not said what you actually told them?---No.

I want to just quickly return to the conversation you had with Lorraine Wolcott at 12:48. Now, at 12:48 - page 33 of the second affidavit, if you have the relevant entry, it records your conversation with her, you'd agree?---That's correct.

Now, the second half of that entry says that you gave reassurance to Lorraine Wolcott that any callouts to Yuendumu community would be for emergencies only, and then there are two bullet points?---That's correct.

Now, the first bullet point says, "I requested that staff speak with elders and traditional owners, police, teachers at Yuendumu and Old Persons Program"? ---that's correct.

Were you informing her of what you had requested of the staff in Yuendumu? ---That's correct.

And that's in blue writing, correct?---Yes.

So that's something that you added three years after the fact?---That's correct.

And can I ask you to turn back a page to the 11:40 entry?---Mm mm.

And the second-last bullet point, second sentence reads, "In particular I requested that staff speak with Elders and traditional owners, police, teachers, Yuendumu Old Persons Program"?---That's correct.

So there is a word perfect reflection of what you told you staff at 11:40 and what you told Lorraine Wolcott that you had told your staff, correct?---I accept that.

MR MCMAHON: Plainly, your Honour, the timeline might be word perfect; I don’t think Ms Gill intended to say the actual conversation was word perfect.

MR COLERIDGE: That's what I am coming to, your Honour.

THE CORONER: Sure.

MR COLERIDGE: Would you agree that it looks like you have copies from one into the other?---I accept that.

Would you agree that you might have made assumptions about what you told one or what you told the other?---I have to accept that.

I just want to ask you finally about a comment that you made that - I think this is still - this is at some time between 11:40 and 2 pm, correct me if I'm wrong. You say, "This reduced service" - and I am assuming the reduced service to Yuendumu, - "was discussed with community members within Yuendumu as well as with the police". Do you see that?---Sorry, can you refer me to where you are?

Sorry. I'm sorry, this is the first affidavit at par 50?---Paragraph?

Fifty, the first sentence?---50 I've got - - -

Of the first affidavit?---Sorry, wrong one.

No, no, that's my fault?---I accept that.

Now, did you make any attempt to follow up with the staff on the ground in Yuendumu to work out who they had spoken to?---No.

You, in fact, knew a number of Elders in the community?---That's correct.

For example, you say, I think in your first affidavit, that due to your longstanding relationship with the central desert area, you knew Eddy Robertson quite well? ---That's correct.

And held him in very high regard?---That's correct.

Given your longstanding relationship with Eddy Robertson, did it occur to you to try and get him on the phone?---No, it did not.

Are you aware that on 11 November, there was a meeting between David Reeve and a number of elders in the community?---I am aware of that.

And that with the exception of Kumanjayi Nelson, who's now passed - - - ?---Mm mm.

- - - the elders were very angry that they hadn't been notified about the decision to leave?---I am aware of that.

Do you think that that's an indication, that the request you made of the staff that they notify elders in the community, failed?---Yeah I accept that.

The last thing I want to ask you about, and I promise it's the last thing, is the call that you had with Superintendent Jody Nobbs at 2.28 pm?---Yes.

You can recall the call?---I can recall that call.

Now he advised you at that time that additional police resources were being sent to Yuendumu?---That's correct.

Can you tell her Honour, what, if anything you remember, he said about those police resources?---I believe that he told me that he was sending in a tactical response team, and the dogs.

And did he tell you what the purpose of sending the tactical team in was?---Was to apprehend a person of interest.

Was there any connection, in his mind, or yours, between that person of interest, and the property offending that had been occurring?---No.

Okay. Did he tell you anything about why that person was a person of interest? ---No.

Did he use that person's name?---No.

Did he tell you that there were other things that the police were going to do in the community at that time?---No.

Was there any reassessment of the level of risk that faced your staff in the community, on the basis of that information that additional police were going in? ---The risk assessment that we made was based on the attempted break-ins to our accommodation, whilst our staff were present in that accommodation. Police were going in, my understanding from Superintendent Nobbs, was that police were attending – extra police were attending Yuendumu, to apprehend a person of interest. I did not enquire, and I did not know that if that person was apprehended then if that number of police were then going to withdraw back into Alice Springs. Police were going in on – to obviously provide a task and a role that they were entering community for. They weren't going in to provide security to our staff.

That assessment that you made, that they weren't going in to provide security, is that based on something Nobbs actually told you, or something that you assumed? ---Police aren't security.

You're aware of the concept of deterrence?---I'm aware of the concept of deterrence.

Then, or now, have you heard that the police were going in to provide high visibility patrols in the community?---I have since heard that during this process.

And the purpose of that, if that's what they were to do, was to deter property offending by engaging in high visibility patrols?---Mm mm.

They might not be security guards, but performing much the same function as a security guard, you'd agree?---I agree.

Okay?---That information though, can I just note, that that's the information I've received now, as part of this proceedings. It wasn't the information that I was privy to on the day that we made these assessments.

Not suggesting to you that it was something that you knew. Would that have been relevant to your assessment of risk, had you known?---If we were aware of that, yes.

And this was at around about 2.28 pm in the afternoon, correct?---That's correct.

And it was at around about 2 pm, that the nurses started rolling out of Yuendumu, correct?---I was not aware of when they started to leave community, because they liaised with Janine Bridge, who was monitoring their travel.

I'll leave it there, your Honour. I note the time. Those are my questions.

THE CORONER: Yes, ma'am, we normally have a morning tea adjournment. So we'll take that now?---Yep.

I expect there will be some further questions for you?---I'm sure there will be, your Honour.

WITNESS WITHDREW

ADJOURNED

RESUMED

HELEN GILL:

THE CORONER: Just before we go to you, Mr Mullins. Can I ask a couple of questions?

MR MULLINS: Certainly, your Honour.

THE CORONER: Thanks.

Ms Gill, I'm just asking, the particular role that you were playing that day, was that a particularly busy on-call role, or is it one that is – you know, it's quite rare to receive calls?---No, it can be a very busy on-call role.

And was it a busy day that day?---Yes, that's correct.

What are the other sorts of jobs that you were dealing with that day?---So I had some transport issues with one of our Aboriginal health practitioners that was going from training. Also we had a bus versus a car incident on the Ernest Giles. And so we had activated two of our health centres to attend to that as well.

So you were dealing with a number of issues?---That's correct.

And I understand that in that role, the person that you would normally be liaising with is Fiona Cameron?---On that rostered day, yes.

And part of the difficulty in communications was because Fiona's telephone system was intermittent, and so a third person was bought into the communication stream? ---That's correct.

And sometimes you could speak to David, and sometimes you could speak to Fiona?---That's correct.

And that may also have contributed to communication difficulties and information being lost, as between the three people who were - - - ?---That's correct.

- - - sharing that information?---Yep.

Yes, Mr Mullins.

MR MULLINS: Yes, thank you, your Honour.

XXN BY MR MULLINS:

MR MULLINS: Ms Gill, my name is Mullins. I appear on behalf - - - ?---Hello.

- - - the Brown, Walker, Lane and Robertson families. Now you have worked as a remote area nurse in Central Australia for a lengthy period of time?---That's correct.

And you list in your second affidavit some of the areas where you've worked, including Docker River, Elliott, Finke, is it?---Finke.

Finke. Larumba?---That's correct.

And of course, you spent a couple of tours in Yuendumu?---That's correct.

And you've always enjoyed the work that you've done in those communities? ---That's correct.

The – even when you spent some time in management, I see that you are happy to return to nursing, and to clinical practise, from time to time?---That's correct.

And do you see yourself as one of the nurses, rather than management?---When I'm on the ground, yes.

Is it the case, because of the experiences that you have, that you feel you have a close affinity to the nursing staff?---I would accept that.

And certainly, when nursing staff are at remote locations, you can empathise with some of the things that they have been through, or are going through?---I accept that.

Now, you were asked some questions about the 11.30 meeting. And I just wanted to clarify, to your recollection, who was there. Sorry, I should say 11.40 meeting. At par 74 of your statement, you list a conference call with Janine Rewaka?---That's correct.

Have you got a copy of your statement in front of you?---I do.

And then you list all of the people on the call?---That's correct.

And Amy Rosser is not there?---She wasn't on the call, that I was aware of.

You didn't initiate the call, Janine did?---That's correct. That's correct, sorry.

Okay. Now there's some evidence from one witness I think, Luana Symonds, who thinks that she was there. But you have no recollection of Amy being on the call at all?---No. Amy wasn't in community at the time.

Do you recommend – recollect any comments of Amy at all on that call?---Not on that call, no.

Nola Fisher was a person who you'd dealt with when you were in Yuendumu? ---That's correct.

And you got along very well with Nola?---That's correct.

She was a great support to you at the community?---That's correct.

And what were the sorts of things that Nola would do that would help you on a day to day basis?---When I was in – working within Yuendumu, Nola was a person that if I was unclear of a situation, or of family relationships, she was someone that was able to explain those. In particular around the children, and the welfare of the children that we may have been dealing with in – in the clinic. She was also able to give me some instruction on language, as in interpretation of what people were saying when I was not able to understand.

Now you were smiling when you said that. Is that because you had some problems with language from time to time?---Sometimes, yes.

And she assisted you there?---That's correct.

Is it the case that Nola, from time to time, actually performed some clinical tasks? ---Early in my role within travelling to Yuendumu, I would say yes, and that her history has been that. That's correct.

And can you tell us some of the clinical tasks that you recollect her performing?---So, Nola was an Aboriginal health practitioner who took a clinical load, which was seeing anybody that came into the community, into the health centre excuse me, and required medical assessment. And during my time, she didn't participate in on-call. She may have previously done, but also she then progressed into a speciality of child health. I'm working with child health too.

Now, the decision you had to make on 9 November 2019 was a very difficult decision?---I accept that.

And you had a lot of telephone calls?---That's correct.

And you had a great deal of empathy for what the nurses were going through? ---That's correct.

And you wanted to make sure that the nursing staff that you were dealing with were well looked after?---That's correct.

And you did the best you could?---That's correct.

At about 11:50, you had a conversation I think with Fiona - - -?---That's correct.

- - - about the decision you were going to convey. At about 12:10, you had a conversation with David Reeve, I think, where you were conveying a decision or had a discussion with him about the decision you were going to convey?---That's correct.

And in fact, you had multiple conversations with those two people who were both senior to you during the course of the day as the decision was unfolding?---That's correct.

Did either of them say to you, have you done a documented risk assessment setting out the factors that you are taking into account in this decision?---No, they did not.

Did either of them say to you, were the Warlpiri members of staff part of that meeting at about 11:40 am?---No, they did not.

You've been asked a lot of questions over the last three years about these events? ---That's correct.

And as you've said, you checked with management the entire way - - -?---I accept that.

- - - during the course of the process on this day?---I accept that.

But you've accepted responsibility for the decisions you made?---I certainly have.

Nothing further. Thank you, your Honour.

THE CORONER: Yes, Mr Derrig.

XXN BY MR DERRIG:

MR DERRIG: Hello, my name is Mr Derrig. I appear on behalf of NAAJA. Now, I know you've already spoken a little bit about this topic, but I just wanted to speak to you a little bit about the Aboriginal staff members from the clinic. What do you think – what do you see as their value or Aboriginal – local Aboriginal staff to a clinic? What do they bring to a clinic. What's their value?---They bring an awareness of the culture for that area that they work – where we're working with them and I see them as an active participant with ensuring that the non-Indigenous staff practise in a culturally-appropriate and safe manner within – whilst in that community. They are certainly a broker between community and non-Indigenous staff and in some times, you could say that within health, they were a broker between community and the health service in general. They were also a broker with health staff and the engagement, community engagement that we do.

And do you think sometimes, they can be people who might pass on information to health?---Absolutely.

What's going on in the community, so they might know what's happening? ---Certainly.

And that might be helpful for the clinic staff to make decisions and whatnot? ---I accept that.

So, then given this circumstance that was occurring on 9 November, do you think they could assist - - -?---Sorry what was that?

Sorry. Do you think they could have given you, well the team, valuable advice about what they understood about the break ins?---I accept that.

And possibly, if not immediately but maybe in the future, ways to try and stop the break ins and things like that or work with community to stop that?---That's correct.

Yes. And if it was the case that there was going to be a withdrawal, perhaps they could assist – if there was going to be a bit of a withdrawal, perhaps they could assist with communicating that measure to the community?---I'd accept that.

Yes. And maybe they'd even tell you who are the best people to speak to in the community to get that message around. They might be able to do that?---I accept that.

Okay. And do you think one thing they might have also done is potentially, from the community's perspective, sort of raised a concern about the risks to the community for withdrawal?---Potentially, yes.

Now, I just wanted to ask you a couple of questions about sort of risk assessment and things like that. So, at pars 36 to 50 of your second affidavit, you do – you talk through how you would do a risk consideration?---Mm mm.

And you talk through the way you consider risk to staff and the way you mitigate the risk to that staff?---Mm mm.

And how to mitigate the risk to the community once the decision to withdraw has been made?---Mm mm.

Yep. Now you'd agree in those paragraphs that there's no consideration of the risk to the community before the decision to withdraw has been made. So, what I mean by that is that there might be a consideration of how to avoid risks if a withdrawal occurs. But in those paragraphs, you don't consider the risk to the community before the decision to withdraw has been made?---Without reading thoroughly right at this point, I would have to accept that.

Okay. Do you think that that should be something that should be taken into account when doing these kinds of risk assessments?---Yes.

Yes. And do you think it should be the case that the risk – there should be maybe a weighing exercise that the risk to the nurses should be weighed against the risk to the community more generally?---Yes.

Okay. Now, just probably to the perspective of lessons learnt and looking forward in the future, I just want to ask you about some considerations that should have been made potentially around the 11:40 meeting, perhaps during the day. What I'm going

to say is a series of propositions. Let me know if any – if there was a discussion about these things to begin with. Was there any, up until the decision had been made in terms of the communications you've had with various people, was there any talk about anyone suggesting alternatives to withdraw such as bringing private security or something like that?---No.

Was there, at that stage up until the decision had been made, any talk about whether or not police might be able to bring in more assistance to assist the nurses or anything like that?---No. Are we talking about the decision that was – I was notified of - - -

That's right?--- - - - admin, yep.

And just only what you know?---Sure.

Do you remember anyone discussing through NT Health's withdrawal policy at that stage?---No.

Was anyone talking about doing handovers for more vulnerable patients in the community?---Yes.

And what kind of discussion was that? What was it?---So, we had the – I discussed vulnerable persons at the 11:40 meeting. And if there were any acutely unwell people in general as well as vulnerable persons. And then community and what provisions, if they – Yuendumu Old Person's Program and – could be provided for them.

And I believe your evidence is that you wanted to make sure that you know, medical was provided, and things like that?---That's correct.

When you were talking through these vulnerable patients, did – were – did any particular names come up, or any individuals come up that were acute?---No.

Did anyone in these conversations discuss maybe talking to say Purple House and their nurses - - - ?---No.

- - - about way to mitigate risks? Okay. Now at par78 of your second affidavit, you talk about Cassandra Holland requesting if she could stay. And ultimately you say, you talk it through, and then you, "This would leave her in a difficult and unsafe position attending the call-outs alone. It's contrary to NT Health policy. Cassie told me that she understood"?---That's correct.

So just to check, that policy you're referring to, is that the requirement that two staff members, in the minimum, were required for each call-out?---That's correct.

Now is it the case that that policy operates that it has to be two nurses - - - ?---No.

- - - or could it say be an Aboriginal staff member and a nurse?---That's correct. So the policy states for Central Australia and the Barkly Region, that it can be a clinician, whether that is a nurse or Aboriginal health practitioner, as first on-call. And it can be a secondary clinician or a second responder. In the Top End, the policy states that in the Top End, it has to be two clinicians.

Now Ms Holland gives evidence –

And for everyone else's benefit – well sorry.

Ms Holland's given evidence that Julie Cook suggested that her and her partner, and herself, might leave the next day instead on the 9th?---Mm mm.

And I believe that was in the 11.40 meeting?---Mm mm.

Do you recall that occurring?---I don't recall that, but it may have been of while I wasn't on the phone.

If it – and just assume that that did occur. Would it be the case at that stage, that you might consider, Julie staying around, and if Cassandra wants to stay around, at least for that day, that perhaps that might have been sufficient to cover the on-call? ---That's correct.

Okay, and sorry, and I might just take one step back. If say it was Cassandra who wanted to stay, and say, one of the Aboriginal health workers was happy to assist as well, for on-call calls?---Mm mm.

Would that have – do you think that might have been a workable situation?---It may have been. But we were still – we would still need to take into consideration the rationale as to why we were withdrawing staff, and that was due to the break-ins to their accommodation. So we needed to still provide a safe environment and accommodation for our – our staff.

At par 48 of your first affidavit?---Mm mm.

You're talking there about whether or not it's acceptable that Yuendumu being withdraw and what not. You say "That this would be acceptable because of the experience", and that Yuelumu would cover Yuendumu. You say "That this would be acceptable because of the experience of the nurses eliminating the assistance to emergency situations, further support from Papunya, no adverse weather effects." Now it seems to me, and correct me if I'm wrong, but according to your extended timeline, it doesn't appear that you, yourself, contacted Papunya, is that correct? ---Not on that timeline, that's correct.

Are you aware of anyone contacting Papunya to provide that?---No.

Now going back one step about Yuelumu. I believe Dr Reeves evidence, is he gave a direction that two staff from Yuelumu would need to assist at, and/or go to

Yuelumu to assist. At that time, on that day, I appreciate you didn't speak to Dr Reeve about that initially, but did you understand that Dr Reeve had made that direction? Or did you think it was more of a request?---My understanding was that it was a request.

You did speak to Dr Reeve later on that day. Did you guys talk about that direction/request?---No.

Now when you did speak to I believe, Janine, when she advised you that none of the Yuendumu nurses were willing to go to Yuelumu?---Mm mm.

You've said in your evidence today, that what you considered was you didn't think it was appropriate to give a direction, and you're considering the trauma of the staff? ---Mm mm.

That would assume – on that basis, you assumed that all the nurses were traumatised – traumatised, is that right?---At some level, yes, to – to state that they were unsafe.

Okay. And you would be aware though, from what you understood at that point in time, that some nurses didn't have their houses broken into on that night, and some did, is that right?---I'm aware of that.

And so did you think, appreciating that all – assume that – did you assume all the nurses, even if their houses weren't broken into, that they would feel a sense of fear. Is that what you were assuming at that stage?---I would have assumed that.

Now, did you ever think though, that okay, fair enough some nurses have been broken into. Did you think though that perhaps some of those nurses who weren't so directly affected, might have been able to go to Yuelumu instead?---Yes.

And so did you think well maybe we should direct those nurses, who weren't so directly affected, to work from Yuelumu?---No I didn't think that. I made the request, as I was asked to do. And the response was – received that there wasn't any staff members. So that's what I needed to work on.

I appreciate that hindsight's 20/20 and what not?---Mm mm.

But in retrospect, do you think it could have been a workable solution that the less affected nurses could have been directed to assist at Yuelumu?---Sure.

This is a bit of a throwaway line in your evidence, but I've got to just ask the question. At par 134 of your second affidavit, you mentioned that you had a communication about the Yuendumu Health Centre with Ms Burnie (?). There's a very brief reference?---That's correct.

I'm going to read to you some of the evidence from I believe Commander Wurst, or Travis Wurst, in any case, about that. And you let me know if you know any different in your experiences in your position.

MR FRECKELTON: Can I just – what paragraph is it?

MR DERRIG: Sorry, that's 134, second (inaudible).

MR FRECKELTON: Perhaps your Honour, Ms Gill could just be asked what she did know about that?

MR DERRIG: Well no, I prefer to ask my question, thank you.

Following – so what - - -

THE CORONER: So we're talking – sorry, just for my benefit. 134 of this witness's affidavit?

MR DERRIG: That's correct, yes.

THE CORONER: Second affidavit?

MR DERRIG: That's correct, yes. It's very brief.

THE CORONER: 134. Yes, okay.

MR DERRIG: Okay. So what he provides is

> "Following an SMS from Nobbs at 11.24 pm, indicating the clinic had been torched. Later at the time, I do not recall if I advised via health clinic was not significant, and there was little or no damage to the health clinic infrastructure. I was not provided any information to the source of the fire, or whether or not it was deliberately lit."

So that's what Commander Wurst says, Travis Wurst says. Is that from your knowledge of the clinic, is that correct? That there was little or no damage to the clinic?---That's correct.

And again, to your own knowledge, are you aware that – of any information that suggests that whether or not it was deliberately lit?---No I have no - - -

Okay, thank you.

That's all my questions?---Thank you.

THE CORONER: There might be more. I'll just check.

THE WITNESS: Sorry.

THE CORONER: Any other questions?

MR HUTTON: I have some questions, your Honour.

THE CORONER: Yes, Mr Hutton.

XXN BY MR HUTTON:

MR HUTTON: Good morning, Ms Gill?---Good morning, Mr Hutton.

I want to start with the timelines, and the questions that you were asked by Counsel Assisting. And you've attached – the first timeline, was prepared, I understand, on 10 November 2019?---That's correct.

And the second timeline's been prepared much more recently than that?---That's correct.

The first timeline that you prepared, did you endeavour in that document, to try to set out every word of every conversation that you had been involved in on 9 November or on 10 November?---No.

It wasn't intended to be that, was it? It wasn't intended to be exhaustive?---No.

You've then tried, for the purposes of this inquest, to provide what further information you could to her Honour?---That's correct.

In order to assist her Honour in conducting this inquest?---That's correct.

THE CORONER: And I appreciate the care and consideration, and reflection, that is obviously shown by the affidavit material that's been provided?---Thank you.

MR HUTTON: Thank you.

You were not thinking of potential adverse findings that might be made?---No.

You weren't thinking about the Root Cause Analysis?---That's correct.

But have you been provided a final copy of the Root Cause Analysis?---Recently I have, yes.

When were you provided that?---Approximately three weeks ago, three or four weeks ago.

In your first affidavit, you were responding to ten questions asked of you by Megan Duncan, is that correct?---That's correct.

Again, in that document, you were not trying to relay everything that you could recall?---That's correct.

You were asked by Counsel Assisting, and I – I think you agreed with this proposition, but tell me if I'm wrong, that you think it's likely the second timeline is in fact missing telephone conversations?---That's correct.

And that is, I anticipate, you were involved in so many that day, is that right?---That's correct.

And you've told her Honour that there were other incidents happening that day as well?---That's correct.

All right. I want to ask you about the group telephone conversation, the 11.40 conversation, as it's been referred to. Firstly as to its participants. You weren't there in the – you were in Alice Springs?---That's correct.

Is it possible that there were other staff who were dialling into the telephone conversation that you were not aware of?---That's a possibility, yes.

Do you recall during that teleconference that – and I take it from your evidence to Mr Derrig – sorry, I'll just ask the question. Do you recall a discussion of the vulnerable persons list during that – the group teleconference?---Yes.

