A 82/94

NORTHERN TERRITORY OF AUSTRALIA

9420219

Rel.case A82/94

CORONERS ACT

SUMMARY OF FINDINGS

PRINCIPAL FINDINGS

S.34 (1)(a)

(i) Identity of deceased person:	Esky Muller, also known as Esky Armstrong.
(ii) Time and place of death:	Between 1am and 1.15am on 17 October 1994 on the Stuart Highway in the Northern Territory And at a point approximately 102km south of Alice Springs.
(iii) Cause of death:	Loss of blood arising from incised wound to the left arm.

Particulars Required to Register the Death under the *Births Deaths and Marriages and Registration Act*.

Full name of deceased person:	Esky Muller, also known as Esky Armstrong
Date and Place of Death:	17 October 1994 on the Stuart Highway in the Northern Territory of Australia at a point approximately 102km south of Alice Springs.
Sex, Age and date of birth of deceased person:	Male. Aged 14 years born 1 February 1980.
Aboriginality:	The deceased was a person of Australian Aboriginal origin.
Report to Coroner:	Cause of death was reported to the coroner.
Post-mortem:	Cause of death was established by post-mortem Examination conducted by Dr Andrzej Ruszkiewicz on 19 October 1994.
Injury:	Injury did contribute to the cause of death. This injury was received when the deceased forced his arm through a window and in so doing received lacerations to the right cubital fossa. These lacerations caused bleeding which resulted in the death of the deceased.

Secondary Findings and Reasons

The deceased died from loss of blood caused when he forced his arm through a window thereby lacerating the right cubital fossa. As to the circumstances in which he came to be at the location where the injury was received and as to his then condition, there is some dispute.

I find that the deceased was a 14-year-old aboriginal male person who normally resided at the Mimili Community in South Australia.

Records of the Royal Darwin Hospital to which the deceased had been admitted on 10 July 1991 indicated that the deceased's date of birth was 1 February 1980 and that he was a "double orphan".

Sandra Armstrong, who gave evidence in this inquest, stated that the deceased was her "sister's grandson" and that as at October 1994 he was living at Mimili. She stated, however, that although the deceased's father had passed away, his mother had not and was living at Mimili.

Circumstances whereby the deceased came to be at Ilpurla

It would appear that the deceased was brought from Mimili to Imampa at the Mimili community's instigation and without prior notice or advice. Mrs Armstrong understood that he was a petrol sniffer and that when he sniffed at Mimili he was sent to Imampa. Mrs Armstrong's son was resident at an outstation known as Ilpurla and at the time of the arrival

of the deceased at Imampa, she was preparing to take supplies to that location. It was common for petrol sniffers to be "looked after" and "saved" there.

Mrs Armstrong stated in her evidence that she received a telephone call from her two sisters who asked that the deceased also be taken to Ilpurla to "save" him from petrol sniffing.

There is some contradiction in the evidence as to how the deceased travelled to Ilpurla. Leo Abbott was, at the time of the death of the deceased, the manager of Ilpurla (otherwise known as Illamerta). In his statement, which was taken on the day of the death (exhibit 4), he states:

> At about lunchtime yesterday, Sunday 16th October, 1994, Sandra Armstrong and her husband Esky Armstrong arrived at Ilpurla with their grandson known to me as "Little Esky" who is also known as Esky Muller, aged about 14 years. "Little Esky" was brought to the centre because of a petrol-sniffing problem.

Leo Armstrong also gave evidence to this inquest. The following questions were asked and answers given (transcript p.53):

> Q. Now back in October 1994 there was a young fellow that was brought to Ilpurla by Sandra Armstrong or by someone that she organised to take him there. Do you remember that?
>
> A. Yes
>
> ...

Q. Do you know who brought him there?

A. Sandra, and Esky, her husband.

...

Q. Do you remember what time of the day it was that he arrived?

A. About lunchtime.

Q. And did you know he was coming? Were you expecting him?

A. No.

Q. And once he arrived, what conversation took place and what was agreed as far as him being left there?

A. Well, Sandra said to me that dad said for her to bring Little Esky out or him to stay out there, so you know I didn't want to sort of fight against what dad said so I said: "Yeah okay then, will if dad said that well he can stay.

Sandra Armstrong's son, Glenn Armstrong, was resident at Ilpurla on the day of the deceased's arrival there. In his statement dated 17 October, 1994 (exhibit 2), he stated:

... on Sunday the 16th October, 1994, at about supper time (lunch time), a relative of mine, Little Esky Armstrong arrived at community. Sandra Armstrong brought him there with Colin Young.

Terry Staines, in his statement dated 17 October 1994 (exhibit 3), stated:

> Yesterday afternoon time (Sunday 16th October, 1994) a young boy, my nephew, I can't say his name came to Ilpurla with Sandra Armstrong from Imampa.

As opposed to these three clear statements, there is evidence given by Sandra Armstrong that she did not take the deceased to Ilpurla. In her evidence given to this inquest on 12 August 1996, the following questions were asked and answers given (transcript p.17):

> Q. So you were taking him to Ilamerta to stop him from sniffing petrol?
>
> A. Yes.
>
> Q. When you took him to Ilamerta did anybody else go with you?
>
> A. I send my daughter, Maria Coulthard, and his wife – husband – to go a short cut to Ilamerta and I went around to buy food at camel farm.
>
> ...
>
> Q. Yeah?
>
> A. I told him "Take this little boy right to Ilamerta and I'll go round the bitumen and I'll get the food. I'll meet up there at Ilamerta.
>
> Q. So who actually took him to Ilamerta?
>
> A. Maria Coulthard and his husband, Colin Young.
>
> Q. So when you got to Ilamerta was that young fellow there?

A. Yes.

...

Q. Now do you remember what time of the day it was when you got to Ilpurla? Was it dark time or daytime?

A. No. I got there round about 5 o'clock.

There were some discrepancies between the same persons as to the condition of the deceased upon his arrival at Ilpurla. In her evidence to this Inquest, Sandra Armstrong stated (transcript p.18):

Q. And when you got there that young fellow was there?

A. Yeah, young fellow was there. He was really good.

...

Q. What you say, he was really?

A. He was good.

Q. Good?

A. Good, and I told him: "I will leave you here. I'm going home. You'll be okay with Uncle Glenn. They all sniffers down here.

Q. Right?

A. And he was, you know, happy to stay with uncle.

This perceived state of the deceased might be contrasted with that depicted in the evidence of Leo Abbott who, in exhibit 4, described the condition of the deceased upon his arrival in the following terms:

> When he arrived he was or appeared to be in withdrawals from petrol and was hallucinating. He was very aggressive and yelling out about god to come and get him and the devil. He was just not making sense.