Can you tell her Honour what the vulnerable persons list is?---So it's a list that we have within our service that is obviously of vulnerable persons, which can be those with rhematic heart disease, diabetes, any children that are under Child and Family Services, any children with medical conditions that we need to monitor. Some of our aged – and anyone providing that, or requiring that extra level of care.

Thank you. Did you recall being told how many people were on the vulnerable persons list?---I believe there were 15 on the list.

The list is updated monthly, is that correct?---That's correct.

Do you recall asking, during the group telephone conversation, whether anyone in Yuendumu was acutely unwell?---Yes I do.

What was the answer?---No there was no.

Do you recall who said that?---I think it was Cassie that told me that.

She was on-call at the time?---That's correct.

Do you recall asking that the offer to withdraw the Aboriginal staff be made to those staff?---That's correct.

And you recall the response coming back with they did not wish to be withdrawn?

---That's correct.

Do you recall why that was?---No I did not ask.

Did the Aboriginal staff in Yuendumu, at that time, participate in the on-call roster? ---No.

Had they been asked previously if they wished to participate in that on-call? ---Previously there were conversations, yeah.

And they had expressed that they did not wish to participate?---That's correct.

Do you know why that was?---No.

That was respected, and they were not consequently, a part of the on-call roster, is that correct?---That's correct.

Is it your recollection now that after you had the group telephone conversation, that you then rang Fiona Cameron and relayed the events of the group telephone conversation to her?---That's correct.

Can I ask you about the group – sorry, can I ask you about the telephone conversations with the Yuelumu staff. You spoke firstly to Lorraine Walcott?---That's correct.

And subsequently, you spoke with Heather Zanker?---That's correct.

Heather is a nurse that you know?---That's correct.

How do you know Heather?---We completed our four week orientation together in 2004, into primary and public health care. She was currently already located at Yuendumu, at that time.

THE CORONER: She calls you "Gilly"?---She does.

MR HUTTON: She was located at Yuendumu at the time you came to know her? ---That's correct.

Ms Zanker has worked for many years at the Yuendumu Health Centre, is that right?---That's correct.

She would understand the orientation of the Yuendumu Health Centre?---That's correct.

Are health centres a standard layout, Ms Gill?---The newer builds are certainly standard layouts. We have standard layouts for our equipment. We have a standardised equipment across the Northern Territory Government, NT Health sites. So that – what I mean by standardised, is that our emergency rooms are

predominantly set up the same. Our emergency trolleys are exactly the same. We have check lists that, as to what goes where in the trolleys. Medication rooms are set up the same. Our – all our emergency packs are the same, from Docker River in Central Australia, up to, you know, anywhere in the Top End. So our equipment is the same.

Thank you. Can you describe for her Honour, the keys to get into the Yuendumu Health Centre?---Yep sure, so our health centres in Yuendumu is the same. So it's a bi-lock lock. So we have one key that will open all doors within the health centre. The only door that the general keys don't open, is the health centre manager's door.

All right. So you don't need a particular knowledge of the keys themselves to get into the health centre?---That's correct.

You discussed with Ms Zanker that additional staff would – you'd try to arrange additional staff the following day?---That's correct.

Did you have staff that you could have sent to her that day?---That is a possibility.

Can I ask you about the NT Health Risk Assessment Matrix?---Mm mm, yes.

Do you have a copy of that document there?---One I prepared earlier, yes, sorry. Yes I do.

Have you looked at that document for the purposes of today?---Yes I have.

And have you tried to track through applying that matrix, which I understand you didn't, from – from your evidence to Mr Mullins, you didn't do at the time?---That's correct.

Have you tried – can you try to track it through now, for her Honour, how – how the events, as you understood them, would be weighed up in that matrix?---Sure.

THE CORONER: Can you put it up on the screen? I can see that [Edited]'s got it there, but I don't have it in front of me. And I think if someone talks to me about this document, without me looking at it, it would be very difficult to follow the evidence.

MR HUTTON: Sorry, your Honour, absolutely.

MR COLERIDGE: Your Honour, we probably should just establish in the first instance whether this was the document in existence at the time.

THE CORONER: Sure.

MR HUTTON: Happy to, I can tell you - - -

MR COLERIDGE: No need to tell me, ask the witness.

MR HUTTON: Sure.

This is the document in place at the time?---That is correct.

Would you endeavour, I think Mr Mullins has a better understanding of this (inaudible), but would you - - - ?---Sure - - -

- - - could you speak to us?---Yep. So – if – don't think I can see that. Based on the reason for our temporary withdrawal, it would come under, if you're looking at the "Consequences, facilities, assets, and data.

I think – sorry, I'll try to help her –

I think Bec you need to scroll down please?---Sorry. Yep, just down there. And so it's "the temporary suspension of services due to the loss, damage and unauthorised access, threat to property, plant and/or equipment and records."

We might need just that again. So perhaps you can point to the version you have, or where the - - -?---Okay, so on your screen - is that the screen that you're seeing, your Honour? So, the second one up - the facilities, first facility.

Access (inaudible)?---Yep, and go over to the middle, yep. So the temporary suspension, that makes it a moderate consequence.

THE CORONER: Go up to the top.

MR MULLINS: If it assists, does your Honour have a hard copy?

THE CORONER: I don't have one here.

MR MULLINS: Would your Honour - - -

THE CORONER: But sure, I'll take yours.

MR MULLINS: - - -It just has a little irrelevant handwriting on it, but it's not prejudicial or anything. In the highlighted box is something that I highlighted. It's not necessarily what - well I think (inaudible) it might've been exactly what the witness has said.

MR HUTTON: (Inaudible).

THE WITNESS: And then - so that makes it a moderate consequence. Then if we take into consideration the likelihood I would refer to this particular incident as likelihood number 5, so almost certain, which shows that the risk event is expected or has already occurred. In this case it had already occurred. Then if you bring those over to our risk ratings, if you go to "consequences" "moderate" they are "almost certain" as a "very high-risk" and then that would make us - looking at an intolerable risk, which is what we decided, so therefore we withdrew our staff.

MR HUTTON: Thank you. Thank you [Edited].

THE CORONER: I hadn't seen those arrows, so I hadn't realised that you worked your way around.

MR HUTTON: And just while we are on the topcic, Ms Gill, you were asked a question by counsel assisting that suggested break-ins in houses may or may not be traumatising but I think the way it was put to you was if it be trauma. In your role have you had discussions with staff who have been broken into?---Yes, I have.

Have you found those experiences have generally caused some trauma to the staff? ---Yes.

And your belief is that events like that can be traumatising for staff?---That's correct.

Yes, thank you. Thank you, your Honour.

MR COLERIDGE: Just very briefly - - -

THE CORONER: Anything else, Mr Coleridge?

MR COLERIDGE: I promise you very briefly.

REXN BY MR COLERIDGE:

MR COLERIDGE: I just wanted to ask you about checklists and standardised equipment?
---Yes.

One reason you standardise - sorry, let's leave standardised equipment alone. One reason that you produce checklists is to ensure that you check on relevant considerations?---That's correct.

And that's what we see on the risk assessment matrix isn't it?---That's correct.

So, for example, because it's there, you can ensure that you take into account any financial consequences of something happening?---That's correct.

Or reputational consequences?---That's correct.

Or clinical consequences?---That's correct.

Now, I am not in any way suggesting that this was intentional or that you personally should feel responsible for this, but would you accept that an outcome of the decision-making process on 9 November might have been that Indigenous staff members felt excluded?---I accept that.

Do you thin that a document like this, given that you're providing services in some cases to overwhelming indigenous communities, where your staff might be indigenous, do you think it's important that a document like this identifies a relevant consideration whether or not there are kind of equal opportunity considerations - or potential impacts on equal opportunity of decision-making?---I accept that.

THE CORONER: Which document are you referring to?

MR COLERIDGE: I am talking about the risk matrix but - - -

THE CORONER: This?

MR COLERIDGE: Yes. But let's forget about that for a second?---Mm mm.

Let's say you know those - I think you put a list of five things that you consider when making a risk assessment?---Sure.

Do you think it would help - just to identify really clearly that one of the things that you have to tick off the box is, "Have Indigenous staff been consulted on the decision to leave"?---I accept that.

Yes, and that's just to ensure that we don't end up in tricky situations like this again? ---Mm mm.

And I anticipate that actually the department of Health has been updating the temporary withdrawal policy?---That's correct, we've - - -

And one of the things that it now mandates is consultation?---That's correct.

Is it fair to say that's a lesson learned in some respects?---Very much so.

Thank you.

THE CORONER: I think you will be pleased to know that there are no further questions?---Thank you very much, your Honour.

I meant it very sincerely when I said thank you for the effort that you have gone to in preparing the documentation that you have made available. You have obviously now been questioned quite closely on that information?---That's correct.

And I appreciate that that can feel difficult in the witness box. It's not directed at you personally, it's directed at understanding the circumstances that occurred on the day so that we can all learn from that experience and, as you say, there has already been steps to reflect on that and change some practices and that's - we're looking to the future?---Yes.

To see if we can do things better. Again, thank you for coming to give evidence today?---Thank you, your Honour.

WITNESS WITHDREW

THE CORONER: Yes, so - - -

MR COLERIDGE: Your Honour, the next witnesses are witnesses from Congress. It's now 10 past 12. Would it be convenient to take an early lunch break and come back at 1:10 and commence then or - - -

THE CORONER: Is that what you would prefer? Or otherwise we can - and we just need an additional chair, is that correct.

DR DWYER: I am told to change the camera angles and some additional chairs. I am happy to start now or to - might I (inaudible) your Honour?

THE CORONER: Sure. Yes, you're allowed.

DR DWYER: Thank you. Your Honour, the witnesses are entirely accommodating of the court so it's really a matter for your Honour. It would - I think we would come back and have 15 minutes worth of evidence is all we would get to really.

THE CORONER: All right. So is everyone happy to just take an early lunch break and come back at ten past 1:00?

All right, we will do that. We will adjourn for lunch.

LUNCHEON ADJOURNMENT

RESUMED

THE CORONER: Yes, Dr Dwyer.

DR DWYER: Thank you, your Honour. Your Honour, the witnesses this afternoon are Dr Ah Chee and Dr Boffa and I call those doctors.

THE CORONER: Thank you. And we won't put you in the hot seat if you need your statement and it hasn't been provided yet.

DR DWYER: It's just arrived.

DONNA MARIE AH CHEE, affirmed:

JOHN BOFFA, affirmed:

THE CORONER: Thank you. Thank you for coming this afternoon and providing your time.

XN BY DR DWYER:

DR DWYER: Just before I start, can I get through some formalities? Dr Ah Chee, can you please state your full name.

THE WITNESS, AH CHEE: Donna Marie Ah Chee.

DR DWYER: And your current employment position?

THE WITNESS, AH CHEE: Chief Executive Officer.

DR DWYER: Where are you based?

THE WITNESS, AH CHEE: In Alice Springs.

DR DWYER: And you're the Chief Executive Officer of the Central Australian Aboriginal Congress?

THE WITNESS, AH CHEE: That's right.

DR DWYER: I'll come to what Congress is shortly.

Dr Boffa, you're full name, please.

THE WITNESS, BOFFA: Dr John Boffa.

DR DWYER: And your current employment position with Congress?

THE WITNESS, BOFFA: I'm the Chief Medical Officer of Public Health.

DR DWYER: I'm grateful to you both for reminding us of the public health measures that we've been failing to take often, do you feel comfortable removing your masks to give evidence? Are you far enough distance apart. I'm just thinking for the livestream, it might be easier?

THE WITNESS, AH CHEE: Yeah, we're comfortable with that.

DR DWYER: Thank you very much.

THE CORONER: I had my fourth injection before I came here.

THE WITNESS, AH CHEE: Excellent.

DR DWYER: You're looking very well, your Honour.

So, just before I finish really with the formalities, particularly for those who are listening into the evidence, to understand your significant qualifications and experience, Dr Ah Chee, you and Dr Boffa set these out in detail in your joint statement. You provided that statement. It is dated 13 September 2022. Correct?

THE WITNESS, AH CHEE: Correct.

DR DWYER: So, just going from that, I won't go through all of them, but starting with you, Dr Ah Chee, you are – well, where did you commence your employment, your early years as - - -

THE WITNESS, AH CHEE: Well, I came to Alice Springs in 1987, initially employed at the Institute for Aboriginal Development and then went on to be the Chief Executive Officer of Central Australian Aboriginal Congress in 1999.

DR DWYER: And Dr Ah Chee, you have an honorary doctorate from Charles Darwin University. Is that right?

THE WITNESS, AH CHEE: That's correct.

DR DWYER: And just in terms of some of your significant experience so that those listening understand, you are currently the chair of the Northern Territory Tripartite Forum on Children and Aboriginal Medical Services Alliance of the Northern Territory, known as AMSANT.

THE WITNESS, AH CHEE: Yes, AMSANT. But then there's the Children and Families Tripartite Forum and I'm the independent chair of that as well.

DR DWYER: Thank you. And you've had experience as a – on a board for many years formulating policy or directing policy.

THE WITNESS, AH CHEE: Many years.

DR DWYER: You are the former chair of the Aboriginal Benefits Account Advisory Committee.

THE WITNESS, AH CHEE: That's correct.

DR DWYER: Also, the Literacy for Life Foundation.

THE WITNESS, AH CHEE: Correct.

DR DWYER: And a former director on the board of National Aboriginal Community Controlled Organisations, or NACCO.

THE WITNESS, AH CHEE: Correct.

DR DWYER: You have also previously served as the CEO of that organisation.

THE WITNESS, AH CHEE: Yes.

DR DWYER: You are a former board member of the Australian National Advisory Council and Alcohol and Drugs?

THE WITNESS, AH CHEE: Yes.

DR DWYER: And just to take a number of your positions rather than go through all of them, you are an expert member of the National Aboriginal and Torres Strait Islander Health Implementation Plan Advisory Group.

THE WITNESS, AH CHEE: That's right.

DR DWYER: Who does that group report to?

THE WITNESS, AH CHEE: To the Commonwealth Chief Executive, Health Chief Executive.

DR DWYER: And you represent Congress on the Alice Springs People's Alcohol Action Coalition.

THE WITNESS, AH CHEE: That's correct.

DR DWYER: I will ask you about some issues relating to alcohol policy shortly. I just want to note that in relation to your experience, you've also been involved in research for many years and been the lead investigator in some key research projects which involve alcohol consumption and the impact on Aboriginal and Torres Strait Islanders.

THE WITNESS, AH CHEE: That's correct.

DR DWYER: You've got many years' experience as a CEO of different Aboriginal organisations, including as I mentioned earlier, NACCO from 2011 to 2012, and you were the CEO of the Institute for Aboriginal Development in Alice Springs from 1995 to 1999.

THE WITNESS, AH CHEE: That's correct.

DR DWYER: Dr Ah Chee, you are an Aboriginal woman. You spent many years in Alice Springs. Where's your country from?

THE WITNESS, AH CHEE: Yes, I'm Bundjalung – a proud Bundjalung woman from the far north coast of New South Wales. My grandmother is from a place called Cabbage Tree Island which is just near Lismore and I've been living here on Central Arrernte country for over 30 years.

DR DWYER: Thank you, Dr Ah Chee, can I – before I delve deeper into some of those qualifications and how you've put them to use, I'll just ask:

Dr Boffa, when did you first come to the Northern Territory?

THE WITNESS, BOFFA: February the 22nd, 1988.

DR DWYER: 19?

THE WITNESS, BOFFA: February, 21st actually, 1988.

DR DWYER: Doctor, you're a medical doctor. Is that right?

THE WITNESS, BOFFA: Yes.

DR DWYER: You are currently the Chief Medical Officer of Congress and you've been in that role since the year 2000. You've had a longer history with Congress though. Is that right?

THE WITNESS, BOFFA: Yes, since 1994.

DR DWYER: What was your first role in Congress?

THE WITNESS, BOFFA: Medical officer for one year and then senior medical officer from 1995, then public health medicalist from 2000, then Chief Medical Officer for Public Health.

DR DWYER: Dr Boffa, prior to that, you were the Senior Medical Officer in Tennant Creek. Is that right?

THE WITNESS, BOFFA: Yes, from 1998 to 1994.

DR DWYER: You set out in your statement helpfully various qualifications and

awards. They include, in 2012, Northern Territory Australian of the Year for your research and reform with alcohol in early childhood illness. Is that right?

THE WITNESS, BOFFA: Yes, that's right.

DR DWYER: You note also that, in your various roles in the Aboriginal health over many years, you've worked with Aboriginal health leaders on significant Aboriginal health policy developments and that included the Royal Commission into Aboriginal deaths in custody in 1991.

THE WITNESS, BOFFA: Yeah, that's correct.

DR DWYER: You were involved in the development of the Aboriginal Community Control Primary Health Care documents in many respects, including development of the CARPA manual, the standard treatment guidelines.

THE WITNESS, BOFFA: Yes, that's true, that first addition.

DR DWYER: CARPA is the Central Australian Rural Practitioners Association?

THE WITNESS, BOFFA: Yes, it is.

DR DWYER: And that's the manual that's still used today - - -

THE WITNESS, BOFFA: Yes, it is.

DR DWYER: - - - and its various additions?

THE WITNESS, BOFFA: Yes. It's a very important way in which practitioners make sure their practising in accordance with the best practice evidence.

DR DWYER: Specifically related to assisting practitioners in a rural or remote situation?

THE WITNESS, BOFFA: And Aboriginal primary health care, but rural and remote primary health care, but more specifically, Aboriginal primary health care.

DR DWYER: In 2016, you were both awarded the Australian Medical Association Award for Excellence in Health Care, a joint award to both of you.

THE WITNESS, BOFFA: Yes, that's true.

DR DWYER: Might I ask first about the background to Congress. Dr Ah Chee, this is set out in your statement from par 14, but in your words, would you mind just telling us what Congress is?

THE WITNESS, AH CHEE: Congress is an Aboriginal community-controlled primary health care service and we're turning 50 next year. It originally started, it

was established to be the voice of Aboriginal people in Central Australia and it wasn't until two years' later in 1975 that the genesis of a medical service with the employment of a doctor, a receptionist and a bus driver, which was the start of what we've got today, which is a comprehensive primary health care service which goes from, you know, quality antenatal care, early childhood, through to detection, early detection and management of chronic disease, through to looking after our old people through our Frail, Aged and Disabled program. But what's equally important as part of primary health care is our role in advocacy.

DR DWYER: And I'll break some of those different roles down, in terms of the geographical area that Central Australia, that Congress covers.

THE WITNESS, AH CHEE: Yeah, we go as far south-west as Mutitjulu, which is about just over 500 kilometres away. We go east as far as Ginger Porter, Santa Teresa, as well as more closer to town, about 22 ks out at Amunugama (?) and we also provide services out west at Utju at Areyonga and a joint service at Indari (?) and Wallace Rockhole.

DR DWYER: I think, looking at your statement and that evidence, in terms of the actual clinics you are in control of, it's five remote clinics serving six communities.

THE WITNESS, AH CHEE: That's right.

DR DWYER: And of course, the additional services in terms of advocacy affect the whole Central Australia. Is that right?

THE WITNESS, AH CHEE: Yes. And sometimes NT, and sometimes nationally.

DR DWYER: In relation to additional services, could you please tell us about Headspace and Congress' involvement with Headspace?

THE WITNESS, AH CHEE: Well, Headspace is – we're one of three in the country where Headspace is located within an Aboriginal community-controlled primary health care service. We were the first in the country. And it is for young people that are – and that have, you know, issues around mental health. But we advocated for Headspace to be part of a comprehensive primary health care service, so that it could have those wraparound support services. And it is a service that we provide to both Aboriginal and non-Aboriginal young people.

DR DWYER: And is that service provided in the clinics that are currently operated by Congress?

THE WITNESS, AH CHEE: No, the Headspace that we currently run at the moment is for Alice Springs, but we have negotiated and establishing an outreach service to Mutitjulu.

DR DWYER: Is it a service where – which is online or does it involve people physically going out to the community?

THE WITNESS, AH CHEE: Physically going to the community.

DR DWYER: Is that a service that you would like to see with more funding and resources, accessing different communities?

THE WITNESS, AH CHEE: Absolutely.

DR DWYER: Can you tell us about the Youth Outreach teams and where they currently operate?

THE WITNESS, AH CHEE: Our Youth Outreach team is mainly in Alice Springs and is sort of integrated as part of our Back on Track program, which is dealing with young people that have been, you know, part of the juvenile justice system and it's really a youth diversion program to keep kids out of youth detention.

DR DWYER: Do the Youth Outreach teams then become - well, some people are nominated as case workers for individual clients?

THE WITNESS, AH CHEE: yes.

DR DWYER: And can they then go into the remote areas where their clients are?

THE WITNESS, AH CHEE: Well, we're not funded to do remote areas so at the moment it's only based in Alice Springs in terms of our youth services.

DR DWYER: Is that a service that you think would be useful to fund to go into remote communities?

THE WITNESS, AH CHEE: Absolutely.

DR DWYER: In terms of being able to offer that service, if you were going to have people living in communities like Yuendumu, you'd need to work with government to accommodate them firstly?

THE WITNESS, AH CHEE: Absolutely.

DR DWYER: I might return to that. Can I ask you about the best practice model that you refer to and Dr Boffa, I might turn to you for this. At par 36 you note that in 2003 Congress took over ITTU(?) in Areyonga from the Northern Territory Department of Health and that is now widely recognised as a model of best practice in remote communities. Just before I ask you about why - what is it that distinguishes the practice of Congress, Dr Ah Chee, I wonder if you could just explain, what are the models - some health care is provided by Northern Territory Health, some by Congress. How is that determined?

THE WITNESS, AH CHEE: Well, in Congress' situation it was driven by the local community to want to have their own Aboriginal community controlled health service

and that happens across the Northern Territory and there is a current policy of the Northern Territory Government and the Commonwealth with the support of the Aboriginal Medical Service Alliance of the NT- AMSANT, for the transition NT government clinics to Aboriginal community control. So there's been a history of Congress in actually supporting communities to transition - either transition clinics to community control or to establish their own Aboriginal community controlled health service.

DR DWYER: Just before I move on to the actual model, can I ask you about some of the history relating to Yuendumu. In your joint statement, from par 30, you and Dr Boffa outline a service provision to Yuendumu and I will direct this question to you Dr Ah Chee and Dr Boffa, I will just ask you at the end if there is anything you want to add to this before we come back to the actual service provision. From late 2002 Congress provided the Willowra/Yuendumu/Nyirripi health zone with primary health care services through an auspice agreement in conjunction with the Willowra/ Yuendumu/Nyirripi Health Board and the Northern Territory government. Was that, in effect, Congress being responsible for the provision of health services or was it a joint model?

THE WITNESS, AH CHEE: No, we were actually responsible for elements of the - it was - it as actually a dual service because there was still the Aboriginal - sorry - the NT Government clinic and we were funded directly from the Commonwealth to provide GP services - a GP and other related staff.

DR DWYER: So the clinic is still owned by NT Government, is that right?

THE WITNESS, AH CHEE: Yes.

DR DWYER: And Congress is, in effect, contracted to provide the health service?

THE WITNESS, AH CHEE: Not the whole health service.

DR DWYER: I see, part of the health - - -

THE WITNESS AH CHEE: Yes.

DR DWYER: The primary health service, is that right?

THE WITNESS, AH CHEE: Do you want to explain that John? I think - it's bit like Indari (?) isn't it?

THE WITNESS, BOFFA: Yes, so Congress is funded to complement what existed through the Territory Government clinic what was largely, you know, remote area nurses and Aboriginal health workers. So Congress has given additional funding from the Commonwealth Government under Primary Health Care access program, to - importantly to employ GPs because community mental health service always have GPs within the service as part of the model, not just a nurse/Aboriginal health worker only service model. So Congress received those additional resources to

employ a lot of additional staff who worked alongside the Territory Government clinic staff to provide a comprehensive primary health care service in its total, yeah, but it was dual provider service model and it happened in an era under the Primary Health Care Access Program where the Northern Territory had been provided up into 21 health zones and so each of those health zones it was thought would end up with their own community child health service, so it was originally thought that the WYN area would become a community child health service. But they by about 2007, with the success of large and regional Aboriginal health services like Katherine West Health Board and Sunrise, the health planners decided it was a minimum population that you needed to get economy to scale to have an effective comprehensive primary health care service. So those original health zones were deemed to be too small and so that as an issue for transition for places like the area like WYN would need to become part of a larger service to develop the community child health service.

DR DWYER: And so this is part of what you - very helpfully there's a slide from the Congress Orientation program which shows the way in which - the services that Congress helped to set up over time. If we have a look then at par 36 of your statement, you explain that planning document from June 2009 - so seven years after Congress started with that dual agreement, there was a planning document which explained the arrangement that WYN health under the auspices of Congress, funded by the then Office of Aboriginal and Torres Strait Islander Health, a Commonwealth Government department, was funded to deliver primary health care services to Yuendumu/Nyirippi and Willowra. These services were provided at the community health centres based in each community, operated by the NT Department of Health and Families, through the Central Australia Remote Health Survives. So there's obviously some complex health planning and bureaucracy that goes into this but at that time the staffing profile provided by WYN under Congress is set out in pars 37 and 38, there's a very significant number of positions that were added to the core clinic positions as a result of Congress' involvement. Is that right?

THE WITNESS, AH CHEE: Yes.

DR DWYER: And I think you said earlier, Dr Boffa, it's essential in the Congress model for general practitioners to be involved rather than nurse led?

THE WITNESS, BOFFA: Yes, and in fact we were guided then by the Central Australian Health Plan Study, which is a joint study commissioned by the Commonwealth, Territory and the Aboriginal Medical Service Alliance. That study set out population starting radios for primary health care, so it said there should be one GP for every 400 people in a remote community. On nurse for every 250 people and one Aboriginal health worker for every 100 people, so we started to build, in 2002, the primary health care system funding levels in Central Australia range from $350 per person in Lake Nash, to around $1500 per person in Elliott - so this funding was - that was completely - it was one that was inequitable and inadequate. So this funding was designed to both increase the absolute level of funding and obviously the number of staff as well as achieve equity across the region and it started to achieve that. So you can see that sort of boost is starting to get to something like

what you need for a population of 900 people who have a significant degree of illness, to be able to deliver an effective primary health care service and importantly, that included resident GPs and it was Dr Russell Thompson, and Dr Alec Kajenskiy and then one was replaced by Dr Rodney Jones. So there were two resident GPs in that community the whole time we had the service and they were part of a team, but you need GPs as part of your team and the more remote you are the more it is important they are that they are resident, because fly in fly out you just lose too much of the clinical services every time and too much of the capacity of GPs to contribute to the whole team in the community.

And does it - in the case of recruitment, having two GPs wo are based in the community, does that make it easier to in fact attract other people in the workforce? ---Absolutely. All health professionals want to work in an effective team and these days that includes social workers, psychologists, nurses, Aboriginal health workers, GPs, it's an incredibly challenging environment for people working. It's incredibly rewarding and it's a great privilege to work in it but it is challenging. But if you're working in an effective team, every problem - with the community - with Aboriginal people from the community as part of that team, everything you're dealing with can be addressed. So it's a really important retention strategy to have an effective team. If you go into a service where there are no staff and everyone is overworked, you will have turnover.

DR DWYER: You – it so it becomes a self-perpetuated problem, from the fewer staff you have, the more difficult it is to attract people and keep them?

THE WITNESS, BOFFA: Yeah, absolutely.

DR DWYER: Do you recall, at that time, I'm trying to remind myself what your position was at that time, Dr Boffa, you were involved with Congress I think, as the Chief Medical Officer. You'd been in the role since the year 2000?

THE WITNESS, BOFFA: I was the Public Health Medical Officer, at that time.

DR DWYER: Do you recall any difficulties in relation to attracting staff, or keeping them, at that time?

THE WITNESS, BOFFA: Yeah look it – one of the doctor's is an international medical graduate. He trained in Russia, then got qualifications in Europe. Came under the Michael Woolridge ING Program, which was a brilliant way to get doctors into remote communities. Fortunately we've still got that program, but just recently the government made the great decision to allow them to practise in MM2 locations. So where – so that's Caroline Springs (?) in Melbourne, is the same as Kintore, for attracting international – that's almost gutted it, in terms of remote communities. But we had one doctor then from the ING Program. One of the doctors was a non-VRGP. He was a surgeon who then decided to leave surgeon and become a general practitioner. As a non-VRGP in those days, he was only allowed to work to attract Medicare, and then MM5 or six, that's remote and very remote. So he had – so he came for that reason. He was very good. And non-VRGPs can be incredibly

effective, because they're often older doctors, who'd had a lot of experience. And one doctor, the third one, Russell Thompson, obtained his fellowship while working for us. So he was – he was the only Australian – well no, not the only – there were two Australians. But he was the only proper general practitioner who got his fellowship while working for us, through that – what's called a Remote Vocational Training Scheme. Which is a scheme that allows doctors to train to fellowship, from one remote community. And so you've got to – you've got to use every avenue, to get doctors into remote communities. And international medical graduates is one avenue. You've got to offer GPs effective training, to fellowship level. And you've got to look at non-VRGPs. But unfortunately, all those avenues, in recent times, have started to dry up. Because with the GP shortage, governments are more worried about the outer metropolitan areas in Melbourne and Sydney, than they are about the remote communities. So we're at a very difficult situation now.

DR DWYER: There's been some recent publicity I note, on the GP shortage around the country. Both of you are highly experienced, and I know may well have an ear still to different government bodies. Is that information being fed up to the Federal Government?

THE WITNESS, AH CHEE: Absolutely, constantly.

THE WITNESS, BOFFA: With solutions.

DR DWYER: I note her Honour's powers don't extend to the Commonwealth, but no doubt you'd be happy of course - - -

THE WITNESS, BOFFA: But if she does want to solve the GP work force crisis, it would be very welcome.

DR DWYER: But no doubt you'd be happy for – that doesn't stop us passing on any information that you've got - - -

THE WITNESS, BOFFA: Yeah.

DR DWYER: - - - so no doubt you'd be happy for us to pass that on to the Federal Government if that's – if you think it would be of assistance. In relation to that – those creative strategies then. I take it that, Dr Ah Chee, and Dr Boffa, you're currently engaged for the health services that you are covering, to think creatively about other ways to ensure that you can have GPs servicing communities?

THE WITNESS, AH CHEE: Yes.

DR DWYER: In relation to the communities that you currently service, so five remote clinics serving six different communities. Is there a general practitioner at each of those communities?

THE WITNESS, BOFFA: Yeah, there's general practitioners full-time in Mutitjulu, Injilatparri (?) Indari (?). And we do – at (inaudible) is a community of 230 people,

there's two days a week for the GP time. And Amoonguna, there's full-time. The one – of all those communities, we have permanent vacancy at Mutitjulu, which – which is about to be filled. It's been for 12 months, we've had to use locums. That's about to be filled by an international medical graduate. And I'm pleased to say, it looks like we poached her from an MM2 location in a capital city, going remote. That's not what's happening. They're all leaving remote to go to MM2 locations in capital cities. So this is against the trend.

DR DWYER: There are – do you want to tell us, Dr Boffa, about what are the advantages. Think of this as a recruitment campaign, to working remotely. Because we've already heard from nursing staff, that you get an opportunity to engage in a wide variety of practise remotely, and of course, the privilege of working with Aboriginal people on country?

THE WITNESS, BOFFA: Yeah, and so it's a very interesting and challenging work environment. There's a lot of varied work. You're part of a team. You really make a difference. People are sick, and but do respond very well to chronic disease management. It's very effective. So you can make a big difference in people's lives. But you also – you get welcomed. You become part of the community. You learn a different culture. It's – it's a really great experience, and – and I concur that there's been some publicity from this hearing which is quite negative. And one thing I'd really like to mention is non-Aboriginal health professionals never get subject to payback. That's just nonsense. It – payback is something that there's particular laws around. And it's – it's practised in a particular way, in accordance with very strict rules and laws, and traditions. And it works within the Aboriginal community. It's not practised on non-Aboriginal health professionals. So health professionals who go out there will be welcomed. If they try their hardest and do their best, they'll be even welcomed more. If mistakes happen, and they do, people are very understanding of those mistakes when then they're genuinely made. There's none of this – you don't need to worry about that sort of – you know, it's just nonsense. I think it's really damaging to have that out there. And that has been in the media. So I think that's worth addressing. So by and large, it's a great opportunity. People are well – well, in some services settings, they're well supported. The work's challenging. But they make a difference. And they a big difference. You're not working with the worried world, you're working with people in which medicine makes a big difference. And also you're working in a structure where you can no only treat sick people and make them well, but you can actually think about what are the structural determinants of illness? And what can we do about that? Which is where Donna's point about advocacy becomes very important. But in some service models, advocacy's much more possible than in ours. It's a lot harder to advocate as an employee of the state.

DR DWYER: Dr Ah Chee, particularly as an Aboriginal person, can I pick up on something that Dr Boffa has talked to about there with payback. I know from speaking to some of Kumanjayi's family members and community, that they feel offended, by the concept that – by payback being used as a concept that non-Aboriginal people just don't understand, and use in a way that is inappropriate. Is that something that you'd like to comment on too?

THE WITNESS, AH CHEE: I think I absolutely support the families view about that. And I support what Dr Boffa has just said about it. That it's been, you know, misused inappropriately in this context.

DR DWYER: Can I just refer back to Yuendumu and the staffing ratio. Dr Boffa referred to some ratios before, or roughly that this is back in 2009. One GP for every 400, one nurse for every 250 people, and I think – I can't read my own scribble, Dr Boffa, one Aboriginal health worker - - -

THE WITNESS, BOFFA: For every 100.

DR DWYER: Are those ratios still appropriate?

THE WITNESS, BOFFA: We still – they're our – that's like the gospel, according to primary health care service planning if you like. It's an – it's, if you like, some would see it as an asymptotic goal, but I think it's still – it's something we work towards. And we're certainly conscious of it. And we try – and this is where coming back o Utju, you look at Utju, why – why Utju is considered to be an exemplar, is it's a community of 230 people. It's four nurses. There's a GP two days a week, and there's an Aboriginal health practitioner. There's an Aboriginal liaison officer. There's a part-time cleaner. So that's a well-resourced primary health care service, in a community of that size. When in other communities like that, that they're under the health department, their clinics have been closed since the middle of last year because of COVID. Similar size or even larger communities actually have a visiting service only now. With no one permanently in the community. So people look at Utju and think wow, we want what they've got, which is good. I think that's what people should be saying. They should be aspiring towards that level of health care, given the level of need. And the other point to make is from 99 to 2018, an article just published in the MJA shows that Territory wide, Aboriginal men's life expectancy's improved nine years, and Aboriginal women's improved five years. The improvements have been bigger in Central Australia. And it's all due to primary health – it's not just primary health care, it's the health system, that's made the difference. Along with opal, unleaded, an alcohol reform. So if the primary health care system goes backwards, this has happened in a period where the other social determinants have not improved, so, educational outcomes, educational participation, early childhood development, over-crowding, unemployment, income, poverty, they haven't changed. But we're still seeing that sort of improvement. Which is very significant. But if the health system starts to collapse, which it's doing now, we'll go backwards very quickly. And we just saw in another article in the MJ a few weeks ago, that in the health department's clinics, of all their chronic disease patients, over 70 percent haven't seen a doctor in 12 months, in more than 12 months. And 90 percent are not picking up their medications. So that's a very rapid – and therefore, end stage renal failure's increased 20 percent in the last 12 months, in government clinics. So I think we can very quickly go backwards, if we're not very, very aware of the crisis we're in, and the need to address it properly.

DR DWYER: End stage renal failure has increased, in the Northern Territory, or across Australia?

THE WITNESS, BOFFA: That's Central Australia.

DR DWYER: That's Central - - -

THE WITNESS, BOFFA: In Territory Government clinic communities. I'm not saying it hasn't increased in community controlled - run communities, we haven't got that data. So it could be across the board. But that's a major concern. We should all be absolutely incredibly concerned about that. And we should be doing everything we can to get the work force we need. And we heard yesterday in evidence, a 25 percent nursing shortage. And then you add to that the GP shortage, and the Aboriginal health practitioner shortage is absolutely much worse. And you've got a work force crisis like we haven't seen since the mid-90s, at a time when we know what a difference access to primary health care makes.

DR DWYER: In relation to the crisis in the availability of Aboriginal health care workers, what do you think the reason for that is?

Actually - - -

THE WITNESS, AH CHEE: I'll answer that. Well there was a change many years ago to have an Aboriginal health practitioner. So raise the actual entry level, and qualification. So we went from Aboriginal health worker, basic skills, to being an Aboriginal health practitioner, in terms of registration. So that – you know, with all the good intentions about increasing the clinical capacity, what it did, in the end, is that it actually decimated the Aboriginal health worker – Aboriginal health practitioner work force, in the Northern Territory. So we've actually gone backwards. And it's a structural thing that needs to be addressed. And that's because we've moved away from the Aboriginal health worker basic skills training program. And there's, you know, to be – to become an Aboriginal health practitioner, you've got to be, you know, of a certain level in terms of educational capacity. So when you look at the Northern Territory in terms of educational disadvantage, it – it just put the, you know, Aboriginal people – the number of Aboriginal people that could train to be an Aboriginal health practitioner, was going to be dramatically reduced. So we're advocating for a return, back to the future, of the Basic Skills Aboriginal Health Worker, and that's where you'll have more Aboriginal language speakers getting – and – getting them back into the – into the health clinics.

DR DWYER: And Dr Ah Chee, that was a – Dr Boffa talked about a Commonwealth initiative that has had adverse unintended effects. Is this a Territory Government initiative?

THE WITNESS, AH CHEE: No this was a – this was a national reform. A national reform.

DR DWYER: And when was it introduced? Just roughly?

THE WITNESS, BOFFA: 1990. So quite a long time ago. And so Batchelor College took over all the training. Originally they did it in partnership with Aboriginal Health Services, and that started to work quite well. But then they – those partnerships stopped. And they've been trying to do it on their own. They've come back to trying to do partnerships with Health Service, but the number of graduates, it'd be less than five a year. Or a very long time we've had less than five graduates a year, for about 15 years. And so you can't – there's – so we've gone from 400 registered health workers, to under – to well under 200 now, Territory wide.

DR DWYER: So is there action that the Northern Territory Government could take? I'm thinking particularly because you understand that her Honour has a recommendations power that can be directed to the Northern Territory Government. Is there lobbying that you're trying to do at that level?

THE WITNESS, AH CHEE: Yeah, well I think we need to return to the Basic Skills Aboriginal Health Worker Training Program. You know, certificate level two, and then there can be pathways into you know, level four, Certificate Level 4 Aboriginal Health Practitioner. But we've got to – we've got to come back, and invest at a lower level community.

THE WITNESS, BOFFA: And I was just going to add, we need about 50 traineeships a year. So that plus the funded positions. Because in the old days, health workers used to say, someone indentified health worker, they'd go up and sign up with DEET in those days. They'd get a training wage, and they'd learn on the job. So it's a combination of being able to employ them, while they're training, and learning on the job, with some extra support from places like Batchelor, would really get us back to a situation where we've got that critical work force. But that, plus nurses, plus doctors. Never that – in the bad old days, you'd have remote clinics with health workers only, trying to do everything. That's certificate – or not event Certificate 4. So that's not where we want to go. It's a team-based approach. And they're an essential part of the team.

DR DWYER: I'm going to say two things that I'm going to suggest are trite and common sense. One is that the more Aboriginal workers that you have, the better for all staff, Kartiya and Yapa, to be able to manage that clinic? And the - - -

THE WITNESS, AH CHEE: Yeah, absolutely.

DR DWYER: - - - and the more buy in you're likely to get the community in terms of respecting and valuing their - - -

THE WITNESS, AH CHEE: Exactly.

DR DWYER: - - - health service?

THE WITNESS, AH CHEE: And you've got to have an active Aboriginalisation policy, which at Congress, that's what we – what we – what we've got. And we've

got a deliberate – a very deliberate policy in terms of training and professional development to invest in – in Aboriginal people and Aboriginal staff. The other thing that I want to pick up on terms of training, is not just at the entry level training. But there's also a need in terms of health professional qualifications. So if we want to get more Aboriginal doctors, more Aboriginal psychologists, more Aboriginal nurses, then we've also got to increase the access to cadetships as well. And I think that's something that needs a good look at as well. And at Congress, just to give some data, and how serious we take this about Aboriginal employment, is that 61 percent of our Aboriginal – of our work force, is Aboriginal, when you take out health professionals. And we've got a 30 percent of our leadership team is Aboriginal. And we've got a target of 40 percent. So it makes a – it makes a big difference in terms of making sure that we've got Aboriginal leadership. And with an Aboriginal board, control.

DR DWYER: And I'll – I'll come back to the Aboriginal board of control in one moment. The employment of Aboriginal people in a clinic setting, and other settings to, I suggest also has a flow on effect for the community, that's really important in terms of improving community health overall?

THE WITNESS, AH CHEE: Exactly. And they're our – they're our contacts as well, to the community as well, yeah.

THE WITNESS, BOFFA: And it's an inter-generational health development strategy. Because there's recent evidence that employment amongst parents could be the principle to determine the school attendance. So it has an – if your parents are working, then the next generation get a great benefit from that. So it's a double whammy. It's – the health service needs these people to be culturally safe and effective, right now. And then, through their employment, their families benefit, so that the next generation of children have role models, parents working, and working parents are more likely to want children to be in child care, to be at school. And that has a huge impact on health. So you know, it's a really important strategy. And the starting wage is a great way to begin.

DR DWYER: And then Dr Ah Chee, you just mentioned answerable to an Aboriginal board, is that right?

THE WITNESS, AH CHEE: Yes.

DR DWYER: What are the benefits of that?

THE WITNESS, AH CHEE: Well they're connected directly to the community. Direct input. I remember many years ago, before we introduced an appointment system at Congress, the board meetings were constantly talking about the waiting times. So that was direct input to the board, about what was going on, on the front line, in the clinic. So that got – obviously got attention after time. But that's a direct way in which community, clients, patients, and the community, can have direct input into the service, and have their issues addressed.

DR DWYER: We have a lot of material in the inquest that supports the community wanting to be empowered, or in some circumstances, it's expressed as being re-empowered, to have control over services that are going into their community. Is having an Aboriginal controlled board, an important way of doing that?

THE WITNESS, AH CHEE: Well it's an expression of self-determination. And it's – and it's – it's key, as one of the – one of the priority reforms for the closing the gap. So, you know, having Aboriginal people in control, and directing, and taking responsibility is one of the key – key reflections of self-determination. So we absolutely support Aboriginal community control of primary health care.

DR DWYER: Do you see the benefit of having an Aboriginal controlled board to be non-Aboriginal staff, as well as the community?

THE WITNESS, AH CHEE: Absolutely. And you know, it's being part of an organisation or a service, as non-Aboriginal people, they actually learn. It's two ways. It's – you know we get non-Aboriginal knowledge, and they get to reflect, they get to be part of working in a cross-cultural environment and getting – you know, learning new things from local Aboriginal and direct – being under the control of Aboriginal people. It's a new thing for some people and it's a bit hard to get used to, but at the end of the day, it is about Aboriginal people taking responsibility.

DR DWYER: One of the – I'm not sure if you've had the opportunity, I know how busy you both are, to listen to any of the evidence this week. But if I could just ask you to accept from me that some of the evidence that's come out is that the workforce in Yuendumu currently and in 2019 at the time of Kumanjayi's death, spent most of the time outside of work hours, socialising within themselves and they did not have much to do in terms of socialising with other stakeholders. And they didn't in fact spend much time in the community, other than one nurse who had a son at school. Do you think it's important for staff to be able to connect with other service providers, socially and within a clinic?

THE WITNESS, AH CHEE: Absolutely. Absolutely, and that is what happens in our remote locations, you know, and our staff are actually embedded as part of the community, so – and the community looks to the health clinic to be part of what's going on in the community and to be supportive and to help. So, it's – yeah, it's staff that work in the clinic that extend beyond the clinic in terms of their engagement with the community and it's also in the community, been seen as a health centre as an entity, that we are there to support the community as well in broader activities and with other providers.

DR DWYER: We've heard at the orientation process for nursing staff in Yuendumu was to spend some time with the Aboriginal health worker, being taken around for the day, for example, looking at different sites where they should and shouldn't go, are there – beyond that, there weren't regular Warlpiri classes and there wasn't a regular orientation process that they attended, are there strategies that Congress uses to ensure that people are embedded in the community?

THE WITNESS, AH CHEE: Absolutely. We've got operating cultural protocols for each of our remote clinics. We have a cultural orientation that's held regularly for new starters. We also have one on one with our – for new staff when they first start, with our two senior cultural advisors, male and female. And we also see that our Aboriginal staff, around 200 of them, are a source of advice to non-Aboriginal people that come and work in our service.

DR DWYER: I'll take you shortly to the document that you – that Congress has prepared in terms of dealing with a temporary reduction in services, in terms of having – of managing any conflict or any perceived risk to staff at a clinic, is the model that you talked about with an Aboriginal board one that makes it easier to have Aboriginal people assist in managing the problem?

THE WITNESS, AH CHEE: Absolutely. And we've had a recent example of where there was a level of unrest in the community, and the impact that that was having and being brought into the clinic. We talked about strategies to manage that, and that was in consultation with the staff. But more importantly, it was actually in consultation with the board. So, even though Congress has its main Aboriginal directors and board, it is equally as important that we speak to the local leadership in that community with that board. So, those strategies were discussed and, you know, sought their advice on those strategies of which they were supported. So, then we operationalised those strategies. So, it was a combination of both Aboriginal – local Aboriginal leadership seeking their advice as well as the staff that work in the actual clinic.

DR DWYER: And you're referring to the instance in Mutitjulu in 2021?

THE WITNESS, AH CHEE: Yes.

DR DWYER: Is that right?

THE WITNESS, AH CHEE: Yes.