In his sworn evidence given to the Inquest Leo Abbott stated further (transcript p.54):

> Q. You saw him when he first got there?
>
> A. Yep.
>
> Q. How was he? What state was he in?
>
> A. He was hallucinating, going crazy, running around yelling and screaming ... picking up rocks and was going to hit people. He put the rocks down and people were talking to him.
>
> ...
>
> Q. That behavior that you've just described, had you seen that behaviour before from people that you believed were petrol sniffers?
>
> A. He would be the worst that I've ever seen.

Barry Abbott also gave evidence to the Inquest. He stated that he did not personally know the deceased but that he knew of the deceased as a petrol sniffer. He stated that on the day

of the deceased's arrival at Ilpurla, he met Sandra Armstrong about 130km from Alice Springs. He stated (transcript p.74):

> ...And that day when they brought him out, I was on my way into town from Ayers Rock. I called into Ilpurla and I seen Sandra Armstrong about 130, 135 out of Alice on the bitumen and I pulled up then talking to her and she asked me she was taking that little boy and I said no don't, you know, because he was the worst kid that I have ever seen. He had not condition at all. He was right down. His eyes was all blood and just right in and I said: "Leave it till the weekend. I'll be back Thursday night and bring it up Friday so I can have it for a few days, then I can watch it over 3 or 4 days", and if he's not going too well then I was going to bring him into town with me for about a week.
>
> ...
>
> She didn't take any notice. She took him in there and she said: "No well his uncle's out there ", that is Glenn, "We'll put leave him there", and I said "Yeah, but that's going to put a lot of pressure on the boys too", because you know, that's the worst one I ever seen.
>
> ...
>
> Q. But Esky was the worst that you've seen?
>
> A. Esky was the worst one that I ever seen, yes. I thought he mightn't last long at all, you know, taking fits and things like that. That's what I thought.
>
> Q. So you thought he mightn't last long at all?
>
> A. Well, first time when you take them out like that and that's the worst one, because I seen kids taking a lot of fits and that when you get them off the petrol

and I thought then, you know, he mightn't last at all because if he take a fit he mightn't come back up at all because he was just skin and bone.

As to the factual matters discussed above, there are obvious inconsistencies as between the evidence of Sandra Armstrong and the other persons referred to. Upon consideration of the evidence and the demeanour of the witnesses who gave evidence touching these issues, I do not accept the evidence of Sandra Armstrong.

I find that it was Sandra Armstrong who personally delivered the deceased to Ilpurla. I also find that, whilst it was an established practice for petrol sniffers to be taken there to be looked after by Barry and Leo Abbott, the delivery of the deceased by Sandra Armstrong was not pre-arranged. I accept that the delivery of the deceased to Ilpurla at a time when Barry Abbott was not present was against the specific advice given by Barry Abbott to Sandra Armstrong.

Further, I find that Sandra Armstrong was not truthful in the assertion made by her to Leo Abbott when she stated that Barry Abbott had approved the taking of the deceased to Ilpurla. It was this false assertion that appears to have swayed Leo Abbott into accepting the deceased into his care despite the concerns he had as to the condition of the deceased.

Events at Ilpurla Preceding the death of the Deceased

There appears to be little dispute as to the events following the delivery of the deceased to Ilpurla and I so find.

The deceased was calmed from his initial behaviour. Sandra Armstrong left Ilpurla. Leo Abbott decided to take the deceased and others out rabbit shooting, which they did. Whilst engaged in this exercise, they also had an evening meal in the bush. The deceased's behaviour appears to have been stable during this time.

The deceased and the others returned to Ilpurla at about 11pm that night. He was provided with accommodation that he shared with Terry Staines. The deceased's behaviour then deteriorated. Such deterioration is well described in the evidence of Leo Abbott (transcript p.56):

> ... And then half an hour after we got back he'd come running and banging on my door, yelling, Esky did.... So I come out and he sort of calmed down a bit and as the boys were sort of taking him back to their place at the camp he bolted and the boys chased him up and grabbed him and calmed him down then and they all went back and everything was all right.
>
> Q. Do you know what time of the night it was when whoever it was that came down and started yelling at your place?
>
> A. Probably about 11.30 I think or nearly 12 o'clock.
>
> Q. And who raised the alarm?
>
> A. Terry [Staines].

Terry Staines, in his evidence, which I accept, stated that the deceased was laying down for a little while in the accommodation which they shared. The deceased was sniffing from a

can that contained cordial but which the deceased thought was petrol. He subsequently "get crazy and he hit the window with arm". The deceased was bleeding and there was a "lot of blood". Mr Staines ran to inform Glenn Armstrong and the deceased followed. Mr Staines then ran to inform Leo Abbott.

I accept that what then occurred was as described by Leo Abbott. Upon being told by Staines that the deceased was bleeding, he saw the deceased coming over towards him and that blood was "squirting out everywhere". Leo Abbott's evidence continued as follows (transcript p.56):

Q. What did you do?

A. Straight away I grabbed him and put him on the floor and grabbed his arm just to stop, you know, try to stop the bleeding.

Q. And how did you try to stop that?

A. Just applying pressure on his arm. ... And that didn't do much, so we put a bandage - grabbed a towel the first thing that my wife – I yelled out to my wife to get a towel and that's the first thing she grabbed so I grabbed that and then we got another shirt and just tightened it around his arm a bit more.

Q. Did that have any effect in stopping the bleeding?

A. No....

Q. What did you do then?

A. Well, in a matter of 10, 15 minutes we'd grabbed a car and put the young fellow

in it and I asked Glenn and Desmond to jump in the back with him, in the station wagon and I drove and all this time I was trying to get in contact with the Royal Flying Doctor Service.

Q. Did you eventually get in contact with them?

A. This was about after 25 minutes of trying while I was driving along.

...

Q. Did you eventually make contact with the Royal Flying Doctor or with the Ambulance Service?

A. Yeah, after about 25 minutes and we was down the road then, nearly getting onto the Tempe Downs road, so I pulled up just this side so I can get better reception talking to the Royal Flying Doctor Service. ... I arranged for – they said they was going to send out an ambulance and so you know they said that the ambulance was going to meet us on the road, so we drove all the way from there and met the ambulance just near the Henbury/Orange Creek – just inside the Orange Creek boundary.

Q. And in the course of the journey along, were you aware of the condition of little Esky?

A. Yeah. I was asking Glenn, you know, keep talking to him, keep the pressure on his arm and you know the main thing is to keep talking to him. Don't let him go to sleep.

Instructions were given along the way by Leo Abbott for Glenn Armstrong to administer

resuscitation. Leo Abbott was of the opinion that the deceased had passed on by the time his motor vehicle met the ambulance at the location referred to above.

I find that the deceased was alive and exhibiting signs of such life until a short time before the rendezvous with the ambulance. Leo Abbott was of the opinion that death had occurred about five minutes before such rendezvous.

It would seem, however, from other evidence that there were still signs of life as at the first attendance by ambulance officers upon the deceased. It also appears that the deceased passed away within minutes after that point in time. I find that death occurred at the point where the ambulance met the vehicle that had been conveying the deceased.