DR DWYER: And I'll take you back there briefly shortly. Just before I leave the history of Yuendumu in terms of Congress' involvement there, you note in your joint statement at par 42 that towards the end of 2009/2010 period, the WYN health board which serviced Willowra, Yuendumu and Nyirripi notified Congress of its intentions to cease the auspice arrangements and RHS, the Congress Remote Health Service branch facilitated the transfer of staff and assets to the Northern Territory Health Department. And since that time, is it the case that the NT Health Department has provided that primary service alone?

THE WITNESS, AH CHEE: Yes.

DR DWYER: Do you know why that occurred?

THE WITNESS, AH CHEE: Well, it was a – we support self-determination, so it was a decision of the WYN board to want to return back to the Department of Health and

so we supported that decision.

DR DWYER: In your statement, you set out clearly what the steps are to take for a community who wishes to return to Congress being in control of the primary service, have you received any approach from Yuendumu to date?

THE WITNESS, AH CHEE: There's been some verbal sort of reports to us and that's happening in a number of Central Australian Aboriginal communities, actually. So, Yuendumu is not the only that is asking Congress for their assistance and for us to provide primary health care services. So, I think there is a genuine need to think and you know, strategically transition NT Government clinics in Central Australia for those communities who want to come across to Congress, that we need to elevate this in a strategic way. Because doing it piecemeal, one here, one over there, you know, a couple of clinics here, it's become – I think we – I think we've done enough done to know what needs to be done. We need to get on and do it and make it happen, but do it strategically. So, it's a shift with not just a personal shift, but an overall significant shift. And because the other point that was made earlier around the complexities, especially when you've got two providers in one community, that's something that Congress has always said is a challenge and the preference is to have one provider. So, you either have an NT Government clinic or you have Aboriginal community control. It is way too difficult to have both.

DR DWYER: At the moment, in terms of the outline of what you're currently providing with the five remote clinics servicing six communities, did you say there was only of those models where it is joint at the moment?

THE WITNESS, AH CHEE: That's right.

DR DWYER: And is that the Ginger Porter model?

THE WITNESS, AH CHEE: No, that's – it's WAHAC.

DR DWYER: It's WAHAC.

THE WITNESS, AH CHEE: Western Arrernte.

DR DWYER: In Hermannsburg. Is that right?

THE WITNESS, AH CHEE: Yeah, that's right.

DR DWYER: And I think you note in your statement also, you're in the process of transitioning three other community clinics that will be - - -

THE WITNESS, AH CHEE: That's right.

DR DWYER: - - - completed by 2023. Which are those clinics?

THE WITNESS, AH CHEE: It will be March next year for Imanpa and Yulara, and

then July will be Docker River.

DR DWYER: And staying with Yuendumu just for a moment, in relation to par 37 where you set out the staffing profile provided by the (inaudible) Congress for Yuendumu back in the 2000s. What we see there, just to remind everybody listening, two resident general practitioners rather than one, which is the situation currently. You also refer there to a male health coordinator, a female health coordinator, maternal and child health coordinator, three Aboriginal community workers as well as an Aboriginal health worker and an Aboriginal liaison officer, two mental health counsellors and two receptionists and a hearing health worker. Is that the sort of staff to community member ratio that you foresee, if Congress was to take over that service? I might let - - -

THE WITNESS, BOFFA: Yeah, you'd have to add, don't forget the remote area nurses and the Aboriginal health workers. So, that time, from memory, there were five remote area nurses and seven Aboriginal health workers, I think, with the Territory Government claim, so when you put all that together, these days you might not have the hearing health worker, you might make it more generic, but it's a very similar - you've got to have enough Aboriginal people to make a difference. It's not just Aboriginal health practices. Aboriginal liaison officers, community workers became necessary because as Donna said, the language speaking local people couldn't get Certificate IV so there's a whole new workforce out here, Aboriginal community workers, Aboriginal family support workers, Aboriginal liaison officers who are critical to being able to deliver a culturally safe service now in the absence of the old basic skills Aboriginal health worker. So when you put that sort of team together yeah, 900 people, one nurse, yeah, you're getting close to the sort of level that you need to do it properly. But I think the really key here is a model health centre where it either gets over the problem of Commonwealth or state cost-shifting, which is community control. Once the money is with the community-controlled health service - even if a position is unfilled, you don't lose the money. But we - the trouble for Aboriginal health immemorial, I've been involved 34 years - and we have not solved the problem of Commonwealth, states cost-shifting. The Northern Territory framework agreement and the Aboriginal Health forum is mean to try and do that but I think until we have either one government, which is not coming, or one health system with funds pooling, there will always be the problem as the Commonwealth puts money in, the states take money out if they can, and that's something what we've seen in Yuendumu and that doesn't happen - when you've got a community health service the money is with the community, controlled by the community and it's there and it's transparent and it won't go anywhere, and you know what you've got per capita. It can't be - it's another really big banner for the community to control. It is - I think it is the only way - in the current structure of our governments - to stop cost-shifting.

DR DWYER: Does that money come into Congress from both the Commonwealth and the Territory?

THE WITNESS BOFFA: The Territory - - -

DR DWYER: But it's held by Congress to be - - -

THE WITNESS, BOFFA: Yes, yeah yeah, and you know, you can't just move it around depending on budget priorities and budget deficits and you know, other ways in which savings are generated.

THE WITNESS, AH CHEE: And the other important way of getting financial resources into the community is the MBS. And the way we treat MBS is that wherever that MBS is generated it stays in that community. So you know, MBS money is generated in Mutitjulu it stays in Mutitjulu - they make the decision about - and contribute to the discussion about where that MBS money should be allocated to.

DR DWYER: Dr Ah Chee, MBS - Medicare Benefit Scheme?

THE WITNESS, AH CHEE: That's right.

DR DWYER: And so you envisage - because I don't want to put you on the spot - but of around 27 staff for Yuendumu if Congress was to take over that health service?

THE WITNESS AH CHEE: Well, if - yes, exactly. The money should still be there unless the Commonwealth - no this is Commonwealth money that came to Congress that went across to the NT Government so yes, that's right, that should still be in the NT Government system, exactly.

DR DWYER: And just in relation to those ratios, what we hear from NT Health is that they have unfilled positions currently so, for example, a psychologist position exists within the structure. There was originally Kerri-Anne Chilvers in that position at the time prior to Kumanjayi's passing and then they were able to fill it with one psychologist after - would you excuse my back for one moment. I think for a considerable period of time I will be corrected it I am wrong but for at least over 12 months they have not been able to fill a position of psychologist in there. Given the difficulty of NT Health in filling those positions - I will start with this one and then ask you about anything else. If you could, in fact, attract a workforce that was considerably bigger in the first place, your evidence to date is that, in fact, that helps with further recruitment?

THE WITNESS AH CHEE: Exactly.

DR DWYER: Any other benefits that Congress has in terms of recruiting for staff that might make it easier for you than NT Health?

THE WITNESS AH CHEE: Well, just getting back to the psychologist position because that was interesting in that we've - for whatever reason - we've been able to - we've got currently 15 psychologists at Congress, headcount for an 11 FTE with one vacancy. So I think what that tells us is that working in an Aboriginal community controlled primary health care service, given the structures, the systems, the

processes - and we also have a wonderful clinical psychologist that actually sees the benefit of investing in psychologists on-the-job training, which is seen as a retention and recruitment strategy, I think that has helped with the recruitment of the psychologists into Congress.

DR DWYER: Are some of those psychologists based in the remote communities that you service?

THE WITNESS AH CHEE: I'm not sure about - no, I don't think so, I think it's a visiting service.

THE WITNESS BOFFA: So we have - yes, we've got resident social workers.

THE WITNESS AH CHEE: Social workers.

THE WITNESS BOFFA: In each of our remote communities who live there and visiting psychologists, so we get two weeks out of three with a psychologist at Mutitjulu, two days a week in (inaudible), two days a week in Santa Teresa but the social workers live there, so it's not just psychologists. You need - and you need them - Aboriginal care management workers with the team to create - so yes, we've got resident social and emotional wellbeing staff, we have visiting psychologists - that are there quite a lot of the time and I think one of the problems with Aboriginal health is you've got an unfilled position for years - you don't keep funding it, you ask "Well, what else can we do with this money - who else can be - is there another provider that's better able to actually get someone on the ground and get the service happening. It's a worry to just let a service not happen in a community of high needs for that sort of length of time.

DR DWYER: I put this to the witness yesterday, Ms Heinrich, and I will put it to you both too. In relation to Yuendumu, of course in terms of the history of the trauma in that community, starting with the Coniston massacre, it may go back before then but the Coniston massacre was 1928, there have been then the displacement of Aboriginal people in that area which must itself have caused terrible trauma, then on top of that there are specific periods like in 2010 when there were riots within that community, many - up to 100 people left the community in 2010 and were repatriated later and there were children who witnessed violence. There have been cycles of unrest since then. Do you agree that there is an enormous amount of unmet needs in terms of the trauma for that community?

THE WITNESS, AH CHEE: Absolutely.

DR DWYER: And then on top of that the tragedy of Kumanjayi's death and the way in which he died and the impact on the community really means it's a crisis of care for - in terms of trauma informed practitioners in that community?

THE WITNESS, AH CHEE: Agreed completely.

DR DWYER: So Dr Ah Chee, if I can direct this to you. How do you feel about the fact that that community is currently not supported by a psychologist or - - -

THE WITNESS, AH CHEE: I just - I just can't believe that the position has been left vacant and hasn't been filled and there haven't been other sort of alternative strategies to try and, you know respond to that unmet need.

DR DWYER: Dr Boffa, is there anything you want to add to that?

THE WITNESS, BOFFA: Only that when it comes to therapeutic services, I think 50 per cent of the outcome is dependent on relationship and about 50 per cent is the technical expertise of the practitioner, like the psychologist where, whether they use CBT - whether they use transactional therapy - other forms of therapy - is part of their effectiveness but you've got to have relationship, you've got to know people, you've got to be there long enough to know people. So it's not just a matter of having someone come in for six months and go - this is where you've got to get people that are going to come and stay for a period of time to be effective otherwise people won't come and see them, they won't get to know them, they won't trust them, but that's true for the whole workforce but it's particularly true for mental health workers. I think they've got to be able to have the ability to form a relationship with the people they are working with.

DR DWYER: Do you have communities of the six communities that you service, that are harder to attract staff to than others?

THE WITNESS, AH CHEE: I think Mutitjulu is probably our main challenge but, you know, like Dr Boffa said, we're just about to sign on the dotted line to have a GP for the Mutitjulu community.

THE WITNESS, BOFFA: And even in Mutitjulu there's a resident social worker, there's a team of nurses and, as I said, there's a psychologist two days a week and we're recruiting a permanent psychologist to Yulara, for that region, he'll live there, so yes, it's - it is harder. The more remote you go the harder it gets. It's almost like a gradient, I think it's pretty true. But when you look at the success of the Pintupi Health Service in Kintore, it's a gold standard I think. It's one of the most remote – they've had a GP there all the time for about 15 years, they've got a lot of staff there. It just shows you, you can have a team that stays there. The team – a lot of the staff were there for seven, eight years. And so you can overcome these challenges.

What is it then about Kintore, if we can use that example, Dr Boffa?

THE WITNESS, BOFFA: Well they had – they had a great – they had a manager that stayed, they had GPs that stayed, they had – they had a team. But also the point you made earlier, I think if you think about the modern trend and start talking about a strength based approach rather than deficit approaches. If you go to a community and you then live in a compound surrounded by barbed wire and you're not allowed to leave, you've got a deficit approach from day one, versus becoming part of the community. And not just as you said, not just part of the Aboriginal

community but the non-Aboriginal community and other organisations. When I went to Tennant Creek, in the first year, if I didn't make friends and socialise with the non-Aboriginal staff working for Julalikari, Junkaratu (?). I used to play tennis once a week with the principle – not once – when the principle legal officer came from CAAALAS, I'd try and beat him every time he came to Tennant Creek. So you form all these relationships as well, as with the Aboriginal community. That's what keeps you there. You then get invited to – into the life of the community, you get invited to ceremony after a while. You know, like if you're in a compound – I know people are doing it to be safe but then what's the hope of ever getting retention in that environment. So we've got to find a better way of doing this. So Kintore, there's no – you know, the staff are part of the community and they walk around the community and they socialise with the community and you can't give up on that if we're going to have an effective primary health care service that has an effective relationship with the community. And relationship is key to every – when you're talking about chronic disease management and lifestyle change, you've got to have a relationship to have those discussions with people, mental health, people that are traumatised, you know. One of the way trauma expresses itself is shame and we've all heard the term shame job. That's an expression of trauma. And to overcome that you've got to have relationships. And so we can't give up on retention and we can't give up on people who live in the community. As hard as it is, we console that problem, it's more expensive. You need new models of housing and communal living, but no with fences. You can have communal living structures where people feel safe without fences around them, where they're actually not just living in isolated houses. I think there's ways of solving this problem but we can't just all move to the idea of people living in gated communities. They won't last long and they won't be very effective. They won't be as effective as they can be.

DR DWYER: In terms of addressing trauma, can I ask you this from a clinical perspective. Does the physical environment make a difference to people being able to move forward in terms of their mental health? So for example, having a living environment which is nicer to be in, having a pool that you can access, having playgrounds that you can go to, having activities that you can access. Is that important for your mental health?

THE WITNESS, BOFFA: Absolutely. I mean probably the best thing you can do for your mental health is exercise, you know, run, whoever, get fit and also socialise, get out. Because in those social occasions comes conversations and conversations that can help people express how they're really feeling and open up to someone. You know, it's not just the health professional interact with, you can open up to a friend, a family member. But those sorts of environments encourage those interactions where people can open up rather than living inside themselves, inside their own house and not talking to people.

DR DWYER: So as a health – I'm asking you a series of Dorothy Dixers, Dr Hoffa. As a health professional looking at Yuendumu, it needs a whole of government approach, doesn't it, so that we can look at health, housing, education and improving the overall health outcomes of the community involves looking at all those sort of things?

THE WITNESS, HOFFA: Yeah. But you know, not just Yuendumu. So remote housing is a – that's our biggest – we would have more resident staff out there now if we had more houses. I mean, you know, in the early years I was on RIPIC, the Rural Incentives Program - that was a national program to get doctors into remote communities. They funded houses. Those houses have been at – there's 12 of them. We've got doctors in those houses. So you know, you've got to build a house, then you attract staff. We've had to put staff in Alice Springs because we don't have houses in our remote communities either. So the housing crisis – I mean there's a bigger housing crisis for the community. At this current rate of investment we worked out even if we do have 200,000 – what's the investment in housing? Yeah, it's 200 million a year.

THE WITNESS, AH CHEE: 100 million a year.

THE WITNESS, BOFFA: Even at 200 million a year, 100 from the Territory and 100 from the Commonwealth, it will take 70 years to get to equity with over crowding in remote communities. Even if that continues, and it's only on the table for a few years, it's not recurrent. So the housing crisis in remote communities for the community is very significant but for health professionals it's a major barrier to getting health professionals into remote communities.

DR DWYER: Can her Honour take it from hearing you both that that's part of the advocacy work that Congress is doing in working with the Department of Housing?

THE WITNESS, AH CHEE: Yes, yes, absolutely. We've been advocating about overcrowding. Actually would like to know of the $1.1 bn that is to be invested over ten years, which I think we're into what, the third year or fourth year, how much of that has actually been expended. And we don't know yet.

DR DWYER: And is that – that's Commonwealth money or a combination of Commonwealth and Territory?

THE WITNESS, AH CHEE: It's mainly NT Government allocation and then the Commonwealth gave an extra half a billion I think it was.

THE WITNESS, BOFFA: Yeah, another $100m a year. So it's $200m all up for a couple of any years at any rate for remote housing. But there's no way of funding – if we want money for health professionals, this doesn't fund – this only funds community housing, which is great, because that's the biggest need. But there is no program to fund new houses for new health staff, except every now and again you get a one-off – you'll get a one-off grant program and there's some money at the moment for infrastructure but there's no recurrent infrastructure funding. So you end up having to employ people in Alice Springs to then travel out when some of those people could be in communities.

THE WITNESS, AH CHEE: And want to be.

THE WITNESS, BOFFA: And want to be in communities.

DR DWYER: And so you don't get the sort of benefits that you talked about earlier of being fully integrated with the community unless there's - - -

THE WITNESS, BOFFA: Yeah. I mean – absolutely, you don't.

DR DWYER: Can I just move to that topic that you have touched on, which is how Congress Clinics deal with managing challenges? You refer in your statement to a particular incident that happened in Mutitjulu that you've touched on and it starts from par 64. You note that Congress has never closed its 24/7 community based on call service for medical emergencies. So far Congress has only had to close one remote clinic for a single weekend. That was in Mutitjulu following a crisis that involved violence in the community in 2021. What was that incident, Dr Ah Chee?

THE WITNESS, AH CHEE: That was community unrest in the community and some of that unrest was being brought into the clinic. And it sort of built up over time and got to a point where there was damage to the clinic. But there was also the incident of a staff member of another organisation who had been raped and our – two of our staff lived either side. So there was a level of anxiety there. So it was a combination of that as well as the sort of impact on the clinic in terms of, yeah, yeah.

DR DWYER: At that time in 2021 you had a policy called Outreach Remote and Isolated Safe Work Practice. It's attached to your joint statement and appears – I don't need to put it on the screen. That's – the note for the review date was 1 February 2020 but I think that that policy is still the one in place, is that right?

THE WITNESS, AH CHEE: That's right.

DR DWYER: So if you could just step through. Once the staff expressed their concerns in relation to that incident, was there community consultation before the service was – had its reduced activity?

THE WITNESS, AH CHEE: Absolutely. We spoke – myself as the Chief Executive Officer along with the General Manager of Health Services Division, I called a meeting, an urgent meeting of the Health Board and discussed with the board the concerns that were raised, along with the clinic manager and also a number of the staff. So it was like a meeting of the leadership, the senior management, executive management of Congress and staff members of the clinic. So it was – and Dr Boffa was involved as well as our Chief Medical Officer of Public Health and we went through the issues and then we went through some of the – some of the strategies to deal with that situation.

DR DWYER: At that stage, how many staff were in Mutitjulu, working for the clinic?

THE WITNESS, BOFFA: Four – four nurses.

DR DWYER: And what was the resolution as to how that would be handled?

THE WITNESS, AH CHEE: A number – we relocated those nurses to Yulara. And we continued to provide the service on a daily basis, as well as the after-hours service as well. And we instituted a security guard, and the security guard stayed I think, for is it two weeks? Could have been longer. Until it settled. And we were also in negotiations with the NT Police. Had direct dialogue with – prior to that though, I think it was the lead up to this, which probably just moved it along quicker, about the need for a third police officer. And that was finally achieved.

DR DWYER: So that was the stakeholders working together to see how that you could resolve that, going forward?

THE WITNESS, AH CHEE: Exactly.

DR DWYER: And one further police officer is stationed now at Mutitjulu as a result of that?

THE WITNESS, AH CHEE: Yes.

DR DWYER: In terms of catering for any emergency for Mutitjulu, while there was reduced services. I think you said that the nurses were moved out to Yulara. Can you tell us how far away Yulara is from Mutitjulu?

THE WITNESS, AH CHEE: I think it's 25 ks.

THE WITNESS, BOFFA: Yeah.

DR DWYER: So if there – for example, if someone had had an acute cardiac event, you would have an expectation that nurses would travel into the community at that time, is that right?

THE WITNESS, AH CHEE: Yes.

DR DWYER: And the on-call services continued?

THE WITNESS, AH CHEE: Yes.

THE WITNESS, BOFFA: Mm mm.

DR DWYER: Since that time then, and the clinic was reopened after the weekend, have you – you haven't had to shut since, is that right?

THE WITNESS, BOFFA: No.

DR DWYER: Has there been work with the community to try and resolve any issues that – from that incident?

THE WITNESS, AH CHEE: Sorry, what - - -

THE WITNESS, BOFFA: Work with the community.

DR DWYER: Work with the community. How does Congress work with the community to try and ensure that that doesn't happen again?

THE WITNESS, AH CHEE: Yeah, we're - - -

THE WITNESS, BOFFA: There was a large community meeting that was convened by the council, AMRAC(?), which Congress attended, to talk about the problem of violence, grog running, what was causing the violence, what could the community do. And as Donna alluded to, the meetings that she conveyed with – at Jamie Chalker's level, with senior police. One thing that it immediately did, it meant that the two police that were there were moved out. And they were part of the problem unfortunately. And two new police came straight away. Before then they agreed to the third police presence. So we employed our own security for a while. But we ended up getting an agreement, and a commitment to new police. And that meant a police person came back who knew the community well, back to this idea you've got to have relationships. It's true for the police as well. So there was an immediate change in the effectiveness of the local police station. Even when it only had two police. It went up to three, plus an Aboriginal Liaison Officer, or Aboriginal Community Police Officer. So we had security for a while. So we haven't had to close again. And it, all up, it's made a difference.

THE WITNESS, AH CHEE: Sorry, but I've just remembered too, the other important thing that was discussed with the board, was around the need to – in that conversation with the community, is how we can facilitate a conversation around violence. So our Inginga (?) male program started doing Outreach from Alice Springs, down in Mutitjulu, and started having meetings with senior men in the community, about the violence in the community. So started having a conversation about it.

DR DWYER: Is that a service offered through Congress?

THE WITNESS, AH CHEE: Yes.

DR DWYER: And that means that there's some community – the community take responsibility for part of the unrest, is that right?

THE WITNESS, AH CHEE: Exactly.

DR DWYER: So can I suggest that the example you just gave of working with the police there underscores the importance of stakeholders having good relationships as well. Being able to work through issues that arise?

THE WITNESS, AH CHEE: Very important.

DR DWYER: I've got two more topics to cover - - -

THE WITNESS, BOFFA: To one – other quick thing. To get the third police, we had to give up one of our houses. Now that – we need that house, but we've given it up, because in the end, you don't have a clinic if your staff aren't safe. So in the end we decided, as much as we needed the house for our operations, and we've had to have a work around, and thank goodness the resort came to the – came to the rescue with – with some accommodation at Yulara. But that – to get a police presence there, we've released one of our health houses.

THE WITNESS, AH CHEE: Mm mm, and that was supported by the Health Board.

DR DWYER: I see. I take it then that's something that you're trying to – that you'd want more accommodation in that area as well?

THE WITNESS, BOFFA: Yeah, we would hope that the police will come up with the resources to have actually had their own extra house, and we can get that house back.

DR DWYER: Dr Boffa, Dr Ah Chee, I've got two more topics to cover. We've been going now since quarter past 1:00 or – do you need a short break, or does her Honour?

THE WITNESS, AH CHEE: No I'm fine.

THE WITNESS, BOFFA: I'm fine.

DR DWYER: Are you content for me to continue, your Honour, or - - -

THE CORONER: I'm content for at least one more topic.