Role of Ambulance Service

As detailed above, those transporting the deceased from Ilpurla were unable to establish contact with emergency services until about twenty-five minutes into the journey towards Alice Springs. At this point, the deceased was still displaying signs of life.

Sharon Smith gave evidence. On the night of the incident the subject of this inquest, she was working in Alice Springs as a Communications Officer with St John Ambulance. Working in the Communications Room, her duties included the taking of emergency calls, the dispatching of ambulances to those calls, taking of calls from communities on weekends for District Medical Officer consultations and the co-ordination of Royal Flying Doctor Service aircraft movement.

On the night of 16 October 1994 when the first call relating to this deceased was received, Dr Gillatt was the medical officer first on call and Dr McCaffery was second on call. On 17 October 1994, Dr Long was first on call and Dr McCaffery was second on call.

The notation made in St John Records indicates that the first call was received by HF Radio at approximately two minutes to midnight on 16 October 1994. Ms Smith recorded the following:

> HF emergency alarm 8 Sierra November Hotel 250 kilometres south on Kings Canyon Road approximately 30 minutes from Stuart Highway, proceeding towards Alice Springs, patient with lacerated wrists.

Ms Smith recalled that the radio reception at that time was particularly bad.

On the "green card", another record kept at that location, Dr McCaffery was listed as the "authorising doctor". Ms Smith explained this on the basis that she knew the authorising doctor was to be Dr McCaffery. This was because the first on call doctor was already engaged elsewhere.

On the Communications Log appears the following entry:

> 0005. Advised Dr McCaffery of rendezvous with vehicle from Kings Canyon Road. Patient with lacerated wrists, uncontrolled haemorrhage, 8 Sierra November Hotel, HF emergency call AS4LD 2358 hours.

Ms Smith had contacted Dr McCaffery at five minutes past midnight by telephone. Information received was passed on and an ambulance was despatched by Ms Smith. Her evidence as to the procedure adopted was as follows (transcript p.721):

> What would have happened is I would have called the ambulance crew, told them they had a code 1 and that they were going on a bush job, a road rendezvous. Then, going by the paperwork, I've called Dr McCaffery at 5 past, let him know what the case is, the nature of the case, that I was in the process of despatching an ambulance which he would have okayed because we were both aware of the circumstances of the aircraft already being tied up. That is the second page of that document 27, ambulance officer's report. The ambulance was despatched at - which means it's the time it actually left the ambulance centre at 10 past midnight to proceed on that case.

Ms Smith conceded that it was the District Medical Officer who must authorise the dispatch of an ambulance out of town.

It is apparent that the ambulance did commence its journey without the necessary authorisation from the District Medical Officer. Whether or not correct procedures were followed in this respect is not a matter with which I concern myself. There was clearly an emergency requiring the urgent dispatch of an ambulance, an aircraft was not available and the ambulance was able to be recalled if the District Medical Officer subsequently did not authorize its journey. Ms Smith acted in a sensible and practical manner in sending the ambulance on its way with the least delay possible.

Another issue arose, however, out of this part of the evidence. Ms Barbara Schmidt, General Manager of Alice Springs Remote Health Services, gave evidence as to protocol in relation to medical emergencies that occur on communities such as Ilpurla. She stated (transcript p.638):

> ... there's a standard emergency procedure that applies across the region that Alice Springs Remote Health Services covers where during the day when a community has needed consultation with a medical officer they contact Remote Health Services where they immediately can speak to the medical officer on call. After hours the procedure is that they contact St John Ambulance who then patch the person through to the District Medical Officer on call. Or if the first medical officer is on call they patch them through to the second medical officer on call.

Ms Schmidt concluded from an examination of relevant documentation that normal procedures were not followed on this occasion in that the call from those in the motor vehicle conveying the deceased was not patched through to the doctor. Those attending to the deceased did not speak directly with the doctor.

Ms Smith acknowledged the standard procedure referred to above but did indicate that there was "nothing written procedure wise" and that whether such an attempt to patch through calls were made may depend on "conditions of the radio". She was unable to recall whether their had been any attempt to patch those attending to the deceased to the doctor in accordance with this procedure. She acknowledged, however, that if there were such an attempt she would have expected to see a record of it in the communications log, which there was not.

Ms Smith did recall that conditions on the night in question were not good. There was much static and fading of conversation. Her recollection in this regard is confirmed by those in the vehicle conveying the deceased towards the rendezvous with the ambulance. Her conclusion as to what probably occurred on that night in this respect appears at page 725 of the transcript:

> From what I've written down and from my memory, after the initial HF call I would have called the doctor, told him - or relayed the information that I got from that vehicle, told him that I had an ambulance that was about to leave the ambulance centre. I can only assume because that transport went ahead that he was happy with that and he was happy with the information that I in turn relayed back to the vehicle from - that was coming from Kings Canyon. If he asked me to patch him through to the car or attempt to, I haven't - I don't have any recollection and I certainly haven't written that down.

Dr McCaffery recorded providing a "consultation" at about twelve midnight. The condition as conveyed to the doctor was that the patient had cut wrists and that he was bleeding. He was then questioned as to the existence of any protocol whereby the ambulance service was supposed to "patch" the doctor through to the vehicle conveying the patient. He answered (transcript p.744):

> The normal procedure would've been for me to talk directly either to a patient or to a patient's carer if that was ... possible. Now, I've never been patched through to a mobile vehicle in the past. And certainly, actually up until the time that I received

your letter, if I'd been asked that question I would've said that no I wouldn't have attempted a patch with a mobile vehicle. Now, the only patches that I can recall having had were with RFDS aircraft, and invariably they were of poor quality. As far as I can recall even where St John's ambulances were on evacuations or transporting patients, if I was required to discuss matters with them, as far as I can recall, in every instance I've talked indirectly through the ambulance controller, and they've acted as a mediator in the conversation.

When Ms Schmidt's assertion of patching being "normal procedure" was put to the doctor, he indicated that this was achieved by using the ambulance controller as an intermediary who relayed questions and answers. He could not recall anything in any manual requiring such patching through and did not understand such a procedure as being something that was supposed to occur. Rather, he understood that if a medical evacuation were being organized or that there was a request for medical consultation, then this would involve the District Medical Officer talking to a patient or to the patient's carer.

Accepting that the procedure normally followed was as Doctor McCaffery indicated, there was no record of questions or answers being conveyed through the ambulance controller by the doctor. There was no record of the doctor having given advice to the ambulance controller to pass on to the carers. The doctor did not recall giving any such advice. Nor did he make inquiries as to the presence of any person with the patient who might have been able to give a more accurate assessment of the condition of the patient then that already conveyed.

It is apparent that the communication received by St John Ambulance, whereby it was

reported that the patient had his eyes open, was still breathing and that bleeding was controlled, was not conveyed to the doctor in the manner envisaged by him. He does state, however, that given the apparent state of the patient at that time, it was not unreasonable to draw the conclusion that the patient was stable and that it was unnecessary to convey such information to him. He did not think that the course of action adopted by the ambulance officer was unreasonable given the information conveyed to her.

On balance, I do not accept that there was a firm protocol requiring the patching through of a doctor to a mobile vehicle in circumstances such those being considered. I do accept that it was usual for a doctor to ask any necessary questions concerning the patient's condition and receive any answers through the ambulance controller.

It would have been appropriate given the report first conveyed to the doctor for him to have made further inquiries as to the patient's condition which may then have enabled further advice to be given. If appropriate questions had been asked by Doctor McCaffery upon first receiving advice from the ambulance controller, then the later report concerning the apparent stability of the patient and control of bleeding may have assumed greater importance in the mind of the ambulance controller and subsequently in the mind of the doctor.

The circumstances as then known to the ambulance controller were conveyed to the doctor and were so conveyed with appropriate speed. The subsequent reactions of the ambulance controller must be seen in the light of the doctor's response to the report and to the subsequent report from the motor vehicle concerning the patient's apparent stability. I do not find that the ambulance controller has acted inappropriately in all of the prevailing

circumstances.

Dr McCaffery did not take all appropriate steps in ascertaining either the patient's condition or as to the presence of persons who might have assisted that patient. The failure to "patch through" the motor vehicle in which the patient was travelling to the doctor was not of great importance. The failure of the doctor to properly ascertain the patient's condition and then to give advice through the ambulance controller was.

I am unable to ascertain whether a more appropriate response by Dr McCaffery would have improved the deceased's chances of survival. Given the time at which communications were able to be established as between the motor vehicle in which the deceased was travelling and St John's, the lack of trained medical personnel in the motor vehicle conveying the deceased and also given the torrential blood loss that had occurred prior to that time it is probable that it would not have made any real difference.

Facilities at Outstation

Doctor Ian Crundall, the Director of the Alcohol and Other Drugs Program of Territory Health Services, confirmed in his evidence that although his office supported the "outstation movement", there had not been any formal process of ensuring that outstations had adequate medical or communications facilities.

Mr. Barry Abbott stated that at the time of the death of the deceased, he was living at the outstation known as Ilpurla each weekend and that his son, Leo Abbott, was "looking after the place" while he was performing other tasks "for the communities". The outstation was

assisting in the "rehabilitation" of petrol sniffers.

The difficulties, which may be encountered when assisting petrol sniffers, are well known.

Mr. Barry Abbott had been dealing with petrol sniffers for about twenty-seven years. He had seen children with a petrol sniffing history taking fits when being withdrawn from petrol. Mr. Abbott was concerned when he saw the deceased immediately prior to being taken to Ilpurla that the deceased "mightn't last" because "if he take a fit he mightn't come back up at all because he was just skin and bone".

Mr Leo Abbott was present when the deceased arrived at the outstation. He recalled that the deceased was "hallucinating, going crazy, running around yelling and screaming...". He was picking up rocks with the apparent intention of using them as weapons.

Sergeant P. Claphin, who investigated this death, gave evidence as to his observations of those abusing petrol. He was the officer in charge of the Kulgera Police Station and had ample opportunity for making such observations. He stated (transcript p.11):

> The physical effects, apart from making them hungry, they become irrational. They start to see things if they're very intoxicated, become very violent. The wrong word to them just sends them right off. They'll become extremely violent. They pick up rocks, stones, axes, whatever they have handy. They're very intimidating.

Those with medical experience also identified particular difficulties encountered when dealing with petrol sniffers. Dr D Scrimgeour gave evidence before the inquest. This doctor

is working part-time as a Senior Research Fellow and also as a District Medical Officer. At page 624 of the transcript he referred to the tendency for chronic petrol sniffers to take fits when withdrawing:

> Certainly it's well known that petrol sniffers are prone to fitting. There's some evidence that it seems to be related to when people stop petrol sniffing and are going through withdrawal that they are more likely to fit.

As to the possible consequences of such fitting, he stated (transcript p.625):

> ... a person can suffer brain damage as a result of prolonged fitting, a person can also suffocate as a result of inhalation of vomit when they're fitting as well.

Whilst a person does not necessarily have to be a doctor to more effectively assist those in such a state, medical training in this aspect would appear necessary. Thus some parents of children with epilepsy learn how to administer medications to their children if they are fitting, often by passing a small tube into the anus and injecting an anti-convulsant.

This doctor also recognised the tendency for those either acutely intoxicated from petrol or withdrawing from petrol sniffing to be "very agitated, easily upset, sometimes violent".

Dr Currie, a physician from Royal Darwin Hospital and the Menzies School of Health Research referred to medical records relating to this deceased. Such records indicate that when the deceased was referred to Royal Darwin Hospital in relation to his petrol sniffing in 1991, he was agitated and slightly aggressive. There was a need for him to be sedated.

Doctor Currie accepted that hallucinations and fits could be part of the process of withdrawing from petrol abuse.

Dr Currie's evidence was that those who engage in heavy consistent sniffing over a short period of time can display complications such as seizures, agitation, disinhibition and sexual disinhibition. There can be nerve and brain damage in chronic sniffers. There is also another condition arising from the cumulative effects of petrol sniffing called acute petrol sniffing encephalopathy. There can be occasions when those suffering from it become semi-conscious. Those persons are eventually unable to communicate with other people. The condition sets up processes that lead to death in many situations because the person is semi-conscious and unable to swallow properly or breathe effectively.

The death of petrol sniffers is often because of pneumonia caused, in turn, by aspiration. That is, they breathe their own secretions back into their lungs. In that regard, it is of interest to note that the autopsy report for this deceased showed extensive aspiration and gastric contents into the terminal bronchi and alveoli.

Doctor Currie raised the possibility that such aspiration was directly involved in the death of the deceased. The autopsy report revealed that the left lung was dark red to brown and diffusely consolidated. When questioned as to this, Dr Currie stated (transcript p.140):

> What I think that that is consistent with as the histology subsequently showed is a – I think they mentioned evidence of aspiration as well and I think I mentioned yesterday, reading this I'm unable to ascertain from the report whether it was thought

that this was something that was a terminal event as in the minutes of dying or whether it was something that may have actually anteceded the cutting of the artery and given that we know that petrol sniffers are prone to aspirating as a major cause of death, that would have be something that I would have been interested in knowing what the feelings of the pathologist were.

The following questions were then asked and answers given:

Q. For instance, could it be the case that this young man punched the window at a time when he was having respiratory problems?

A. Exactly

Q. And his frustration?

A. Yes, it's possible. He could, conservatively, because I would suggest in fact from the gross examination that that – to actually be consolidated diffusely suggests that it is more than just a very recent event. He could conceivably have, without it being known, been acutely unwell from an aspiration with the pneumonia and therefore with hypoxia or low oxygen levels, and that could have made him, on top of other problems, agitated and could certainly have – it's speculation but it could have - hypoxic people without oxygen flowing to their brain become very agitated and that may have anteceded his ...