DR DWYER: That topic is this. You're familiar with Dr Kerry Anne Chilvers, who I think she's in the middle of her PhD, but Ms Chilvers who was the psychologist for a period of time, who worked with Kumanjayi in different roles. She was the Mt Theo outstation coordinator through WYDAC from 2013 to 2015. A Youth Case Coordinator and Program Facilitator through – a Tangentyerre Program, and then a Community Counsellor and Psychologist in Yuendumu, through the Remote Alcohol and Other Drug Work Force. It's not clear to me currently who funded her during the – her period as the Remote Alcohol and Other Drug Work Force Counsellor and Psychologist. Do you know that, Dr Boffa?

THE WITNESS, BOFFA: Yeah, look the NTPHM received a very significant amount of funding for alcohol and other drug services about five years ago. We went through a joint planning exercise under the Northern Territory Aboriginal Health Forum. And that model was built on a psychologist and an Aboriginal Case Management Worker, or Aboriginal IRD (?) worker for every community of a certain size across the Territory. So when you – when that was distributed, the Northern Territory Department of Health were given two positions for the remote communities in Central Australia that they service. Yuendumu being the largest, got the lion's

share of one position. But there were two full-time psychologists funded at that time, with that funding. As so were positions funded at Ampilatwatja, Yurapunga, Pintupi homelands. We got mental health services, either social workers or psychologists. Didn't have to be psychologists. But we got them spread out, as part of primary health care, throughout the Northern Territory. It was a really – it was a very good exercise in needs-based resource allocation.

DR DWYER: Dr Boffa, and Dr Ah Chee, I gave you a copy of the statement provided by Ms Chilver. She's provided a couple of – a statutory declaration, and a separate statement. They say much the same thing. That in relation to Ms Chilvers statement, it appears in the brief at 8-10. I don't need to put it on the screen. I just wanted to ask you about her evidence.

THE WITNESS, BOFFA: 8 10?

DR DWYER: Sorry, if you have a look at her statement at par 9.5.

THE WITNESS, BOFFA: Right, I'm there. Yep.

DR DWYER: And you'll see, just at the very top of the page, the reference to 8-10 is just a – that's a brief reference.

THE WITNESS, BOFFA: Mm mm.

DR DWYER: So in her statement, and I anticipate she will give this evidence, she's talking about the situation for Kumanjayi in 2018 firstly. And she says in January that year, she left the Tangentyerre Program, and started working with the Remote Alcohol and Other Drug Work Force Program, where she stayed until June 2019. During that time you'll see AW, whose Kumanjayi, spent time both in CAAAPU, and in the Alice Springs Correctional Centre, as well as in Yuendumu. He successfully completed the CAAAPU program, and the only issue reported to her, was him talking loudly on the phone. So you'll see at par 9.3, she writes "I was advised that he was receiving social and emotional support through Congress, while he was in CAAAPU." Are you aware of what sort of social and emotional support would have been available to a young person like him? At that stage he turned – he was 17 in 2018?

THE WITNESS, BOFFA: Yeah okay, look so Donna and I have been champions of what we call the three streams of care. Alcohol and drug service model. That means you have GP, psychologist, Aboriginal community worker, providing the care. So we've added that into residential treatment. So in residential treatment, you've got, if you like, social and culture support. And supportive accommodation. But you don't have psychologist and you don't have GPs. And you've got to have all three to have an effective alcohol and other drug treatment. So about – about here, about 2019-2018, we felt (inaudible) with CARPU, we have a GP goes there, several sessions a week. Everyone on intake sees the GP. Assessed for chronic diseases, medical certificate given. Mental health care plan done. Then our phycologists go in an provide therapeutic care to the clients, once a week, paid for through Medicare. So that's a service model that could exist in every residential treatment service in the

country, if they just did – came to an arrangement with a primary care service. So this client, like all other clients, would have had access to our therapist, whose a psychologist, while in CAAAPU.

DR DWYER: I see. And I've put you on the spot by providing you this statement today. Are you aware now of anybody from Congress who was working with Kumanjayi at that time?

THE WITNESS, BOFFA: No, I'm not. We'd - - -

THE WITNESS, AH CHEE: No.

THE WITNESS, BOFFA: - - - have to find out who it was and I'm – certainly, this is the first time I've ever seen that there was an attempt made to ask for us to do an assessment. Now, phone calls, emails, we'll have to look into this and see whether there is any record of this. But having said that, look I just think, in the era of the NDIS, it's a gamechanger like Medicare is. Central Australia gets at least $25m a year now from NDIS, and should be getting a lot more. So, if any health professional has got a client who they think could have FASD, there's an obligation on the health professional to make sure the assessment happens. Now, Congress can't be everything to everyone. We've got – really, we've got the only assessment service for neurodevelopment as far as in the country, I think, outside of capital cities. We've scrounged money together from five different sources, none of its recurrent. We've got a waiting list of over 200 people, young people and children, to be assessed. We can only complete two comprehensive assessments per week. That's neuropsychologist, speech pathologist, occupational therapist, paediatrician an Aboriginal family support workers as a team. It takes about six weeks to do one assessment. And so, all roads lead to Rome, everyone thinks that we can assess everyone. We can't. We can assess – we've got a – our main funded contract is with Territory Families, so we have to give priority one to children in child protection and young people in youth detention. And 83 percent of all young people in youth detention have a neurodevelopmental disorder. Surprise, surprise. That's what other people have found in other parts of the country and other parts of the world. So, we're really locking up people with neurodevelopment issues that need NDIS plans. So, he should have been assessed, there's no doubt about it. But the Health Department has obligations to make sure these assessments happen. Now, if this had have come to our attention properly, as it did – so earlier this year, we were rung up about a remote community because a petrol sniffing outbreak had occurred. They wanted us to assess 20 young people from that community. So, I said, look, we've got too big a waiting list. We can't do it. Go to Patches Paediatrics, they'll do it for about $9000 per assessment. They did do that. That was funded, not by government, but by CAALAS, but I understand only six of those young people have been assessed so far. There should be 20. There's another remote community where the paediatrician says 70 children need to be assessed. None of those children have been assessed. So, we're doing our level best. We've fought very hard to get the money we've got. We've got it from five different funding bodies. None of its recurrent. We put a team together which is impressive. We've got two neuropsychologists, two speech pathologists. This is a public health issue that has

to be addressed. We've been telling the Territory Government since the NDIS started that they should have transferred all the positions for their old disability service organisation, and there's about 12 of them, to do assessments, not to compete with the NDIS for service delivery, they could have funded a massive assessment service in Central Australia. They didn't. Both positions are competing with the NDIS for services, but the NDIS does not fund assessments. So, to get money to fund assessments is difficult. It would logically – anyone who sat down and thought about it would think it's in the State's interest to get these children assessed because then they get on a plan, the plan could be worth $60,000, $100,000 a year per young person. That funds services, it brings money into the economy and why wouldn't the State fund assessment to get access to the NDIS. It's like getting assess to Medicare. It is – it's an uncapped program. We could be doing much better here and it's frustrating to hear – you know, this is almost a bit like cost-shifting. It's the primary – if you've got a psychologist who thinks they've got a client who's got FASD, then follow up until the client gets assessed and ask your own department to get the assessment done. Don't just come to Congress. But come to Congress properly, and if you don't get an answer from a phone call, don't give up. Like, you know, we can look into whether there was an email – and we're not aware of this, we just saw it today, and we will find out, but I don't think that – I think you've got a duty of care as a professional to do more than that to make sure a client that you think's got FASD is getting assessed and getting onto the NDIS if they need to get onto the NDIS.

DR DWYER: And we'll hear from Kerrie-Anne Chilvers about it. You're referring to the fact that she notes in her statement that it was around 2018/2019 that she says she reached out to Congress. We've got her file notes and I'll just remind you, because then I'll ask you a couple of questions about them before we stop for the break. But in Ms Chilvers' document which, for the benefit of those at the bar table, is 8:11. What we see is on 4 April, she notes, and I'll just read them to you, Dr Boffa, but if you wanted to follow it, it's at page 34 of her attachments. She notes, for example, on that day, 9 April, that she becomes aware of a cognitive assessment undertaken by forensic psychologist, Kate Crawley, in 2017 and she makes a note here that she arranges for that to be forwarded to Congress. If you just look over the page at page 35, she says she makes a phone call to Congress Child and Family Services to find out where to send the referral in for Kumanjayi to be assessed for FASD. She leaves a message bank on 9 April, there's a note, "Phone call to Congress Social and Emotional Wellbeing team. Was advised that whilst at CAAAPU, Kumanjayi had seen Alex? psychologist, Bill Walcott, social worker and John Paul (?), manager. It was put forward to John Paul, left a message on the answering machine." No doubt, you can follow that up for your own learnings, but at page 37, the last note that I can see about it is that in June that year, "Advised Christine of referral to Congress who haven't got back to me." So, putting that to one side, what I suppose I want to suggest to you is that for your service, your primary – your concern is that all children in Central Australia and no doubt the whole of the Northern Territory who need a FASD assessment get one.

THE WITNESS, BOFFA: And young people.

DR DWYER: And young people.

THE WITNESS, BOFFA: And now adults. We've got a lot of acquired brain injury amongst adults. It's a major reason why people become dependent on alcohol.

DR DWYER: And it's a major reason why people end up in the criminal justice system?

THE WITNESS, BOFFA: Yeah, yeah, major - - -

DR DWYER: And a major reason why they end up in conflict with police.

THE WITNESS, BOFFA: Yeah, it's the major reason why we shouldn't turn the tap back on for alcohol.

DR DWYER: I'm going to come to that. That's the last topic I'm going to finish you on, but I'll do that after the break. But just before we leave these FASD assessments, in relation to somebody like – in relation to anybody, the earlier you get somebody assessed and the earlier you get treatment, the better opportunity you have to - - -

THE WITNESS, AH CHEE: Intervene.

DR DWYER: - - - to intervene. And the cost effectiveness for society is obvious, isn't it, if you get those early interventions and they're effective?

THE WITNESS, BOFFA: Absolutely.

DR DWYER: So, it makes sense to get more money into having these assessments and in terms of - - -

THE CORONER: Can you tell me; do you see effective interventions?

THE WITNESS, AH CHEE: Yes. We've got what we call the child health and development program and it's based on the Joseph Sparling model. And what that does is promote enriched care giving, language, learning games - what is it, John?

THE WITNESS, BOFFA: Language priority, (inaudible) learning games and conversational readings.

THE WITNESS, AH CHEE: And reading, conversational readings. So, it's all about stimulating the brain. So, that's at the frontend, but then you've got the pointy end which Dr Boffa can respond to from a medical perspective. But if you really get in early, you can make a difference with these kids. And it's not just – you know, we've got the data that tells us through the Australian Early Development – Early Childhood Development index, it tells us that in some of our remote communities in Central Australia, we've got kids that are developmentally vulnerable on two or more domains. So, the data is telling us, we need a system's approach to actual

assessments and treatment. Some of those other medical treatments, you can - - -

THE WITNESS, BOFFA: Yes, well I think, in terms of the capacity to rewire itself, which is slow-stream rehab, which is what you need for – to getting on top of FASD, not FAS, FASD. I think the classic example is what happened to the petrol sniffers. Someone should do a film like Awaken. So, in 2005/2006, we were looking after a lot of petrol sniffers who were in nursing homes, supported accommodation, in wheelchairs, couldn't walk, severely brain damaged. Most of those people are now walking, recovered after ten – 15 years. It took a long time, but they're better. So, again, with FASD, once you're diagnosed with it, intervention through speech pathology, through occupation therapy, through neuropsychologists with families and giving give advice to parents about behavioural management and a range of other skills to support these young people and to the teachers in the schools, you've got to talk to the teachers and preferably in preschools, but by the time a lot of these – you don't really diagnose it until children of seven. So, you're talking to primary school teachers, everyone works to a consistent plan, you make a big difference. And we've got the resources now, because these kids get an NDIS plan, which is significant resources and we can get the Workforce. And so, it's unethical now not to screen children, children under 5, using the ASQ development assessment tool. You've got to screen kids early, you've got to pick these things up early. They've got to be referred – they get an early childhood early intervention plan. It's all there. But in remote health the across the Territory we're still not screening children. We are now assessing – the screening is what comes first, then a more comprehensive assessment with the team I'm talking about. This is all – it's expensive but it's worth it, because we've got the NIDS to fund the treatment. And so we can make a difference to these young people and children but the diagnosis has to happen, it has to come first. Now you know, we've diagnosed about 67 children with FASD since 2020 and about 17 with FAS, that's the syndrome, the full syndrome, along with a lot of children with ADHD, global development delays. So these things are there in the community. That's only – that's the tip of the iceberg. So I think this is an issue, these children will enter school. The longer children stays from Canada which led to the development of the Australian Early Development Census which assesses all children in the first year of primary school, tells us that children are developmentally vulnerable on two or more domains. There's five domains. The most important are the emotional domain, which is self regulation, self control and the cognitive domain, which is language. And there's three others, social, communication, physical development. Children are developmentally behind on two or more domains won't complete year 10. Almost – unless you get them back to normal by age 7 they're going to not complete school. So they've got to have very intensive support in the early years which is not in – just about any of our schools. And so – and the data on the AEDC from the 2021 census is the worst we've seen. So we're going – we're not heading in the right direction for the next generation of children. And so it's a huge concern. Now if we're going to try and turn that around you've got to – Donna mentioned the Early Childhood Development Centre, that's primary prevention. That's critical. But as well as that, we can diagnose the kids early and it leaves that secondary prevention, what we're doing then is we've already got the issue. But the brain can rewire itself with support and with the right, you know, with the right interventions. But it becomes harder and harder, it's the law of

diminishing returns. The older the child, the later you start, the more difficult it is and the harder it is to get a good outcome. And if you've got a 14-year-old that's unregulated, can't concentrate, has dropped out of school, engaging them in the therapeutic process for treatment, which is what is difficult, I won't say impossible, but difficult. But you've got to, you know – so yeah, youth detention is late to be picking this up but it's better to pick it up then than not pick it up at all. And we don't have – there's nothing – there's no similar service in Darwin at all. There's no neuropsychologist in Darwin and you can't diagnose neurodevelopmental disorders without – no good having a forensic psychologist. That's just like, not useless but not good enough. You've got to have neuropsychologist and they've got to be child and adolescent neuropsychologist. People said to us you'll never recruit, why would we fund that for, you'll never – we've got three that want to come and work. And we've got an adult neuropsychologist as well. We would have more if we had more funding. So it's not true that you can't recruit these people to remote areas. But we've got to get it in remote communities around like, you know, petrol sniffing coming back again this year is – it's gone again, for now and luckily with Opal unleaded, it's not addictive. But – without going into detail, I just think it's not – we're lucky it's not addictive but it still is harmful if you sniff it the wrong way. So no one – you know, no children have died from that outbreak. But prior to Opal unleaded we used to see eight young people a year die in Central Australia petrol sniffing. So that's gone and we don't want anything to come back. We've had one death since 2018, on Opal. SoI if you sniff Opal for 15 minutes or more you'll become hypoxic and you can die. So it's still possible but not – it didn't spread like a contagion. Although it did spread to other communities. So those children need to be assessed and then there needs to be interventions. And we can't expect the education system to work miracles without a lot of additional support for these sorts of children. It's not there at the moment, without, you know – I don't want to sound too pessimistic because I think we can make a difference here but we've got to know what we're doing and we've got to know the extent of the problem and without screening we don't know the extent of the problem, without the ability to assess.

DR DWYER: What does screening involve?

THE WITNESS, BOFFA: Screening involves primary health care practitioners, nurses, not so much doctors, nurses, Aboriginal health workers, Aboriginal people doing the ASQ track. So ASQ stands for Ages and Stages Questionnaire, it's done on children all over the country. You assess children – you can assess kids at 6 months, 9 months, 12 months, 18 months, 2 years, 3 years, 2 and a half, there's lots of stages. That assessment – it's very similar to the AEDC. So you're assessing children's development in those five domains but you're starting early.

DR DWYER: Do you do that in your clinic?

THE WITNESS, BOFFA: Yeah, we do that in our clinics and we train our staff - - -

DR DWYER: Do NT Health do it in their clinics?

THE WITNESS, BOFFA: They're doing it through their FAFT program but not – it hasn't been systematised in clinics. Now there's been a bit of resistance from remote are nurses to this because people say we're too busy, we don't have time. We can assess kids, we can check their weight, their head circumference, we can immunise them, we can do all that but to do the developmental assessment, which is now more important. Most kids are a good weight. You know, the days where we had to worry so much about underweight children are not there. So it's now the development that we need to assess. So this has to be systematised across the primary health care system, everyone has to be trained. It's a two-day training program. It's not that hard to get trained. You don't have to be a health professional to do this well. Parents love it because when you do the assessment parents actually see what it is you're looking at, they see the level of development their children have got, they can see areas where they might need to put in extra effort. It's a great tool. But we haven't systematised it. Although it is a priority for the NT Aboriginal Health Forum, it's a priority for the child and families tripartite forum that Donna chairs to make this happen.

DR DWYER: Is it one of your KPIs to measure that?

THE WITNESS, BOFFA: Not yet.

THE WITNESS, AH CHEE: Not yet.

THE WITNESS, BOFFA: We've suggested it should be a KPI. We report on it.

THE WITNESS, BOFFA: But it is a CTG target in terms of bringing down, you know, seeing a reduction in the AEDC scores.

THE WITNESS, BOFFA: And it did take us many years to - - -

DR DWYER: Can you explain it to me (inaudible).

THE WITNESS, AH CHEE: Australian Early Childhood Development Census data that tells us how bad the situation is.

DR DWYER: And CTG is closing the gap?

THE WITNESS, AH CHEE: Sorry, closing the gap.

THE WITNESS, BOFFA: Yeah. And there was a problem for a few years, it took us – it's taken us years to advocate to get access for these kids straight into the NDIS. So until that happened you could argue it's unethical to screen. Because you'd screen, find a problem, nothing would be done. But now if the child is under 7 and an ASQ track alone will be accepted by the NDIA for an early childhood early intervention plan and they'll give money up front. And those plans might be $50,000, $60,000 per child just on the basis of – as long as the ASQ track is done by a trained practitioner, they'll accept that as all they need under 7 to access an early childhood early intervention plan, which then funds your speech pathology, OTs and other –

you could fund an Aboriginal family support worker to work with the family. You know, you can do a lot with that package. That's accessible now. So it's unethical not to screen now. It's a problem for the system to not be diagnosing these kids early. I mean it's hard – you know, under 2, you're only going to pick up kids who have got severe problems, but as the children get older – by 4 a child that lacks self regulation is relatively easy to assess by age 4. So you've probably all seen the marshmallow study. You know that one? 1969 that was done and the kids were given – put in a room, one marshmallow - - -

DR DWYER: All of us sitting in this room probably would have left the marshmallow.

THE WITNESS, BOFFA: I think I would have eaten it.

DR DWYER: I definitely know that some of my kids would not have.

THE WITNESS, BOFFA: Anyway, so we know how – so self regulation can be really well assessed by age 4. And then there's the alert program, there's intervention that really make a difference for kids that lack emotional regulation early and we should be absolutely trying to make sure we've diagnosed every child with that sort of issue by aged 4 and we're giving them the benefit of something like the alert program, you know, in their early years of primary school.

THE WITNESS, AH CHEE: And then when we've got kids that are in school there should be a genuine partnership between the education – between the school and the primary health care service. So that's what Dr Boffa was talking about earlier around learning plans, that have in it the actual provision of health services to work with those young kids and to work with the teachers. So it's not left to the school to have to worry for that stuff, they can get on and teach while we in partnership as a health service can be working with those kids.

THE WITNESS, BOFFA: So some clear recommendations on this stuff and FASD assessment would be really useful.

DR DWYER: Dr Boffa, is we have a go at drafting some of those up, can I impose on you and Dr Ah Chee to review them for us an add your expertise.

THE WITNESS, BOFFA: No, I'm happy to.

THE CORONER: We'll take a 15 minute break and then we'll come back and hear about alcohol and I'll try not to grab the first marshmellow.

DR DWYER: I'll be more worried about Mr Coleridge, your Honour.

MR COLERIDGE: Well, I definitely ate the whole thing.

ADJOURNED

RESUMED

DR BOFFA:

DR AH CHEE:

THE CORONER: Thanks for coming back into the witness box. Please take a seat. Just before we return to your evidence, I need to publish a ruling.

On 29 September I heard oral argument and eight discrete objections to evidence by Constable Rolfe. Since then, Constable James Kirstenfeldt, Sergeant Lee Bauwens, and Sergeant Paul Kirkby have filed submissions in support of the same, or similar objections. In my view, for the reasons I now publish to the parties, each of the objections should be dismissed. For the avoidance of doubt, this ruling does not consider whether I should receive NAAJA's report, which is item 10-22B on the brief of evidence at the moment.

I also make a non-publication over the reasons until 9.30 on Monday, 17 October 2022.

DR DWYER: And just for the benefit of any journalists in the room, or listening, I note that your Honour, the fact that your Honour just read out, can be published. It's just the reasons, the written reasons, and – that are going to be published on Monday, after all parties have an opportunity to make relevant submissions.

THE CORONER: Yes.

Yes, we can return to the last topic of your questions, Dr Dwyer.

DR DWYER: Thank you, your Honour.

XN BY DR DWYER:

DR DWYER: Dr Ah Chee, Dr Boffa, as foreshadowed, I just wanted to ask you some questions about alcohol policy and availability in the Northern Territory. Might I note that you have both written in this area, and I take by way of an example, of an article that I intend to tender, which is titled "Preventing Alcohol Related Harm in Aboriginal and Torres Strait Islander Communities, The Experience of an Aboriginal Community Controlled Health Service in Central Australia." It's authored by yourselves, Dr Boffa, and Dr Ah Chee, along with Edward Tilton. It is dated December 2018.

Your Honour, I tender that article. And I'll make it available.

THE CORONER: Thank you.

DR DWYER: Dr Boffa, this is an issue that you and Dr Ah Chee are passionate about, is that right?

THE WITNESS, AH CHEE: Yes.

THE WITNESS, BOFFA: Absolutely.

DR DWYER: In your – in this article, and it's one of many, but you note for example, that despite the determined efforts of Aboriginal and Torres Strait Island individuals, families, communities, and organisations, that had resulted in some local successes, alcohol continue to contribute significantly to the total burden of disease and injury. It also significantly undermines progress on social and economic issues, including education, employment and community safety. Taking Kumanjayi, for example, we understand that Kumanjayi's parents had – were affected by alcohol related illness themselves, and that – with no disrespect to Kumanjayi's mum, that she was consuming excessive amounts of alcohol. What impact then, can you say, it has on the prospects of someone like Kumanjayi? That early involvement for parents who suffer from an illness related to alcohol abuse?

THE WITNESS, BOFFA: Well there's two clear mechanisms where it has inter-generational impact. One is through epigenetics. So if both your parents are drinkers, then epigenetic changes mean you're then genetically predisposed, greater susceptibility to becoming someone whose dependent on alcohol. Secondly, with parents – of three ways. Then there's the problem itself of alcohol causing harm – direct harm, toxic harm to the foetus. So that's Foetal Alcohol Syndrome, or Spectrum Disorder. That can be both the father and the mother. So people don't get the fact it's not just – if the father's drunk at the time of conception, I keep telling people the concept of drunk sperm is a cause of Foetal Alcohol Disorder, and not just the mother's drinking. So often it – and it really is the time of conception. So often we talk about doing things once women know they're pregnant. Mostly that's too late. So this is why you need a population approach to alcohol. Because you've got to prevent heavy use, at the time of conception. Not once women know they're pregnant, unfortunately. So often – even – and sometimes women get pregnant, and then think I've got to stop drinking. Which is great. But the damage could already be done. So there' that. There's the epigenetic changes. Then there's the problem of early childhood trauma. From parents who drink. Parents who fight. Now we know alcohol is a significant cause of domestic violence, and I'd like to get that out. Because causation of domestic violence is complex. Which means it's non-linear. Too many people think there's only one cause in linear causality terms. And they think the cause is patriarchy. And when I say that, this is often the women's movement will not accept that alcohol is a cause on a circle of causes. There's multiple causes. Patriarchy is one. Early childhood trauma. Trauma in early childhood is a major cause of social and development addiction. So if you've got both parents who are heavy drinkers, you've got a genetic predisposition. You've got the potential direct toxic damage to the growing brain in utero. Then you've got the impact of trauma in early childhood, in those early years. And lack of responsive care. And all those things absolutely affecting brain development. Because when a baby's born, 25 percent of the brain's developed. By age four, 92 percent's developed. So in those first four years of life, you've got massive neural networks being laid down. And hard wiring's happening. And you need iron rich

food. You need love, you need care, you need sleep, you need exercise. You need to be read to. So Einstein said, what did he say, he said if you want your kid to be genius, read them fairy tales. And if you want them to be even cleverer, read them more fairy tales. It doesn't have to be fairy tales. Any rich story, and it can be spoken to children. So traditional stories spoken with children is an incredibly powerful way to develop the brain. It can be reading a book every day. But you've got to talk to kids. And you've got to tell them stories that use their imagination. And that – all that's important. So – but if on top – if you don't get that, instead you get exposed to violence and stress and trauma, the brain doesn't develop. And once you pass critical milestones – so the critical period for the development of emotional self regulation is 6 months to 2, it's very young. And so once you pass those critical periods it takes a lot of effort to then unwire that pathway into the brain. And so those three combinations mean that unfortunately they're the intergenerational impacts, which is why you've got to take an intergenerational approach to addressing this problem. So people say we can't have supply reduction forever. That's true. There's an end point. And once you start seeing the AEDC scores improve, at age 5, you can then start to say we're getting there. But if you've got AEDC scores like we've got now, we know the next generation of children that are going to have problems with dependency to alcohol, tobacco and other drugs, gambling, emotional dysregulation in terms of getting upset and being violent, it all stems back to this pattern of how the brain hasn't developed properly and how you haven't got the normal ability to regulate emotions. And suicide is another big one. So what happens there is young people are already struggling with emotional regulation, get really upset when they're really drunk and then you get an impulsive act. It's not something you can easily predict other than at a population level, you notice you've got young people that have issues with emotional regulation, there's a risk. And the main thing to prevent that is the message I think should be if a young person gets drunk, don't leave them alone. Take them home, hand them over to someone. Don't let a drunk young person go anywhere on their own. And if we all did that as peers and as community, we would have a big impact on preventing suicide.

DR DWYER: Dr Boffa, this might seem like an obvious question that follows but we know that Kumanjayi was suspected sadly of having FASD and that was Kerri-Ann Chilver's concern. We also know that he had some negative engagement with the police and committed some offences of violence ultimately with his partner. What's the relationship between his exposure to alcohol in utero and earlier years and in consuming alcohol and exposure to violence on his own behaviour?

THE WITNESS, BOFFA: So there could be, you know, a very strong relationship, depending on whether he did or didn't have FASD. And I think at this stage – I haven't seen the basis of the opinion of the psychologist that Kumanjayi had FASD, I've only read, you know, obviously quite a lot about him now and maybe the way he reacted quickly and potentially, you know, sometimes violently, picking up weapons when he was upset, that suggests lack of emotional regulation, which is one of the things, lack of understanding of consequences of actions is another aspect of this. So - - -

DR DWYER: Another really thing that comes out strongly in his history is his lack of verbal skills. He had very, very limited language.

THE WITNESS, BOFFA: Okay. Well that – you know, all those things and that can be autism spectrum disorder as well. So that's another one of the things we unfortunately diagnose more frequently than the norm in young children. So there's – you know, there's a number of explanations in which FASD is one for these behaviours. But all of them add up to a pattern, you know, early childhood trauma can cause any one of these patterns of behaviour. It could be autism spectrum, it could be FASD, it could be global developmental delay. They've got some combinations. So I think that, you know, we don't know exactly what it was but it's very likely with that history that he was impacted and didn't get diagnosed, didn't get the support he needed and we could have made a bigger difference with the appropriate assessment, appropriate interventions if that had have happened.

DR DWYER: So better and earlier assessment and treatment might have avoided that negative interaction with the police?

THE WITNESS, BOFFA: Yeah. But also population health measures on alcohol. If I showed you the data of what's happened to alcohol consumption in pregnancy for Aboriginals around Alice Springs from 1998 to 2018, it's dropped dramatically to 2018. And we're really concerned now it will start going back up again.

DR DWYER: I'm going to come to that shortly. Just one more before I do. And that is if you had – if you're dealing with the end point where you know you've got a young adult of 18 or 19 years – Kumanjayi was 19. If you know him to be someone who has poor impulse control which is related to those early indicators of FASD or trauma or both, if you knew that and you're a police officer engaging with him, does it help you to try and minimise conflict?

THE WITNESS, BOFFA: Yeah, absolutely. You know you've got to – it's not – you've got to be extra careful, you've got to be aware of that and you can be helped with strategies from the appropriate – this is – OT, speech pathologist, neuropsychiatrist will tell you what you can do and how you can approach someone like that, in ways that are not necessarily going to lead to a reaction.

DR DWYER: So if you're a police officer, example, stationed in a remote community and you get to know the local community members, is it helpful to have training then in how to dela with or at least who to ask in terms of how to approach young people with that?

THE WITNESS, BOFFA: Yeah, it is helpful and it's even more imperative to have family and someone who knows the person with you and to make sure you've got people with a relationship with the person. It becomes more important in someone who is brain damaged to do that and not to have strangers. It's like as old people get demented, strangers set them off but people they know well, they can still remember, they can still relate to. It's similar to that. The brain is not working at its best then people with strong – people you know well with very deep, strong

relationships, they're going to be able to regulate you, help regulate you much more than strangers.

DR DWYER: Do you think it's plausible then to have a level of trauma informed training incorporated in police training?

THE WITNESS, BOFFA: Yeah, absolutely. I mean we all need trauma informed training, all of us working in this area. In fact, you know – it's become – trauma has become – it's so clear that trauma is, I think, the foundation of addictions of all types that – when you think about how common addictions are throughout the community, Aboriginal, non-Aboriginal Australia, internationally, so we've all got to learn about trauma and the impacts of trauma and how to approach and how to work with people that are trauma – in a shame sensitive way and in ways that are cognisant of the neurodevelopmental problems that these people have. They're all the ways we've got to learn to deal with people.

DR DWYER: Dr Boffa, can I return to the issue - - -

THE CORONER: Can I - - -

DR DWYER: Sorry, your Honour.

THE CORONER: Ideally screening happens early in a child's life and I've learnt that from you today and I appreciate that information. When children are a little bit older or getting into early teens, if they are coming into contact with police, do you think that at that stage really all children should be screened and/or assessed once they're at a stage where there are police involved?

THE WITNESS, BOFFA: Absolutely. If we're seeing in youth detention 83 percent in our detention centre here, but even in the one in Perth, what's it called – Banksia, yeah. Banksia Hill, they had the same 84 percent. So if that level of neurodevelopmental disorder is there, then any child that comes into contact with the police should be assessed, because it makes a big difference as to how you go on and manage that child or young person.

THE CORONER: Because many children obviously start coming into contact with police well before the age of criminal responsibility. So if there are those interactions with 8, 9, 10-year-olds, you would support assessment at that point in time?

THE WITNESS, BOFFA: Absolutely. And you've got to then have the right team. So you've got to have a neuropsychologist in the team. You can't assess properly for neurodevelopment disorders without that. Yeah.

DR DWYER: Dr Boffa and Dr Ah Chee, I just wanted to come to your concerns now that – I think you referred to the statistics that we've got leading up to 2018 that show a drop off in the number of mothers drinking alcohol during pregnancy. We know that the NT Intervention which has caused a lot of concern in some areas, had an impact in restricting availability of alcohol in communities. We have heard evidence

so far in this inquest that anecdotally this year since alcohol became more freely available after the sunset clause meant that some of the restrictions introduced in the intervention have lifted, that there is more alcohol being made available in communities, including Yuendumu. That some parents are coming in from Yuendumu into town to be able to drink in camps around town where alcohol is now available. That the offending is getting more serious and that injuries are worse because of the increase consumption of alcohol. At this stage that is anecdotal. Is that evidence that you are beginning to gather for Congress?

THE WITNESS, AH CHEE: That is consistent with, anecdotally based on community feedback that we're getting as well. But we're also experiencing it as a health service. There have been a couple of occasions where we've had to call the ambulance to our social and emotional wellbeing site because, in one instance, a male was so intoxicated that he actually collapsed and couldn't walk, and you know. So – and we've had another situation where a female had come into the reception area, had been subject to domestic violence order, very agitated and so, obviously, we helped her. But yeah, we're seeing it and I'm seeing it myself. I haven't seen broken glass on the streets – I mean, it's not as bad as it used to be, but it's certainly starting to see broken glass on path, walking paths, again and we haven't seen that for years.

DR DWYER: Since when, Dr Ah Chee? When you say - - -

THE WITNESS, AH CHEE: Since the lifting of the Stronger Futures legislation.

DR DWYER: So, what does that – when you say, "It's not as bad as it used to be", what period do you say was particularly bad?

THE WITNESS, AH CHEE: It's probably been about ten years.

DR DWYER: So, the restrictions that were introduced over the last ten-year period have, in your view, effectively restricted the supply of alcohol into community.

THE WITNESS, AH CHEE: Absolutely. A combination of a minimum of law price, the PALIs, the Police Auxiliary Liquor Inspectors on takeaway outlets has definitely had a major positive impact on the reduction of consumption of alcohol.

DR DWYER: In the article I mentioned earlier that you're both co-authors in, along with your colleague, it's noted there at page 2 that the two main approaches that have shown success in Aboriginal and Torres Strait Islander, Australia and elsewhere in reducing both economic availability – is to reduce the economic availability and the physical availability to increase the full price and to restrict supply. Dr Boffa, is there anything else you wanted to say?

THE WITNESS, BOFFA: Only, just to correct, when you said the Stronger Futures interventions had an impact, in and of themselves, they had no impact.

DR DWYER: I see.

THE WITNESS, BOFFA: All they did was make alcohol available on town camps and in certain communities. That initially was completely ineffective. What made it effective was an initiative which began from the local police station here to put police on outlets. So, it turned that into a supply of action measure. Prior to that, all it was, was banning – we didn't support it in its initial form, because it didn't work, because you can't stop – if you – all you're doing is saying to people, you can't drink alcohol on town camps and you can't drink alcohol, but you can still buy it. People still buy it and the police can't possibly stop people. They can't police that. So, that was completely ineffective and it was racially based. But what changed everything was – and we didn't initially support this. We thought this was, you know, clearly discriminatory, but it was so effective, we supported it in the end, because that's the issue, that it's a form of positive discrimination, because it's so effective. And so, we saw things, if you look at courses of alcohol attributable to hospitalisations, they started dropping in 2013 which is exactly when we had initially what was called, not POSIs. Initially they were called TBLs, Temporary Beat Locations, then they were called POSI, then they back PALIs and they became PALIs. And they became PALIs in 2018, because that was when police auxiliaries were funded. It didn't have to be police themselves, but you can see the on again/off again, they were on in 2013, they were off in 2014, the data goes up and down. So, there were two major peaks of harm. One was 2015 one was 2011/12, which was ten years ago, where we've seen the worst of what can happen. It's been getting better since then, but we'll have to see in the data now – you know, we haven't seen (inaudible) totally and I've said before, where I live in Gosse Street, there were – in a four-week period, there were two major crime scenes. We haven't seen that for more than ten years. So, one was a woman who was raped and one was woman who was drunk pushed into – these are remote people drinking in that area in the public spaces, one was a woman pushed into a fire, badly burnt. So, that's anecdotally again. So, we're trying to see, particularly the serious harm data, so out of all the assaults, the assaults you most worry about, the assaults causing grievous bodily harm. They're the ones that couldn't have killed someone but didn't. We've heard, anecdotally, they've gone up, but that's only published NT wide. We don't want to see it NT wide, because Tennant Creek's improved a lot. You see, in Tennant Creek, nothing's changed, because all the town camps were general restricted areas. So, they're our controlled community. Things in Tennant Creek have got a lot better, which is what we were expecting to see as the COVID situation settled down. It's all over the world, during the COVID years, alcohol consumption's gone up; so much so that, even in America right now, there's a campaign for a floor price. There's a campaign for all these things, because they've seen how much alcohol consumption harm's gone up in the COVID years. But as things improve, we expected to see things return more towards what they were pre-COVID and Tennant Creek's doing that at the same time as Alice Springs is going in the other direction. And we need to look at Alice Springs, Tennant Creek, Katherine and Darwin differently. Nothing has changed in Darwin, because there were no PALIs in Darwin. So, it's here that we are most worried we'd see an impact and we'd see remote people coming to town, which is what we're seeing. And we were at a board meeting yesterday. One of our remote clinics, and the board members at the end of the meeting had other business. What did they want to talk about? They wanted to talk about the people who had left their

community, gone to town, drinking and their kids aren't going to school. How do they get them back? How do we stop that? That's from one small remote community.

THE WITNESS, AH CHEE: Well, that's the second time that's been raised.

THE WITNESS, BOFFA: Yeah. So, people are seeing it, they're worrying about it. And you know, we're trying to get evidence and if - you know, I heard in evidence earlier this week that the clinic was saying in Yuendumu they've seen people come in with broken arms, cuts, lacerations. If that's what's going on, then go public, say that. Because we're hearing nothing really about how much – and you can't just say - of course there's tensions in all communities, it's a question of how much worse things get when you add alcohol to whatever's going on, whatever pre-existed, you add alcohol into the mix, everything gets worse. And the question – what we want answered is, how much worse.

DR DWYER: What we're hearing anecdotally for Yuendumu, which remains a dry community, is nevertheless, that some adults are leaving the community to come into town to drink, which leaves young people unsupervised and then the break in – the problem with break ins occurs.

THE WITNESS, BOFFA: Right.

THE WITNESS, AH CHEE: Well, that's consistent with the messages that we're getting from our remote community leaders.

DR DWYER: So, tying that back to Kumanjayi's life again, if you think of him being a young person who is in need of love, care and support, and a young person who was affected by alcohol, the more you limit supply for somebody in his position, the better his outcome is, potentially.

THE WITNESS, BOFFA: Yes.

DR DWYER: Or the more you make it available, the worse the outcomes.

THE WITNESS, AH CHEE: Agreed, yep.

DR DWYER: I take it that's a message that has been strongly communicated by Congress to the NT Government.

THE WITNESS, AH CHEE: Absolutely. And we've called for, along with a number of other organisations, for the establishment of an alcohol monitoring group that enables to have government and Aboriginal community leaders sitting at the table and looking at the relevant data that Boffa's talking about. So, you know, admissions to hospitals, presentations to ED, child protection data, police data, alcohol-related crime. So, we want to be looking at this data, rather than this anecdotal he said/she said, let's have a look at what the actual numbers are saying.

DR DWYER: Thank you very much, Doctors.

THE CORONER: Other questions?

MR ESPIE: Yes, your Honour.

THE CORONER: Yes, Mr Espie.

XXN BY MR ESPIE:

MR ESPIE: Doctors, my name is Mr Espie, I appear on behalf of NAAJA. Thank you both for your presence here today, and that was very thorough evidence-in-chief. I'll try not to repeat some of the questions. I'm also interested as to whether – perhaps if we came back to you with the transcript, we could clarify some of the acronyms that were used.

THE WITNESS, AH CHEE: Sorry.

MR ESPIE: I think we've settled whether the health or the legal profession has more acronyms.

THE WITNESS, BOFFA: Health wins. And at tennis.

MR ESPIE: And Dr Ah Chee, just to confirm and just picking up on something you were – you said to my friend, you're a Bundjalung woman from New South Wales. You've been living, and have family connections here in Alice Springs for about 30 years or so, connected into our local Arunta Community as well. Well you're married to an Arrernte man from a kinship perspective, you're Ngwarrey skin, is that correct?

THE WITNESS, AH CHEE: That's correct, my husband's Ngale (?).

MR ESPIE: And you're aware that myself and my family are Ngwarrey so just to clarify that would, for the kinship relationship, that would put us as sibling, or brother and sister relationship. If I was to walk into one of your clinics, as an Aboriginal man, and then yourself as a doctor, or a receptionist, or a health worker, or anyone in the relationship of a brother to you, or to another staff member, that might change the way yourself, or your colleagues interacted with me, coming into your clinic. Is that correct?

THE WITNESS, AH CHEE: Absolutely.

MR ESPIE: It would mean you probably wouldn't necessarily be the person to treat me, for example.

THE WITNESS, AH CHEE: Exactly. And we've also got specific male and female services, for that very reason as well. So – so some, you know, men –males, don't necessarily want to go to the main clinic, or to our general clinics, but would rather go to Inginga (?) which is a male specific clinic.

MR ESPIE: And that takes into account some of the gender - - -

THE WITNESS, AH CHEE: Gender.

MR ESPIE: - - - segregation issues, or gender issues that arise in our culture, many Aboriginal cultures. Similarly, if from a social and emotional well-being, if I was to attend for counselling, for example, in one of your services, you know, and I was having some issues with – domestic issues with a partner, as a – someone that you would call a brother, that's probably something you also wouldn't – wouldn't be appropriate for you to discuss with me.

THE WITNESS, AH CHEE: Exactly.

MR ESPIE: And you didn't get – commence a relationship, and suddenly you certainly had all this knowledge about Central Australian Aboriginal culture. Be it Arrernte, or Warlpiri, or Luritja (?). That's something you've gained over many years?

THE WITNESS, AH CHEE: That's true. That's right.

MR ESPIE: It's fair to say it's not only from a personal perspective, but from a professional perspective, that's something that you've seen as valuable, and important, to get an understanding of that?

THE WITNESS, AH CHEE: Absolutely, and I'm – and I'm still learning. And that was one of the key reasons, from a professional perspective, at Congress, that – that I actually thought it was very important to establish these cultural operating protocols. So it wasn't only for our non-Aboriginal colleagues, but also for Aboriginal people, who are not from this country. So it was for both.

MR ESPIE: All right. And I have a few of them here. They're protocols that are tailored depending on where your clinics are, and what language groups, and what people you work with?

THE WITNESS, AH CHEE: Exactly. And the relevant health boards, basically gave the advice about the content. Because only they would be the ones that can inform that protocol.

MR ESPIE: And those are the health boards in your various community - - -

THE WITNESS, AH CHEE: Remote clinics.

MR ESPIE: - - - clinics. And they consist of local Aboriginal people, from that community?

THE WITNESS, AH CHEE: From that community.

MR ESPIE: So very specific to those regional places, and those language groups?

THE WITNESS, AH CHEE: Yes, exactly.

MR ESPIE: And you, being from quite a faraway place in New South Wales, it's – it's not only that your Aboriginal, that you value that, and you understand that anyone working in this profession can put some sort of value on that, if – you know, from a professional point of view, and make efforts to gain that sort of knowledge?

THE WITNESS, AH CHEE: Yes. Yes.

MR ESPIE: And I'll perhaps come back to that in a moment.

Dr Boffa, you made some comments earlier in your evidence about – and perhaps many people, many Aboriginal people would have felt the comments you said about some of the concerning evidence you've heard through this inquest relating to payback. And your understanding is that that suggestion that Aboriginal people being enraged and angry would – and attacking non-Aboriginal health workers, or police, or anyone, is in any way related to some of the traditional forms of payback and restorative processes of Aboriginal people. And you understand that through your many year of working in this region, and working – and learning from Aboriginal colleagues and friends, is that right?

THE WITNESS, BOFFA: Yeah, yeah, in 34 years I've never ever heard of that ever happening, to a non-Aboriginal health person. In fact quite the opposite. I've seen many examples where Aboriginal people incredibly forgiving and accepting that health professionals, doing their very best, sometimes don't get it right. In fact to the point perhaps where there's a tendency to be too forgiving, and too accepting. And sometimes you've got to be a bit tougher and take things up. But I think the exact opposite, is my experience over 34 years, and – and I just think it's really important message to get out there, that any health professions that come to work in remote Aboriginal communities, would be very much accepted, and very gratefully accepted. And very openly accepted. And people will accept them into the community, if they're prepared to commit. Now if you're only coming for a few weeks, well don't expect that.

MR ESPIE: No.

THE WITNESS, BOFFA: If you're coming with an open-ended commitment - - -

THE WITNESS, AH CHEE: Mm mm.

THE WITNESS, BOFFA: - - - you can expect to get, in return, more than you give.

THE WITNESS, AH CHEE: And in my ten years of – as the Chief Executive Officer of Congress, I've never – it's never come up in – at Congress.

THE CORONER: But what about health practitioner being blamed for a bad outcome, and then kind of banished from the town, or something like that? Have you ever heard of anything like that?

THE WITNESS, BOFFA: I haven't.

THE WITNESS, AH CHEE: No.

MR ESPIE: We heard from Senior Elder Warren Williams, who made comments about Kartiya people coming to Yuendumu, and – and walking in two worlds. So not only Aboriginal professionals, or Warlpiri professionals, having to walk in two worlds, but Aboriginal – sorry, non-Aboriginal people also – I take it, well from what both of you are saying, but just – just reflecting on your evidence, Dr Boffa, you make the comments about payback, not only to sort of let the wider profession know that that's not something you experienced. But you also I take it, because you – you could feel how those sort of comments would probably hurt many of your Aboriginal friends and colleagues?

THE WITNESS, BOFFA: Yeah, I think – I could see how they're very hurtful to Aboriginal people. But as well as that, very worrying in terms of we need health professionals to come and work in remote community, and this is getting a lot of publicity this inquest. And I worry that people will get the wrong end of the stick. But yeah, people could – I know that people would be very offended by that, because payback is very, very strictly regulated by traditional law. And it doesn't happen on an ad hoc basis, no.

MR ESPIE: Dr Ah Chee, you said Congress is almost about to celebrate its 50th birthday. Congress is an organisation that's arisen out of Aboriginal people in this area, filling gaps in services, or – or creating more appropriate – culturally appropriate and responsive services for Aboriginal people. And we've heard a wealth of evidence about your sort of whole of life approach to many – to a whole range of issues, and health issues that face Aboriginal people. It's fair to say that you continue to grow, not for the sake of building some empire, but out of addressing gaps, deficiencies, adapting to issues that arise in this region?