Q. They can also hallucinate, can't they in those circumstances?

A. Absolutely yes.

Q. Could that have also explained if he was having difficulty in getting oxygen to the brain because of this problem, could that have also affected his ability to recognise the petrol as against raspberry cordial?

A. Sure, he could have been confused and even disorientated because of the low oxygen.

This aspect will be commented further upon later.

It is apparent that it is accepted without question by those in the medical fraternity and by those with close and frequent contact with petrol sniffers that those who have engaged in petrol sniffing require careful and somewhat specialised care and treatment. They may be suffering from a broad range of medical conditions that places their safety and wellbeing at risk. The training of supervising personnel and the facilities available at establishments holding themselves out as places to which such petrol sniffers may resort must be of a type which cater for those in the condition described.

Communications consisted of "two-way radios". There was no telephone. On the evidence of Mr Barry Abbott, as at the date of him giving evidence (13 August 1996), they had been waiting for six years for such a service. The efficacy of such radio communications system is well described by Mr Abbott (transcript p.77):

> Well two way radios, after 6 o'clock you can't even get through properly because we're in the hills and even you know a few times we had you know people got real crook and that, tried to get through to the Royal Flying Doctors because you got to set alarm on and then when somebody does answer then you can't hear it properly.

> You don't know what you saying and what they saying too.
>
> ...
>
> Two way radio not much good at all after hours unless you're talking, you know, from the centre here to Western Australia or whatever, yes, it will go through but anything close just dies down on you.

Doctor McCaffery, who was performing the duties of District Medical Officer (second on call) on the night in question, gave evidence as to the difference that the presence of a telephone might have made in this particular situation. He said (at transcript page 763):

> If there was a telephone at the community what would've happened was that the community would have phoned St Johns. St Johns would've got their phone number and rung me and then I would've rung from home to the community directly on the line. There would have been no need to patch.

The doctor agreed that this would have enabled him to ask more questions concerning the injury and the patient's state but, importantly, would have enabled him to implement the "highest level of first aid possible".

The question of trained personnel being present at such an establishment was also addressed by Dr McCaffery. He acknowledged the importance of having persons trained in first aid present and also that if such persons were present he would have been able to talk them through the application of a tourniquet.

He concluded that if there were appropriate communications facilities and trained first aid

personnel present, then the deceased's chances of survival would have improved.

Dr Currie was of the belief that it may have made a difference if an arterial bleeding tourniquet had been applied above the site of the laceration.

Mr. Barry Abbott stated that his son did not have any formal medical training although there were weekly visits to the outstation by the nurse from Imampa. Leo Abbott, who was present with the deceased, had completed a first aid course when working as a ranger. He was the only person who had any form of medical or first aid training at the outstation. A clinic had been built but there were no medicines or equipment other than those for first aid treatment.

It is not acceptable that an outstation should accept those suffering from the abuse of petrol and whilst acknowledging the dangers not ensure adequate provision of emergency facilities by way of adequately trained staff and acceptable communications. A general first aid qualification obtained in former employment is not sufficient safeguard for those at risk of suffering the conditions referred to above. What is of particular concern is that the dangers faced by petrol sniffers when suffering from that substance abuse or when withdrawing from it were well known. The dangers appear to be well known and yet such outstations operate without regulation or inquiry as to expertise or facilities available.

I find that the absence of sufficiently trained medical personnel at Ilpurla contributed to the death of the deceased. The absence of acceptable communications facilities compounded the problem preventing both the earlier dispatch of an ambulance and the adequate communication of earlier advice as to treatment of the bleeding. Whether or not a person

with better first aid skills or whether the existing personnel with the assistance of better communications would have been able to save the life of deceased cannot be decided. It is doubtful. The absence of such expertise and facilities certainly reduced the deceased's chances of survival.

The use of Outstations as a Repository for Petrol Sniffers

The evidence establishes that Territory Health Services do not directly refer petrol sniffers or those recovering from such practice to outstations of a type similar to Ilpurla. Rather, such persons tend to find themselves there as a result of the actions of community members or, on occasion, following submissions in court by their legal representative and their subsequent referral by way of bail or bond condition. The deceased found himself at Ilpurla as a result of the perceived benefits seen by extended family members.

From the evidence of both Dr Crundle and Ms Korner, it would appear, however, that reliance is placed upon the use of outstations for the purpose of assisting petrol sniffers. Ms Korner identified Exhibit 9– a document entitled "The Prevention of Petrol Sniffing in Aboriginal Communities" by Mr Peter d'Abbs, as having been adopted by Territory Health Services as its "departmental drug and alcohol policy" (transcript p.296).

Ms Korner is the general manager for Public Health and Regional Programs with Territory Health Services. She identified the use of such outstations as being a very important strategy but emphasised that the outstation movement was not developed solely for that purpose. She was asked whether there had been any attempt by Territory Health Services to establish what occurs at the outstations. Although her own knowledge was restricted to

what occurs at Mt Theo outstation, she expressed the belief that (transcript p.261):

> Primarily they go out there and what happens is that they get a time to sort of dry out; they're removed from the actual source. At Mt Theo there's no vehicles, there's just no access to petrol at all and it gives the youngsters a time to clear the head and then you can start talking about introducing them back to – like what does their tradition, their culture, etcetera mean to them and that's undertaken by Peggy and her husband and other elders who visit. So primarily we look at it in that particular sense. A lot of that is purely respite in the first instance.

At transcript page 269 she said:

> In terms of actually dealing with the chronic sniffers who will not give up I can't say that there is any special program that's being delivered for them. But again we come back and say what can we do to support the communities where petrol sniffing is a problem and in addition to sort of like the outstations we can give some practical support in terms of what they're doing there. It needs to be understood that its only a temporary respite and so you need – we then have to work much – we are working much more closely with the communities and the councils themselves in terms of what strategies need to be actually put into place ...

Ms Korner also acknowledged that there was no mechanism in place whereby the success or otherwise of outstations such as Ilpurla could be ascertained (transcript p.286).

The author of Exhibit 9, Peter d'Abbs, however, recognized the limitations of such use of

outstations when he wrote at page 47 of that Exhibit:

> The movement of families to outstations represents another action with useful primary *preventive* (my emphasis) consequences and, within the constraints created by the need to provide services to many small, remote communities, should be encouraged. However, this movement does not solve the problems of those who remain in the host community, who will therefore continue to require recreational and/or other programs. Also, the use of outstations as *temporary remedial centres* (my emphasis again) to which sniffers are banished (a secondary prevention measure, nevertheless considered here) is not advisable, because it does not alter the setting to which the sniffer will eventually return, and because it may place undue stress on social life in the outstation.

It seems, from the quoted passage that the author of that document did not intend that the outstation movement should be used as a method of delivery of rehabilitation services or, indeed, respite.