THE WITNESS, AH CHEE: Yeah, absolutely, and our focus, in the last few years, you know, five or so years, has been in the early childhood space. Because we think that that's where – we've got to shift the attention, if we're really going to change the trajectory in a child's life, we really need to be focussing on that primary prevention and early childhood is the key.

MR ESPIE: And within your organisation you've talked about being led by boards and having that layer of what perhaps we'll call "Aboriginal oversight and input" there's other layers of input you have, you have more than 200 Aboriginal staff across your organisation, you have Aboriginal staff advisory group, is that correct, and the other ways you get input from the Aboriginal staff?

THE WITNESS, AH CHEE: Yes, we've, yes, got our Aboriginal staff advisory group, our board, our executive has three senior Aboriginal executive members, all female. We do need to see some more males in our service - Aboriginal males at executive positions but, you know, that's an area of work that we need to focus on but yeah, and we've got, as we mentioned earlier, Aboriginal family support workers, Aboriginal liaison officers, we've got - yes, two senior cultural leads. So there's a whole network within the organisation around where we can make sure that we're supporting Aboriginal self determination but also making it a safe culturally secure place for not just Aboriginal people that work there but our non-Aboriginal colleagues as well.

MR ESPIE: That was my next question. You having all those supports where you can't fill a role with an Aboriginal nurse or doctor etcetera, you are quite comfortable in the advice - the inductions - the processes you have to support your non-Aboriginal staff in getting an understanding of the people they're working with?

THE WITNESS, AH CHEE: Absolutely. We have a regular - for new starters, for new staff we have a staff orientation program/workshop that we share with new staff about the history of Congress, what its strategic directions are. Dr Boffa goes into the political economy of health, so you've heard a bit of that today.

MR ESPIE: Yes. I must say you and others have done a good job in educating Dr Boffa as well, from some of the comments he has made today.

THE WITNESS, AH CHEE: Absolutely.

MR ESPIE: More broader than Congress, there's other networking opportunities, capacity building and training opportunities for you and all your staff through connections across the Territory with AMSANT which is an Aboriginal alliance and then national (inaudible) with NACCHO and you seem to have quite good retention of both your Aboriginal and non-Aboriginal staff.

THE WITNESS, AH CHEE: Actually, our Aboriginal staff retention is better than our non-Aboriginal staff, but having said that, in terms of our GP workforce, what's the average length of stay, Boff, is it nine years?

THE WITNESS, BOFFA: Mm mm.

THE WITNESS, AH CHEE: So even though we've got a GP crisis at the moment, we do have a cohort of GPs in Congress that have been with us for quite some time.

MR ESPIE: And nine years is a long time not only for community having a familiar face, but for the core knowledge of your staff and your clinics and again, just considering - or reflecting on evidence we've heard in the last few weeks there's reference by Derek Williams, who is an Aboriginal Community Police Officer and he described the challenges he has had in continuously building relationships with people that come and work in the community. He described them coming and his putting all this effort into giving them knowledge and then - as he describes it -

"birdfeeding" that they take all the seed then off they go. You understand that sentiment?

THE WITNESS, AH CHEE: Absolutely. Very frustrating.

MR ESPIE: So your remote clinics similarly you have relatively good retention of your staff?

THE WITNESS, AH CHEE: I think it waxes and wanes. But we do have the opportunity to relocate, you know, remote health staff across the clinics in our remote areas. But we're not immune to the - you know, to the challenges of workforce in our remote communities, so yes, we're lucky enough at the moment, like we said earlier, that we've got one FTE GP vacancy at the moment out of 20 but we do have - of that 20 we've got four that are locum GPs but - yeah.

THE CORONER: Mr Espie, I note the time. I am not sure - I think there are some other people who do have questions, so I am not sue how much you've got left.

MR ESPIE: Probably ten minutes, your Honour, I'm not sure how long I've got - - -

THE CORONER: I don't think you've got ten minutes.

MR ESPIE: I will be three minutes.

THE CORONER: Okay, three. Mr McMahon?

MR MCMAHON: I don't think there will be anything, your Honour, thank you.

MR ESPIE: Perhaps I could - - -

MR HUTTON: I will have as much as I am allowed, your Honour. I'd like 20 minutes.

THE CORONER: Okay. You've got five - and we might just need to sit a little bit later.

MR ESPIE: Yes. Perhaps just some quick questions. You've heard some of the evidence and you're aware of what has happened, after hearing some of the evidence today. In getting - in making a decision about reducing your services because you say you've never had to totally close any of your clinics as a result of safety concerns, but you would only make those sort of decisions with local input with your staff including your aboriginal staff and your Aboriginal staff a remote community clinic would most certainly include the local staff that have come from that place?

THE WITNESS, AH CHEE: Yes, they would, definitely.

MR ESPIE: You wouldn't treat them any differently to any of the other staff?

THE WITNESS, AH CHEE: No.

MR ESPIE: Perhaps just some quick comments. Would you think what you have heard today about burglaries and that sort of thing would trigger the need for one of your clinics to either reduce or close your services?

THE WITNESS, AH CHEE: Sorry, I missed that.

THE WITNESS, BOFFA: Would burglaries be sufficient to trigger closing services?

THE WITNESS, AH CHEE: No.

MR ESPIE: No. And some of the alternative arrangements you took into account in the Mutitjulu situation included relocating 20 - 25 minutes away. Do you think your decision would have been different if you didn't have such a short distance to travel, for example being an hour away, would that have made a difference to the way you responded?

THE WITNESS, AH CHEE: Yes, we probably would have had to bring people into town if we didn't have that facility there.

THE WITNESS, BOFFA: Or we would've had to get more of a connection with the police to actually work with us straight away, which we couldn't get and we couldn't get security. Once we got security we were back in the community but that took a few days to organise.

MR ESPIE: And you mentioned that the police being replaced with two different police and then an additional officer. Were they police that performed a different style of policing to the previous police that were in the community as far as you're aware?

THE WITNESS, AH CHEE: Well, the feedback that we've had from the health board since the employment of those two new police is that the relationship is very good, so it's been positive feedback.

MR ESPIE: Right, and Dr Boffa, you mentioned relationship, that they were very much into developing relationship in the community?

THE WITNESS, BOFFA: Yes, it's critical for all of the professionals that work in communities.

MR ESPIE: So more of a community policing style of operation?

THE WITNESS, BOFFA: Yes.

MR ESPIE: And perhaps just quickly also, your after-hour services in communities includes Aboriginal staff assisting in after hours or on call services?

THE WITNESS, AH CHEE: You can do the after hours - - -

THE WITNESS, BOFFA: Yes, well so since 2018 or '17 yes, we've had to people have to be on every call-out and the best way to do that is a registered nurse and a local Aboriginal person that we call a "Mulpa" worker, so they are the two people. If we can't get Mulpa we have a second nurse but obviously using two nurses is problematic not only from the cost point of view but from the actual amount of time they then spend on a call because if you have anything less than a one-in-four on-call roster you're going to lose people. There's good research about that. So if you're using two nurses every night on call you're going to have them all doing more than a one-in-four on-call roster and that's not sustainable. So we work very hard to get local Aboriginal community members as Mulpas who know the community to work with the nurses after hours.

MR ESPIE: Right. And just some final quick points. I think it's been recognised through the closing the gap agreement and you've said in your statement that your model or an Aboriginal community control model is often more cost effective, has better health outcomes. Would you agree with those two comments?

THE WITNESS, BOFFA: Yep. And more – it's going to have a social and preventative programs, it's going to have - - -

THE CORONER: I think we've already heard that, Mr Espie, so.

THE WITNESS, BOFFA: - - - social determinants.

THE CORONER: We don't need to reinforce what's already been said.

MR ESPIE: Perhaps I have run out of time, your Honour. I have many more questions but I'll leave it at that.

THE CORONER: Thanks.

Mr McMahon, two minutes.

MR MCMAHON: Thank you.

Thank you doctors. I appear for the Parumparru Committee, which is the justice committee of Yuendumu and you're probably aware that there's likely to be people from there watching now. And I've just got one question. I'll just restrict it to one question and it's about the idea of Yuendumu coming within the auspices of Congress and that's why I mentioned the live-streaming, because your comments may be useful to the community right now and it will be useful for our submissions later. So could you just comment on this idea of the practical reality of Yuendumu becoming part of Congress, if that was possible, what Congress's attitude to that would be – which I think is very obvious from what you've said today – and finally, to incorporate that answer into what you, Dr Ah Chee said about the need for a

strategic move, which sounded to me like you're saying a number of communities should join at once with a more significant approach than what's happened until now where a maximum of three communities can join at any one time?

THE WITNESS, AH CHEE: Yes, that's right.

MR MCMAHON: So could you comment on that for the benefit of her Honour and those listening? That's the question.

THE WITNESS, AH CHEE: So we support – if a community is making a decision that they would like to come to Congress, then we will obviously consider that very seriously. We'd need the community to write to Congress and formally seek that request. And then there's a process in facilitating that, like a government process. Because it's all part of the pathways to community control policy framework that operates in the Northern Territory with, as I mentioned earlier, the Northern Territory Government, the Commonwealth and the Aboriginal Community Control Sector, which is AMSANT that represents the health services across the Northern Territory. So there would be – there's a process for that, for that transition. But like I said, I think that the process so far has been quite slow and I think in light of the fact that there's been not just an approach that would possibly come from Yuendumu community but we've had approaches from other remote communities in Central Australia that I think that it needs to be done strategically and not just this sort of incremental - - -

MR MCMAHON: By incremental you mean for instance, if their leadership group at Yuendumu wrote to Congress that would be an incremental approach, but you're saying you really need it to be more strategically organised with a number of communities at once, that would be the most beneficial way for Congress to deal with that kind of move? Is that what you're saying?

THE WITNESS, AH CHEE: Yes.

MR MCMAHON: And I know it's obvious but it's something that Congress would welcome?

THE WITNESS, AH CHEE: Yes.

MR MCMAHON: Yes, thank you.

THE CORONER: Mr Hutton.

MR HUTTON: Thank you, your Honour.

Dr Boffa and Dr Ah Chee, my name is Tom Hutton and I'm appearing for the Department of Health in this inquest. I don't understand there's a maximum number of communities that can transition to Congress under the current arrangement, is there?

THE WITNESS, AH CHEE: Not so much maximum number, it would be within the region of Central Australia and that would need to be consistent with our constitution which basically is Central Australia. So it wouldn't include the Barkley and it would need to be, you know, Congress, our board would need to consider to what extent that geographic boundary would go. So at the moment, you know, when you look at Yuendumu or Titjikala has been in contact with us. Anguwala mob have been in contract with us. We just need to be able to consider that in a strategic way.

MR HUTTON: Sure. Sorry, my question though is under the current arrangement the forum that governs the process, there's no restriction to say only three can be transitioned?

THE WITNESS, BOFFA: No, there is. There's a policy that only three areas can be transitioning at any one time. At the moment there's two areas, there's West Arnhem transitioning, that's the Jabiru area, Oenpelli and there's – as Donna said earlier, there's the Imampa, Yulara, Kukuljara area around Mutitjulu(inaudible), that's two. There's one open vacancy. Because the (inaudible) transitioned and East Arm has transitioned. So there is the possibility but the policy at the moment is you can only have three regions at any one time. The question would be could Central Australia be considered as a region rather than say Apijula (?) or Inkunji (?) or you know, like rather than one community to make up that third spot. But there is a restriction that there's only – there's only – the policy environment says we can only work on three areas across the NT at any one time.

MR HUTTON: Thank you. At paragraph 41 of your joint affidavit you state that Team Health terminated the previous auspicing arrangement because of governance issues between Congress and the Women's Health Board, you say there are a number of important governance issues. What were they?

THE WITNESS, AH CHEE: Well there were issues around not what we'd considered good governance practices. And we tried to work that through with the board and in the end, we didn't get resolution on that. And the board made the decision that they no longer wanted Congress to be their auspicing service.

MR HUTTON: Can you explain what those governance issues were?

THE WITNESS, AH CHEE: Well there were issues of meeting in Alice Springs and meeting more often than what was needed.

MR HUTTON: I'm not sure if - - -

THE WITNESS, AH CHEE: From our perspective, from Congress's perspective.

MR HUTTON: That there is more meetings than what you thought - - -

THE WITNESS, AH CHEE: What was needed.

MR HUTTON: And that was the extent of the disagreement or were there other issues?

THE WITNESS, AH CHEE: We had a health service manager that was operating in a way that we felt was also not necessarily consistent with our management practices as well. So in questioning that then caused a level of disagreement between Congress and the board.

MR HUTTON: Were there any issues relating to service delivery?

THE WITNESS, AH CHEE: Not that I'm aware of.

MR HUTTON: At par 43 of your affidavit you state that previous Coronial inquest have exposed the issue when a service relies only on remote area nurses without the benefit of a residential GP who can assess patients in person and then you've cited an inquest there into the death of Kumanjayi Brown in 2014. And can I suggest to you that there were no recommendations arising from that inquest regarding residential GPs?

THE WITNESS, BOFFA: But what's that's referring to is in evidence it was quite clear that the District Medical Officer who was based in Alice Springs at the time was basically able to say that they were unable to make any sort of correct diagnosis because they were relying on the input they had been given from the remote area nurses. And if they had have been there on the ground in the community diagnosing meningitis early is something that doctors learn. You see it rarely, it's not common, it's a difficult diagnosis to make and you couldn't expect remote area nurses to pick it up early from the experience and training that they have. Remember there's no – remote area nurses can be nurses straight out of – they can just graduate and go remote, there's no extra qualification in becoming a remote area nurse. It could be a very junior nurse. So the issue then was if a doctor had have been in the community there was a much higher chance that that young man would have been diagnosed and not sent home three times from the clinic. So although there was no recommendation about that, Congress wasn't asked to give evidence in that inquest either. So there was no perspective given to the Coroner at that time - - -

MR HUTTON: I'm sure her Honour will defer to the findings rather than - - -

THE WITNESS, BOFFA: No, I think there's an issue about the process and I have complained - - -

THE CORONER: I'm happy to hear it because it's difficult in inquests to know who the experts are to bring the right evidence to the inquest and sometimes findings are very limited to a narrow perspective of issues, when – with a greater analysis from a number of – or a greater source of input, we could have much more meaningful findings.

THE WITNESS, BOFFA: And so on that issue, because I think coronial inquest's are great opportunities to highlight systems issues. And it'd be about 15 years ago,

there was a major change. Congress used to be asked to give evidence in a lot of inquests, from a systems perspective, like we are here, which is great. Big change. So we raised that with Counsel Assisting. We raised it directly with Greg Cavanagh, that we were really concerned that an inquest like that, we weren't asked to give this sort of evidence about the level of resourcing of the health service. Didn't come up. None of that evidence was there. There was no – so it didn't – it's not that there - there were no recommendations, because there was nothing in evidence about why there weren't resident GPs in the community. And why the clinic had declined to the level that it had in terms of number of staff. And that, to my mind, was a missed opportunity to look at the broader systems issues then. And if they were looked at then, we mightn't be here now, in the same situation. So I think that – but that's not the only inquest. There's been a lot of inquests where I think we would have been able to give valuable, independent, expert evidence, about systems contributions to deaths. And that all got stopped. And I'm not sure why that policy changed. And it's really great to see that – that we've been asked to be part of this one. And I just think it's really important that coronial inquests do seek evidence beyond the Department being – and the same would apply to us. If Congress was subject to an inquest, we'd be – we would expect other expert to be giving evidence about whatever it is that we have failed to do. So I think this is a really big opportunity for system change. I've seen it happen out at (inaudible) Coronial inquest. And that one was a missed opportunity.

MR HUTTON: I won't take that inquest any further, other than to say, my understanding of that circumstance is there was in the – the patient in question was seen twice by a general practitioner, and once by a registered nurse and never by a remote area nurse. But I'm sure your Honour will – will read - - -

THE CORONER: I'm going to have to have a look at it. I know that it's referred to in our large volume of material.

MR HUTTON: At par 45, you state that Aboriginal community-controlled health services are historically well recognised in terms of cost effectiveness, improved health gains for Aboriginal people, and decreased avoidable hospitalisations. How does Congress monitor the increased avoidable hospitalisations?

THE WITNESS, BOFFA: So we're currently part of a research project, which now involves every health service in Central Australia, community controlled and government, to look at the impact of primary health care on avoidable hospitalisations. We're drawing that from existing literature about the effectiveness of primary health care services on avoidable hospitalisations. And we are now trying to look at whether there is a differential impact between community (inaudible) and government clinics, and avoidable hospitalisations. So that research projects now – it's a data linkage project. It's at the stage where data extraction's occurring, and it'll finalise its findings probably about mid next year.

MR HUTTON: Is there any publically available data now that would support that statement?

THE WITNESS, BOFFA: There's publically available data from one study from the Top End about the importance of primary health care on avoidable hospitalisations, which shows that if services are seeing clients between five and 15 times a year, they have their maximum impact on avoidable hospitalisations. In that study, in the government clinics, there was a large proportion of people in community didn't use the service once a year. Community controlled health services don't have that. We had very few – in a given year, we see about 87 percent of our – so a resident population 10,000 people, 87 percent of time come to our service in a given year. So we have – and over two years, it's more like 95 percent. So on the basis that we have – we have more clients coming between the five to 15 episodes of care per year, than government clinics in that study, I think it's reasonable to assume we're having a significant impact on avoidable hospitalisations. Because there is a sweet spot. Less than five times, and you don't. Greater than 15 times, you have, again it's a u-shaped curve. We're really on the bottom of u-shape curve.

MR HUTTON: Do you share your data with NT Health ordinarily?

THE WITNESS, BOFFA: What do you mean share it?

MR HUTTON: In terms of consultations - - -

THE WITNESS, BOFFA: Yeah, yeah, yeah. So our NT KPI - all the NT KPI report data from every clinic, community controlled, government, goes to the NT data warehouse, which is - - -

MR HUTTON: It's okay, we've heard about this one.

THE WITNESS, BOFFA: - - - yeah, so that's controlled by the Northern Territory Department. They see all the data. There's a committee that includes NT Government senior people and AMSANT senior people who review that data. And all those reports go to all health services. So it's one data base, and the NT Aboriginal Health Forum gets those reports every six months, across the system.

MR HUTTON: Thank you. At various places in your affidavit, you refer to a work force crisis, and that it's making staffing remote clinics harder. What are the vacancies – what are vacancies rates at Congress and remote clinics (Inaudible)? Do you know?

THE WITNESS, BOFFA: Do you want to - - -

THE WITNESS, AH CHEE: In remote clinics.

THE WITNESS, BOFFA: - - - so there's 20 – it's about 20. So we've got 20 remote area nurse positions. 12 of them are full-time occupied. Four of them have got locum staff in them, and four of them are unfilled. So in terms of unfilled, it's 20 percent - - -

THE WITNESS, AH CHEE: I think that was the GPs - - -

THE WITNESS, BOFFA: No that – that was nurses.

THE WITNESS, AH CHEE: Okay.

THE WITNESS, BOFFA: Yeah, and so – so four of them are unfilled, which gives a vacancy rate of 20 percent. But there's four with locum staff in them. For GPs we also 20 FTEGPs across the whole of Congress. In September we had 20 FTE, but now we've got four vacancies in our GPs, of which one's in a remote community. And as you heard in psychologists, we've got 11 FTE, with one FTE vacancy.

MR HUTTON: And the one FTE vacancy is for the psychologist in Yulara?

THE WITNESS, BOFFA: No that's a new position.

THE WITNESS, AH CHEE: No.

MR HUTTON: That's a new position.

THE WITNESS, BOFFA: Yeah.

MR HUTTON: How long have you been recruiting for that position?

THE WITNESS, BOFFA: We haven't – I don't think we've actually – so we're still in the process of setting up that new satellite service. We're just about there. We've got accommodation from the resort. They haven't actually advertised yet for that position.

THE WITNESS, AH CHEE: That's the Headspace one.

THE WITNESS, BOFFA: Yeah. That's over and above the 11 FTE. So I - - -

MR HUTTON: Can I ask you - - -

THE WITNESS, BOFFA: - - - haven't – and we don't – we haven't got the data in front of us for our town-based nursing positions. That was just 20 for remote.

MR HUTTON: Sure, thank you. Can I ask you now about the Outreach – Outreach Remote and Isolated Safe Work Practise Policy and Procedure (inaudible), which are annexed to your affidavit. Those documents were issued on 1 February 2017. And approved by you, Dr Ah Chee, in your capacity as CEO. Did Congress have a policy for remote worker safety prior to that (inaudible)?

THE WITNESS, AH CHEE: No. That's the comprehensive one that we've done.

MR HUTTON: And what prompted the introduction of these policies?

THE WITNESS, AH CHEE: Sorry?

MR HUTTON: What prompted the introduced of these policies?

THE WITNESS, AH CHEE: It was I think the need to make sure that we had appropriate systems and processes in place. And particularly what happened in South Australia.

MR HUTTON: The death of - - -?

THE WITNESS, AH CHEE: I think it really – yeah, yeah.

MR HUTTON: The introduction to the procedure, which is at page 87 of the affidavit, states:

> "Workers working in outreach, remote and isolated settings faced a particular set of risks associated with working in environments that do not have access to normal safety arrangements. As they are away from access to rapid support from other staff, and emergency services, such as police. Workers face a number of potential risks to health and safety, including transportation to and from when the service is provided. Working in unfamiliar environments. Working is isolation. Possible delayed response by support workers."

So you set out there that the safety arrangements that many of us take for granted in more urban settings, are not as prevalent in remote (inaudible)?

THE WITNESS, AH CHEE: Remote.

MR HUTTON: There's also additionally to that, a wealth of literature, isn't there, that says that the risks to safety, in remote communities, are also higher?

THE WITNESS, BOFFA: Yeah, but – but – it's true. But we've also advocated for many years that every – wherever there's a permanent resident nurse, there should be permanent police. We're really concerned about the inequity in the distribution of the police work force. So Alice Springs has one police to less than a 100 people. Tennant Creek, it's close to 150. But think about that. One more hundred, you go to most remote communities, Utju which is 230 people, no police. Santa Teresa, 600 people. Police aren't there all the time. Alpulrula (?) (inaudible) - - -

THE WITNESS, AH CHEE: Lake Bennett.

THE WITNESS, BOFFA: - - - no police. So here we've got a really severe inequity in the distribution of police. It would really help us a lot, to maintain the safety in our remote clinics, if we had adequate numbers of police, and a ratio that was worked on, in the same way we work on population ratios for health professions. We should have population ratios for police. But government, having presented that as a good idea, you can see why they don't think it's a good idea, because you either have to redistribute police out of the urban centres, or you have to find a lot more money to

put police in remote communities. And I think – but it is – it is difficult. It's a challenge to run a health service in a community that doesn't have police.

MR HUTTON: No doubt. I don't have time to go through some of the literature that I'm aware of with you now, it's before your Honour and annexed to the affidavit of Christine Fleming, but one proposition he's took in that literature is that the violence experienced by remote area nurses in remote communities is double that of urban professionals. Would you agree with that?