Barry Abbott, in his evidence referred to what occurred at Ilpurla in the context of "rehabilitation" (transcript p.76):

> Q. What was being done in the context of rehabilitation with these lads that were taken out there?
>
> A. Well we used working day to day things, whatever comes up because we didn't have any program set up like these other mob got because that's a load of crap to me, because a lot of things they got them all written down on a piece of paper. It's a waste of time, and I never seen any one of them work yet.

Q. When you say programs that other mob have got, what do you mean? Who are you referring to?

A. Well they got some in Alice Springs here; like that got CAAPU and they got few other working things in town here or what they call themselves? There's another mob in town here and also ... and Kintore had another lot and also Docker River had another lot and its getting worse and worse.

It is interesting that the author of Exhibit 9, when writing in 1991 about the rehabilitation of petrol sniffers commented (Ex. 9 p.43):

> This is an area in which program development appears to be singularly primitive, with little evidence of treatment goals, treatment models, or assessment procedures. Three basic approaches appear in the literature: the use of outstations or other remote settings as rehabilitation camps; residential rehabilitation, and community-based rehabilitation.

The author of that report also cited the Senate Select Committee on Volatile Substance Fumes' opposition to the use of such facilities.

Part of the reason for the reliance by many upon the outstation movement in this area might be an apparent reticence to be seen to be "imposing" any form of solution upon the communities. It appeared to be the attitude of some witnesses in these proceedings that any proposed solution to the problem must come from within the community that is suffering the problem. This approach ignores the gravity of the problem and exaggerates the ability of

any community either European or Aboriginal to cope with such a problem.

By way of example, Ms Korner of Territory Health Services related the importance of reaffirming those actions taken by aboriginal people to address the problem. At page 254 of the transcript she said:

> ... The other part of it is incredibly important to actually reaffirm what the Aboriginal people are doing. We – can I just say that can view the figures at Yuendumu of say 6 to 8 petrol sniffers being out there and 20 as being a sad thing, however, it also is a positive thing in terms that the Aboriginal people themselves have actually worked out strategies of how to actually sort of manage this and the fact is that by taking a lot of the activities they've taken the figure from 40 down to the 6 to 8. There's always going to be people I guess who experiment and take risks but a lot of those activities they engage in is actually about the behaviour that's acceptable to that particular community.

The folly of such a simplistic attitude is demonstrated by her earlier evidence that at Hermannsburg there were more than 49 sniffers and yet the community was divided as to how to deal with the problem. That division has stifled attempts to address the problem. She stated (transcript page 262):

> ... there's been at least a number of strategies tried with Hermannsburg. The actual communities have attempted to set up an outstation just outside of Hermannsburg but there has been some family dynamics that's not been totally well supported.
>
> ...

...But also we have discussed with Gus Williams the president out at Hermannsburg and he's indicated strong support but with qualification. He wanted to work with - one of his strategies was that, yes we need to do work with the children out there however it has to be more than just taking the children to a place such as Injatnama. It needed to include the families being part of that particular solution. And he was trying to set up a situation where the children could go to Injatnama on a day program with the parents and it just didn't really eventuate but it just fizzled out. We're now back in discussion with the actual community. ...

Q. This inquest has heard some evidence from a couple of people in Hermannsburg who seem to be of the view that the council at Hermannsburg didn't see it as an issue that the community had to resolve but rather that it was a family problem; do you have the same impression based on the discussions you've had with Gus Williams in his capacity as president of the council?

A. Certainly, he certainly is emphasizing that it is a family issue, however it's – I am getting the sense though that there is a broader understanding that it can't just be done by individuals. It's too difficult.

The difficulties faced by communities in attempting to deal with the problem themselves and the problem in only adopting strategies "owned" by the communities are aggravated by the existence of a strong ethic of non-interference in the business of others. Aboriginal people of Central Australia believe they do not have the right to comment upon, intervene in or chastise other peoples' actions. This is particularly true in relation to the activities of children. Even as to their own children, the socialization practices of the "Western Desert cultural block" are very much different to those practices of European society. The

evidence of Ms M. Brady was particularly informative in that regard (transcript p.887):

> ... I think that it's important to remember that in the Aboriginal situation, particularly in the Western Desert sort of cultural block if you like, that that is not the case [children being in a subordinate role as in European culture] and that children are treated as independent entities and the task of adults is to show love and affection to that child and to – and that means to indulge the child, to be generous to the child, to be constantly compassionate to the child, and that means acceding in demands made by children and not crossing the child, and the other sort of element if you like that comes into this and has I think a huge impact on the whole issue of sniffing is that – and this perhaps isn't so very different to the rest of us, is that there really is a strong ethic of non-interference in the business of other people ... it's a crucial factor that it is simply not part of the world view of people living in Central Australia to feel that they have the right to comment on, to intervene in or to chastise other people for doing things, certainly not other peoples' children.
>
> ...
>
> I have documented situations like this where a child will, for example, go on a sniffing rampage and willfully damage things in a temper and the response of adults will be to buy the child a bike, a mountain bike, because his display of anger was seen to be indicative of distress and so he was considered to be ... someone who is deserving of compassion, and so to show compassion and sorrow and love, the response was to buy him a present ... .

It is just not realistic to expect a small community in the deserts of Central Australia to come up with solutions for this complex problem and also to expect that they will be able to

implement corrective measures. This also was the subject of evidence by Ms Brady (transcript p.889):

> I mean it's too hard. There are so many other things that communities are dealing with and I must say that it's occurred to me over the years that in many cases we are expecting small communities of Aboriginal people to do the full range of things that we are not expected to do. I mean they are expected to sort of keep law and order, ... consult with everybody who turns up in the community to ask their advice. They're expected to cope with chronic drinking, with chronic petrol sniffing, with the problems of you know modernizing youth with massive unemployment. I mean they are expected to deal with huge social problems in many cases with very little help, and petrol sniffing is yet another of those things that stream in upon communities and ... obviously it is the hardest one.
>
> ... people have – whatever the situation with alcohol use is, alcohol is a much more known substance to people and there are expectancies with alcohol. With petrol sniffing it's doubly complex because the behaviour of petrol sniffers is bewildering and terrifying and completely unpredictable and so on top of all the other problems that a community council might have in just keeping itself together in actually having its meetings and dealing with visitors and all the sort of day to day problems they're confronted with this behaviour which is completely ... in which people move into a different state of mind in which people project all sorts of strange beliefs onto those kids.

There is no evidence that Ilpurla or any of the other outstations referred to in evidence have

assisted in addressing the problems of those abusing petrol other than, perhaps, providing respite to the sniffer or his community. There is no evidence that the involvement of such outstations has achieved any long term benefit from those it is thought should be assisted by placement there. There is no evidence of program development, involvement of suitable health professionals, sharing of information or ability or desire to explore developments within the medical or scientific areas. The approach taken is simplistic. There is no regulation of such outstations or of the control or treatment administered by them. As will be seen below, the approach is also fraught with danger to those who are most vulnerable.