THE WITNESS, BOFFA: Absolutely. I mean - and you look at the violence – I mean Aboriginal women in remote areas, you know, 40/50 times more likely to be hospitalised from domestic violence. So, the community – so that gap is multiplied many, many times to the community. But of course, it's worse in remote communities than it is in urban areas for a whole range of reasons, and one of them is the lack of police.

MR HUTTON: On page 99 of the affidavit in the procedure, there is a text box that states, "Dispensing of medications and providing other treatments from staff accommodation, no matter how minor is not acceptable. This is not supported by management at all and will be considered inappropriate conduct." Why is that considered to be unsafe.

THE CORONER: So, where are you going - - -?

THE WITNESS, BOFFA: Do you want me – so, following the – one of the main lessons - - -

THE CORONER: Sorry, I just need to find the – where did you go to for that?

MR HUTTON: I went to – in fact, it's in the procedure, your Honour.

THE CORONER: It's got the Congress procedures here. And where it is?

MR HUTTON: It's page 99 of the whole document.

THE CORONER: I might not have the whole document. I've got up to like 65, which I thought was the Congress procedures, but - - -

THE WITNESS, BOFFA: That's in a highlight box. It's one of the vast – it's such a long document, the highlight boxes, you can read them and get the ten main points and that's one of them. So, that came out of – so if you look at the tragic death on the AP lands, after that, we decided that afterhours, if people need to be seen, they come to the clinic. We didn't want our staff going to people's houses, particularly for repeat medications and for minor things like that. You know, you can wait to the next day for medications. So, you needed to balance the risk benefit cogent meant that the practise of seeing people in their homes or having people come to your home, which used to be commonplace, even – it used to be happening in our – even before that, we were saying, don't do that. But we didn't have a policy saying, don't do that.

So, we made that very clear statement that we actually don't want that practice where people were actually going to houses for the purpose of dispensing medications, afterhours this is.

MR HUTTON: Do you accept that the risk to staff of dispensing medication to community members would be lower than the risk that's presented when somebody is trying to break into their house when they're home?

THE WITNESS, BOFFA: The risk is about – you might go there to dispense medications, but what else is going on in the house at night afterhours. And you're often not aware of that until you get there and so, it's not, you know, dispensing medication is not the issue, it's the context in which that's happening that could create an unacceptable risk for a staff member for a purpose that's not lifesaving.

MR HUTTON: It's people coming to your house that you're trying to avoid?

THE WITNESS, BOFFA: Yeah, and also our staff going to their houses. So, people were told to come to the clinic. If we have to, we'll go to a house, if there's no transport or no way they can to the clinic, but that was a shift making sure people came to the clinic and we'd see people in the clinic where it's a safer environment.

MR HUTTON: On page 111, I'm sorry, I'm not sure what page of the document it is, but it's only a short reference. It reads, "If a worker feels unsafe 'at any time' --", and those words are involved, "they should call for backup or retreat, if possible." And why is that?

THE WITNESS, BOFFA: So, we wanted to make it clear to staff that we were not expecting or requiring staff to put themselves at risk, and if they felt – if they feel unsafe, then they need to stop and talk to someone about what they're doing. So, that was the trigger in which – and obviously, there's another part in a box where we say that staff have to go with another person. That was a change. We were letting staff prior to that, on-call staff, will you be on your own? Who that's, they're not on their own. So, there's a combination of saying, you'll go – two people will go, but if you're feeling unsafe, you need to stop and say, well why am I feeling unsafe. And if you're not sure, talk to someone and make sure that what you're doing is okay and you've done a risk assessment properly.

MR HUTTON: The procedure then continues on to the considerations that may apply to a reduction of services and it states, "Indications --", and this is on page 133 of the entire document.

THE CORONER: I'm sure I've got it here, I just can't find it, because I'm going by the paragraph numbers like 3.1 or - - -

MR HUTTON: Yes, I think this might be 8.1.

THE CORONER: Sorry, 8.1?

MR HUTTON: That's what I had a short moment ago.

THE CORONER: Decision-making process?

MR HUTTON: No, I beg your pardon, it's 8, your Honour, section 8.

THE CORONER: Temporary reduction or withdrawal.

MR HUTTON: Thank you. Do you have a copy of that?

THE WITNESS, AH CHEE: Which one? Which document?

MR HUTTON: The procedure.

THE WITNESS, AH CHEE: The procedure itself. What number is that?

THE CORONER: Section 8, yes. It's page 48, at 65.

THE WITNESS, BOFFA: Yep, got it.

MR HUTTON: "Indications for any reduction to normal service provision include, but are not limited to, community violence, individual threat towards the health service, inability of Congress to resource." What does the – and I note this is by way of example rather than exhaustive, what does "individual threat towards the health service" contemplate?

THE WITNESS, BOFFA: Well, it's really referring to the threat of interpersonal violence, threat to safety, a person's safety.

MR HUTTON: A threat to a person's safety would be grounds to consider a possible reduction of the service.

THE WITNESS, BOFFA: Yeah. Which is what, in the Mutitjulu situation, that did happen inside the clinic where the violence was such that staff were physically threatened.

MR HUTTON: Okay. And if we go over the page, we get to the decision-making processes to a temporary withdrawal. That's at section 8.1 in the second paragraph, it requires a risk assessment to be completed. Is that what I take from the first sentence in the second paragraph, "The decision to withdraw service from a given community needs to be ultimately based on a current risk assessment." Is there a document that Congress uses for completing a risk assessment like that?

THE WITNESS, AH CHEE: Yeah, which is our Congress Risk Management policy and we've got a framework as well.

MR HUTTON: And the paragraph goes on to state, "It's recognised that communities need to be responsible and involved in the management of bad

behaviour." What does that statement mean?

THE WITNESS, AH CHEE: Well, that's the – I think that's the response that we took to the unrest that we were experiencing in Mutitjulu.

MR HUTTON: This document was obviously written a few years before that.

THE WITNESS, AH CHEE: Yep.

MR HUTTON: What is it trying to capture here?

THE WITNESS, AH CHEE: Well, that you've got both a service provision response, but you've also got to think about a community response.

MR HUTTON: All right. And there's no requirement in this procedure, is there, that other stakeholders such as police be consulted with?

THE WITNESS, AH CHEE: Yeah, it says, "Issues and invoke intervention of groups such as local government and police". But we did it anyway.

MR HUTTON: Well, we'll come to Mutitjulu in a moment, but is there a requirement in the procedure that other stakeholders be consulted with before a decision is made.

THE WITNESS, BOFFA: I think it's – I mean, it is in that paragraph, it mentions "police, local government, other stakeholders". And that's what our practice is, so whether it's clear enough in writing, it's – those stakeholders are mentioned and we always do it. Yeah, there's never been a time when we've had – and it's a combination of – you meet with the community, what can they do, what's their part. They've got a part to play, health services have got a part to play, the police have got a part to play and sometimes, local government have got a part to play. And sometimes, other organisations like NPY Women's Council at Mutitjulu or a range of other stakeholders. So, you identify whichever stakeholders have some sort of role in community unrest, community violence and you need them all.

MR HUTTON: Certainly, from my read of the policies, it doesn't require any consultation, but it suggests that they may be involved because they're wider community issues. But should the policy make clear who is to be consulted before a withdrawal occurs?

THE WITNESS, BOFFA: It may not. And if it doesn't, we might take that onboard and review it. We already said that, with one aspect of going through this policy to this commission, it's an opportunity for everyone to review what they do, including us, and I think if you've had a good read of it and you reckon it's not clear, we will have a good look at it and we'll make it clear crystal.

THE WITNESS, AH CHEE: We'll need to make it clear.

THE WITNESS BOFFA: And the other thing we wanted to make clear - - -

THE CORONER: It does say here "Responsibilities for clinic manager and Congress medical director be actively involved in ascertaining relevant details about the situation."

THE WITNESS BOFFA: But we could make it more explicit and we also thought we'd make more explicit that it's actually the CEO who makes a decision and it's not clear enough, that was another thing we thought about, so there's a few things going to this has got us thinking about in terms of this - improvements we can make.

MR HUTTON: Sure. Can I ask you about Mutitjulu in particular? So who did make that decision ultimately?

THE WITNESS AH CHEE: It was myself as a CEO in consultation with the board.

MR HUTTON: Do you recall the date of that serious matter?

THE WITNESS AH CHEE: No.

THE WITNESS BUFFA: I think it was - so when we said the weekend, the clinic was closed on the Friday as well as the weekend. The clinic staff were in the clinic on the Friday though but the clinic was closed and so it probably would've been the Thursday I think, or the Friday morning that decision was made.

THE CORONER: I don't want to be a barracker for Congress against NT Health. But if you look at the appendix 1 "Off site activity flow chart" - - -

MR HUTTON: What page is that, your Honour?

THE CORONER: I don't know the page, it's Appendix 1.

MR HUTTON: I couldn't possibly (inaudible).

THE CORONER: Just have look - it's only a little bit further on. So it's the risk assessment stage - complete off site risk assessment form, subsequent visits, check off site risk assessment form, views risk assessment tool to determine appropriate actions, consultation with third parties may be appropriate.

MR HUTTON: That may be appropriate indeed.

That doesn't require it does it, your Honour?

THE WITNESS BOFFA: Yes, we can strengthen that. I think that's - it's happened and we've done it but - - -

MR HUTTON: I get the sense you might be in trouble if you don't (inaudible).

THE CORONER: I just - obviously these documents contemplate a whole variety of risk and this document includes, you know, running away in the face of risk, in which case there's no time for consultation. So it depends on the circumstances. If you need to run - and flee - that is contemplated and you are not required to get in contact with management and go through other processes if you think that you are facing imminent danger and you need to flee.

MR HUTTON: Precisely right, your Honour.

THE CORONER: So if there's a bushfire coming you don't have to consult. It it's on your doorstep, get out.

THE WITNESS, BOFFA: Yes, that's right. Which hasn't happened but it's got to be said.

MR HUTTON: And Dr Ah Chee, you mentioned in your evidence earlier that the situation had been building before the withdrawal occurred in Mutitjulu. Was there community meeting held before withdrawal?

THE WITNESS, AH CHEE: Yes. There had been other community meetings and so that the additional one that was part of our strategy was, you know, an additional community meeting to say from a health service perspective this is, you know, serious, it's now impacting on the operations of the clinic, it is impacting on the wellbeing of our staff and so as a community, we need to talk about this.

MR HUTTON: Your statement says - - -

THE WITNESS, BOFFA: And just to add to that, at one of the community meetings that happened a few months earlier the police came down, at a very high level, to that community meeting and they gave a commitment to the community that there would be a third police person. But, you know, come the incident, there hadn't - that hadn't been implemented so that it just - every incident was used - Diane was on the phone to the Commissioner multiple times over months - and back onto him - and back onto him saying, "Well hang on, it hasn't turned around, it's getting worse, we've got to make this happen - we've got to get a third police - we've got to make change." And so it wasn't like just one simple approach it was a continual approach over time which led to an outcome. And a commitment to the community given that eventually was implemented with the help of us giving up a house. But if we hadn't have made that house available it wouldn't have happened.

MR HUTTON: Your statement goes on to say that Congress informed the board what was happening and why. It doesn't suggest it was a consultative discussion. It suggested it was a notification to the board?

THE WITNESS, AH CHEE: No, that's - that's - - -

MR HUTTON: It's the wrong language?

THE WITNESS, AH CHEE: Yes.

MR HUTTON: Do you remember the discussion with the board?

THE WITNESS, AH CHEE: Yes, it was in - down in the meeting room at the clinic.

MR HUTTON: Did they ask you to stay?

THE WITNESS, AH CHEE: To stay?

MR HUTTON: To not withdraw from the community?

THE WITNESS, AH CHEE: No, they didn't - they didn't actually, they recognised that there was a serious situation here and we talked through what the response to that should be. So they didn't actually say "Shut the clinic" - they didn't' say that, that's not my recollection. Do you recall that Dr Boffa?

THE WITNESS, BOFFA: Yes, they were actually adamant that we had to maintain an on-call service, so we had to find a way of doing things with that service maintained. They wouldn't have accepted no on-call service and that was - that was the bottom line that we couldn't go below, so we - so we worked out a way to make sure there was an on-call service that was not too far - because an ambulance with a siren on could get there within 15 minutes.

MR HUTTON: From Yulara?

THE WITNESS, BOFFA: Yes. It's only 25 kilometres, you've got the siren on and you're driving - - -

THE WITNESS, AH CHEE: No traffic.

THE WITNESS, BOFFA: 15 - 20 minutes, you know, it's - - -

THE WITNESS AH CHEE: After hours - we're talking about after hours.

THE WITNESS, BOFFA: After hours - we're talking after hours, 20 minutes - with the siren on. I think 20 minutes maybe, max but - - -

MR HUTTON: It take some time to load the ambulance?

THE WITNESS BOFFA: What's that?

MR HUTTON: It takes some time to load the ambulance?

THE WITNESS BOFFA: Well, we have it all ready. We have - we've spoken to Dave Reeve, we have permission to use the Yulara clinic because we weren't planning that weekend to have an open clinic, we had planned to go, get someone, come back to Yulara to treat them, unless it was so life threatening that we had to

actually open the clinic. But we were going to try and avoid, normally an emergency would go to the Mutitjulu Clinic, and we deal with it there. But this time we were planning to go into the community, with security, get the person in the ambulance. Come back to Yulara, treat them there. And the Health Department were very supportive of that. So we'd used the Yulara Clinic.

MR HUTTON: I appreciate that, and I've been some email correspondence that suggests that that certainly did occur. But there was no consultation, or notification to the health clinic, until well after the decision had been made, later that evening. Is that right?

THE WITNESS, BOFFA: To which health clinic?

THE WITNESS, AH CHEE: No, no, they're talking about the NTG clinic at Yulara.

MR HUTTON: Sorry, your Honour (inaudible).

THE WITNESS, BOFFA: I - - -

MR HUTTON: That wasn't – that wasn't someone that was consulted with?

THE WITNESS, AH CHEE: I can't – I can't answer that.

THE WITNESS, BOFFA: I think the day of - - -

THE CORONER: Where is this going, Mr Hutton? Are you suggesting that Congress' procedures could also be improved, or - - -

MR HUTTON: I think- - -

THE CORONER: - - - they could learn from that experience?

MR HUTTON: - - - I think we can all learn from these experiences, your Honour.

THE CORONER: Sure, sure.

MR HUTTON: I suppose we've spent the better part of the week, in fact all of the week with people asking our clients about the completion of written risk assessments, so - - -

THE CORONER: Sure. So you're suggesting that there's – we've identified some problems in NT Health. And they're not isolated - - -

MR HUTTON: Indeed.

THE CORONER: - - - likely not isolated to NT Health. And that hopefully, anyone who looks in – who's in a health service provider, might pay attention to these proceedings, and go back and check their own procedures.

MR HUTTON: Certainly.

THE CORONER: And perhaps other – other service providers procedures could also be strengthened.

MR HUTTON: Yes.

THE CORONER: But NT Health is not alone in perhaps having procedures that are either from time to time, overlooked, or when put to the test, could be improved.

MR HUTTON: Precisely, thank you, you've - - -

THE WITNESS, BOFFA: But in answer to your question, my understanding is that David Reeves and the clinic manager of Yulara knew we were going to use the Yulara Clinic by Friday afternoon. That's - - -

MR HUTTON: After that - so the email correspondence suggests - - -

DR DWYER: Your Honour, I object. It - - -

THE CORONER: It doesn't really matter.

DR DWYER: - - - it doesn't go anywhere, and it's impossible for these witnesses to answer the question.

MR HUTTON: I'm happy for them not to answer that question.

Can I ask you this, was there a written risk assessment completed?

THE WITNESS, BOFFA: There was a risk assessment done, using the same framework you talked about before, operation and risk (inaudible) use the same matrix. Whether that was written, I'm not sure.

MR HUTTON: I mean, that would be an interesting document I'm sure, for NT Health to receive, if it's possible.

THE CORONER: Do you do a written risk assessment? Is that what – I can't – I haven't read it enough – I have read that document, and I have looked at some of the attachments, and some of the flow paths that you've identified. Do you know if you require a written assessment?

THE WITNESS, AH CHEE: We haven't got a written pro forma as such but we use it as a guide in order to make the decisions.

THE WITNESS, BOFFA: And we minute the meetings that we had where we had the discussion about the risks and this benefit, yeah.

MR HUTTON: How do you consider risks – if you have an approach to – within the community itself, the health of the community, how is that taken account of? Mutitjulu (inaudible)?

THE WITNESS, BOFFA: So for instance, I mean every time if you were to ever withdraw an on call service, that's potentially creating a life threatening risk. And the larger the community the more chance there is that that risk will be realised. So we're very aware of, you know, the consequences. You know, we've got the same risk matrix that we use – that everyone uses. And so when you're balancing all the way through what reactions are, what you're (inaudible). Obviously we continued the emergency on call service and stopped everything else and looked at the risks of what that would mean if people didn't get medications for a few days, all of those sorts of things. But taking into account nurses making sure we were there for any life-threatening emergency but we're happy to accept that people with – you know, people with infections, people needing daily dressings, some of that wouldn't have happened for those three days. So that was the risk benefit equation. So all that was talked about and taken into account.

MR HUTTON: Did you recall whether the two nurses that were withdrawn from Mutitjulu were indigenous?

THE WITNESS, BOFFA: I think it was more than two nurses at the time.

MR HUTTON: That was your evidence earlier. I beg your pardon if it was not.

THE WITNESS, BOFFA: Was it. I thought it was – we had four nurses in the community at the time. One was on leave but I think it was three that were removed and I think at the time we did have one Indigenous nurse and that Indigenous nurse was one who was thinking she'd stay. And but did agree – did want to come – did come out initially with the staff but wished to go back as soon as she could along with the cleaning manager. And so - - -

THE WITNESS, AH CHEE: Because her husband was with her.

MR HUTTON: She asked to remain in community but it was considered unsafe to have her around?

THE WITNESS, BOFFA: I think we let her remain in the community because her husband was there.

THE WITNESS, AH CHEE: Yeah, we did. Things had settled.

MR HUTTON: She remained in the community?

THE WITNESS, AH CHEE: Yes.

THE WITNESS, BOFFA: Yeah, she remained in the community but the clinic wasn't open that weekend but she remained in the community.

THE WITNESS, AH CHEE: And we had the security guard there on the Monday, so. It was a Monday?

THE WITNESS, BOFFA: Yeah. Yeah, we opened the clinic again on the Monday with security there. And this all helped us get that security, otherwise we wouldn't have been able to get someone as quickly. She was safe. She felt safe in her house.

MR HUTTON: And when did the security guards arrive, if you can remember?

THE CORONER: Monday for the clinic.

THE WITNESS, BOFFA: Yeah.

MR HUTTON: I beg your pardon. When did you first start using security guards generally?

THE WITNESS, BOFFA: At Mutitjulu that was the first time. We haven't used them much historically but this was the first time and we have used them at Utju recently.

MR HUTTON: And I understand Congress has also withdrawn its staff from Hermannsburg?

THE WITNESS, AH CHEE: Sorry?

THE WITNESS, BOFFA: No.

MR HUTTON: I understand that Congress has also withdrawn its staff from Hermannsburg?

THE WITNESS, AH CHEE: Don't know.

THE WITNESS, BOFFA: Not that we know of.

MR HUTTON: October 2017?

THE WITNESS, AH CHEE: Not that I know of.

MR HUTTON: All right. At par 68 of your affidavit you stated that you undertook an audit to ensure that staff are not subjected to repeated break-ins. Do you recall what measures that audit found to prevent repeated break-ins?

THE WITNESS, AH CHEE: That audit is still being looked at within Congress. We're currently considering the draft report. But as an immediate response to the issues around security, what we did do was increase – we installed duress alarms in staff housing. Also in the clinic, was also improved the security between the

reception and to the consult rooms. And there was also improved fencing in the staff housing.

THE CORONER: What kind of fencing, sorry?

THE WITNESS, AH CHEE: Fencing.

THE CORONER: So just improved fencing?

THE WITNESS, AH CHEE: Improved, yeah. And installation of lighting, because we've been told that having good lighting would have a positive impact. So we immediately undertook that work while at the same time getting an independent person who's got expertise in security to do this risk assessment for us.

MR HUTTON: How long has this audit been going on for?

THE WITNESS, AH CHEE: We've only just got the report recently.

MR HUTTON: Do you know when it was commissioned?

THE WITNESS, AH CHEE: Do you know?

THE WITNESS, BOFFA: Earlier this year.

MR HUTTON: All right.

THE CORONER: And you said that you immediately made those improvements. Did you have to go through the Department of Housing or how did you get immediate improvements?

THE WITNESS, AH CHEE: We did the – yeah, the actual necessary applications.

THE CORONER: And they responded promptly?

THE WITNESS, AH CHEE: And they responded, yes.

THE WITNESS, BOFFA: And it also includes CRIMsafe, extra CRiMsafe window and some of the properties with fences had no fences before. So you know, we're talking about fences that are low level fences, not - - -

MR HUTTON: Not Colourbond?

THE WITNESS, BOFFA: Yeah, not - - -

THE CORONER: Not Colourbond laid horizontally to create a ladder.

MR HUTTON: Final question. Do I understand from your evidence before in a response to a question from her Honour that you have never heard of a non-

Indigenous staff member being asked not to return to a community following a critical incident?

THE WITNESS, BOFFA: Not in any of the health services that I'm familiar with.

MR HUTTON: What about the non-Congress health services?

THE WITNESS, BOFFA: I might know of one in the Top End where it happened.

MR HUTTON: Just one?

THE WITNESS, BOFFA: Just one.

MR HUTTON: Dr Ah Chee?

THE WITNESS, AH CHEE: No, I'm not aware of anyone.

MR HUTTON: Thank you.

THE CORONER: Mr Maher.

MR MAHER: I'm sorry. I had just one question.

THE CORONER: One minute.

XXN BY MR MAHER:

MR MAHER: I only need 60 seconds.

Dr Ah Chee, Mr Espie asked you just to date the cultural approvals. Can you recollect that and you sent him an email with the dates?

THE WITNESS, AH CHEE: Yes, July 2019.

MR MAHER: Well there's six of them. The Alice Springs was approved on 30 April 2021.

THE WITNESS, AH CHEE: Yeah.

MR MAHER: The WAHAC was approved 1 July 2021.

THE WITNESS, AH CHEE: So Alice Springs was approved on 30 April 2021. Mutitjulu, Santa Theresa, Utju and Amoonguna were approved on 27 September 2019 and WAHAC was approved on 1 July 2021.

MR MAHER: Thank you.

Thank you, your Honour. Mr Boe only asked me to do one thing, I just didn't want him to say "You had one job."

THE CORONER: All right. We'll adjourn to Monday at 9.30. And I should thank you very, very much. I'm sorry it's so late and clearly we've all been completely listening to you intently. I think you've observed that for yourself. So you can see we have appreciate the information you've given, not only in your evidence today but in the detailed affidavit that's been provided.

THE WITNESS, AH CHEE: Thank you.

THE WITNESS, BOFFA: Thank you.

ADJOURNED