Requirement for medical examination

It was the evidence of Doctor Crundall, Director of the Alcohol and Other Drugs Program, that there was no formal procedure in place whereby those sent to outstations by their communities were medically or psychologically examined. This was despite the acknowledgment by Doctor Crundall that many of those attending such outstations might have medical and psychological problems.

It is clear that serious health conditions and complications are characteristic of habitual and chronic petrol sniffers.

As to the deceased, it was the evidence of the Director of Medicine at Alice Springs Hospital, Dr Kirubakaran, that given the deceased's described state, he " should have been admitted into the hospital straight away" and that complications could develop as a result of petrol sniffing or withdrawal and that the patient could "get into trouble". Counsel assisting the Coroner questioned the doctor about the appropriateness of persons in the state of the

deceased being sent to outstations. The question, although somewhat long, should probably be referred to here so that the doctor's answer can be properly understood (transcript page 430):

> Q. Is it a matter of concern to you as a medical practitioner with a knowledge of the conditions that these sniffers present with, that such individuals are, it would seem, routinely referred, pretty much as a result of family level decision making in various aboriginal communities, that they are really routinely referred to outstations which are regarded at Aboriginal community level as being places of rehabilitation or respite ... from the otherwise typical sniffing environment in a community where they're with other sniffers and there's ready access to petrol? Do you have any concerns about what risks in fact someone in that state at the time a family or some other agency decides to refer them to one of these outstations, do you have any concerns about the risks that in fact they might be subject to when they get referred to such an environment, such a place?
>
> A. Well, the case which you describe certainly would concern me and other cases in that kind of medical situation where they are almost in encephalopathic state then I would feel that it is very inappropriate to send them to an outstation for detoxification or whatever you call it.

If medical examinations were required before acceptance of persons into outstations, then it is probable that the deceased would have been under the more intense and constant care and supervision as described by Dr Kirubakaran in his evidence.

Dr Kirubakaran was not alone in voicing his concerns. Doctor Currie described as both

essential and appropriate that organisations, which attempt to run programs of rehabilitation for petrol sniffers, have medical examinations undertaken of those persons entering their programs.

As indicated by Doctor Currie, if the deceased had been experiencing lung problems prior to his death, this may have been causative of the behaviour which led to the laceration of his arm. The aggressive behaviour and hallucinations may have arisen as a result of aspiration. If such problems were present for some time, as was thought possible, the condition may have been detected by such a medical examination and the risk faced by the deceased substantially reduced. Indeed, it is probable in those circumstances that the deceased would not remain at such an outstation and would be treated, instead, at a hospital.

The Need for Residential Facilities

As discussed above, there are major deficiencies in the manner in which the current outstations are permitted to act as the only "rehabilitation" facilities in Central Australia. The non-existence of any real rehabilitation program, the lack of appropriate medical and other facilities, the lack of counselling facilities and failure to share or, indeed, taken any interest in research materials are some of the concerns.

It is acknowledged that those deficiencies could probably be overcome. An alternative may be, however, for the use of such outstations in a limited role. It may be appropriate for consideration to be given to the establishment of a central rehabilitation facility probably based in Alice Springs. This facility could be the initial place of reference for chronic petrol sniffers who would then be either sent back directly to their communities or through the

existing outstations. Those existing outstations would not then face the same risks of medical and other complications that they face when having chronic sniffers sent there directly from the communities. Further, programs may be devised whereby the initial difficult and more complicated steps are taken at the central facility with further long term aspects undertaken at the Outstation.

As discussed earlier, some witnesses reject any proposed model where the program is not "owned" by the communities from which the petrol sniffer has come. They further reject any model which involves the need to remove the petrol sniffer from his country.

The approach of such persons again places too much reliance upon the communities to be able to cope with such a complex and demanding problem. It also fails to accept the realities of communities acknowledging their inability to handle the problem and the calls for help to central locations which have been and continue to be made.

The acceptability and suitability of a centralised rehabilitation program has been demonstrated by an existing facility in Darwin. Mrs Barbara Nasir is the Executive Director of the Darwin based Aboriginal Alcohol Program Services Incorporated ("CAAPS"). The charter of that organisation is to provide effective community awareness, family counselling, treatment and accredited training programs for Aboriginal people suffering from substance abuse problems which result in serious family dysfunction.

I note, in passing that the majority of funding for that establishment is derived from the Commonwealth Government following the transfer of responsibility from ATSIC in 1995.

Her evidence was that the organisation whilst targeting alcohol and substance abuse, does that through a family program. It is thought that it is of no use attempting to rehabilitate the individual if that individual then must return to a dysfunctional family or community situation where the problem will then return. Indeed, a constant thread of the evidence throughout this Inquest was the resumption of petrol sniffing by abusers shortly after returning to their communities from outstations or medical facilities.

At the time of the death of the deceased, it would appear that this Darwin based facility would not have been available even if the family of the deceased had been aware of it or had wanted to use it. The demand on the facility by petrol sniffers and their families had just become too much. Ms Nasir stated (transcript p.502):

> Prior to myself coming into the organisation you had the referrals coming through the courts. Referrals coming through family and through the hospital and in 1994 we closed the doors to petrol sniffing because the numbers were getting so great and we just didn't have the facility or the resources. Then just recently in 1996 we said yes to petrol sniffers again because there was such a request in greater numbers and the need was there.

As to the reticence of remote area Aboriginals attending such an urban based facility, it was the evidence of Ms Nasir that most of those treated were from remote areas. There was not the refusal of communities to participate in programs not "owned" by them that some would expect. Again the evidence of Ms Nasir was relevant on this point (transcript p.503):

> There were calls from parents mainly, coming from families asking us to take

them in and you had about three or four calls a week asking to take petrol sniffers. ... From the families in the communities.

Ms Nasir also directly addressed this question as to whether an urban based facility was appropriate (transcript p.507):

> I think it's really important that you have a central base to support the communities. There's a need to do that. It's too hard to just take it straight to the communities where you've got the alcohol problem, the kava problem, and you've also got petrol sniffing, glue sniffing. So there's a whole lot of big problems right in the community. So it's a time bomb there. So you need to have some support for the communities, for the families and for the client.

As to what was done in that program, Ms Nasir indicated that the program itself lasted about 6 weeks but in individual cases, clients and their families were able to stay longer. The program itself includes lectures, one-on-one and group counselling. There are recreational facilities and an attempt to show the clients that they are able to manage their own lives.

One of the reasons for the apparent success of this establishment is probably the attention given to not only the client but also the family of the client. As already discussed, this addresses the long term environment into which the client must return and live. It attempts to ensure that those factors predisposing the client to substance abuse are addressed in a family way and that there may be, therefore, support of an ongoing nature from within the family group.

The families themselves do not seem to have a difficulty in attending and participating in the program (transcript p.509):

> It happens all the time. Families come in all the time. I mean on site now you've got families, you've got husband and wife, you've got children.

These families travel to the facility from quite distant and remote locations. For those who are concerned about the problems of removing a petrol sniffer from his country, the problem is addressed by he or she having family present and being part of the same program.

The importance of follow up is addressed by the family being involved in the rehabilitation program and also as discussed by Ms.Nasir (transcript p.511):

> A person will complete their program – their 6 weeks program but they also work with treatment on a plan of what to do when they go back to their community of how to stay safe in there, what things to look for so that the council and the client are always working together on how to stay safe once they leave the program but we also have a team that's a mobile team that works out in Jabiru and Gumbalanya area ...

The central facility is also able to act as a base for training community workers so that ongoing care can be provided once the client and family returns to their community. The course provided at CAAPS is described as "Introduction to Prevention and Treatment of Substance Misuse" and is designed as a general awareness course for understanding substance misuse. CAAPS also has a certificate course in the prevention and treatment of

substance misuse.

Of particular attraction is that the course is delivered by Aboriginal people and it is structured on the way Aboriginal people learn. It has been developed with the assistance of Aboriginal people.

I have commented elsewhere on the non-existence of any facility whereby research materials and information is readily available for either professionals or to the communities or families of petrol sniffers. It may be that if such a residential facility were available in Central Australia, this facility could also perform that role.

It has been acknowledged in the course of the Inquest that Alice Springs is particularly well placed to provide any such central facility. The Alice Springs Hospital is the central medical service provider for all in Central Australia regardless of what state or territory the patient may be from.

The location of such a facility here would also ensure that those operating the facility would have access to medical, psychological and counselling support when needed. As discussed, such a proposition does not necessarily mean that the outstations are rendered superfluous. It may be that they could be used, subject to proper guidelines, for longer term rehabilitation or aftercare subsequent to the discharge of the sniffer from the central facility.

In my comments I have intentionally steered away from a consideration of funding governmental funding arrangements. Individual governments obviously have many demands upon them and a need to allocate scarce resources. Those factors are obviously

beyond the scope of this Inquest. I do note, however, that the majority of funding for CAAPS is derived from the Commonwealth Government. Further, any facility in Central Australia would be used by persons from not only the Northern Territory but also South Australia and Western Australia. It seems appropriate in those circumstances for the Commonwealth Government to accept responsibility for the establishment and funding of such an establishment if this proposition is accepted.

Prevalence of Petrol Sniffing

It is clear that the phenomenon of petrol sniffing is not new. It has been reported in a number of locations throughout the Northern Territory for many years and, regardless of any efforts that may be taken, is unlikely to be eradicated.

Some observers date the abuse of petrol to the presence of American servicemen in the Northern Territory during the Second World War. Indeed, the problem is not one that is being addressed only in Australia. Similar problems exist amongst the Native American population in the United States of America and also in Canada, and South Africa. The Northern Territory should not shy away from attempting to learn from the experiences of those in other countries.

There is little hard data from which accurate figures of deaths to which the abuse of petrol has contributed can be ascertained. Table 1 of Exhibit 41 lists 67 deaths associated with petrol sniffing in South Australia, Western Australia and the Northern Territory for the years 1981 to 1992. Those that compiled this Table are at pains to point out that the list is an underestimate of deaths so associated because national collections of data do not enumerate

petrol-related deaths separately, and several ICD codes could apply to such deaths. Indeed, it is interesting to note that the abuse of petrol is not listed as a contributing factor to the death of the deceased, the subject of this inquest.

It is essential that appropriate statistics be gathered which may then assist governmental agencies and researchers in being aware of the level and location of any outbreak of petrol sniffing. Such statistics may also assist in the assessment of the efficacy of any program that has been directed at the problem. The inclusion of appropriate information on death certificates is the subject of a recommendation at the conclusion of these findings. The co-ordination of effort as between governmental and other agencies is the subject of another section of these comments and of a recommendation.

The reasons why persons engage in the practice of petrol sniffing are diverse. As Ms M. Brady stated in the course of her evidence, however, one should not look past the obvious as to the reasons for petrol abuse. True it is that the problem of petrol abuse is primarily a problem of the more remote areas of Australia but it is also the case that problems of inhalant abuse exist throughout this country and overseas.

It would seem, from the evidence placed before me, that like many of Australia's youth in other areas, the abuse of petrol is seen as "cultish", exciting and fun to engage in as a group activity. This is especially the situation where there are limited job opportunities, few youth workers and limited entertainment or recreational activities. Further, the physical effects are those which often attract substance abusers throughout the country – initial euphoria, clouding of the conscious state, and general intoxication with pleasurable feelings. It should also be noted that petrol is easily obtainable and cheap.

Unfortunately, as noted elsewhere in these findings, consistent sniffing can also lead to seizures, agitation, disinhibition (especially sexual), cumulative nerve damage, physical abnormalities, psychological addiction and irrational and violent behaviour often leading to the use of weapons.

Whilst an accurate assessment of the number of persons actively abusing petrol is difficult to make, it is clear that it is a problem of major concern in many communities in Central Australia and in the areas of states adjoining the Northern Territory. The Police and the Courts are all too familiar with the crime associated with abuse of petrol and the social costs that flow therefrom.

Information as to numbers of petrol sniffers and the precise nature of their abuse is able to flow to Territory Health Services through health professionals in the communities. As acknowledged by Ms Korner of that organisation, however, only those petrol sniffers who present with health problems are detected in that manner. Further, the health services provided to aboriginal communities in the Central Australian area are somewhat fragmented with not all services provided by the Northern Territory Government. This creates difficulties in enforcing requests for information and also in ensuring that a consistent approach is applied to such intelligence gathering.

It is clear, however, that the abuse of petrol in the communities of Central Australia is rife and there is no indication that the problem is abating.

Co-ordination of Effort

The problem of petrol sniffers is not one that is neatly confined by state boundaries. On the evidence it is clear that the problem extends throughout the Central Australian region with participants wandering from place to place and often crossing state and territory borders.

The problem of petrol sniffing is not new and various attempts have been made over the years to address the problem. These attempts have been fragmented as between governments and government and non-government agencies. Attempts to address the problem have often been concluded as a result of either shortage of funding or a perception, either rightly or wrongly held, that the problem in a particular area has abated.

Other evidence in the inquest confirmed that there has been little sharing of information or co-ordination as between the various organizations and establishments with an interest or involvement in the area.

Ms Korner from Territory Health Services gave evidence of her concern that the method of delivery of health services to aboriginal communities even within the Northern Territory resulted in a fragmentation of resources and information. Imampa Community was one cited by her as having a significant number of petrol sniffers. That community, however, has an independent health service funded by the Commonwealth of Australia. The only involvement of Territory Health Services is by invitation and that is restricted to medical supportive services.

Other health services operated independently of Territory Health Services are those at Mutitjulu, Utopia, Ampilatwatja and the visiting medical services provided by the Central

Australian Aboriginal Congress. This fragmentation results in difficulties being encountered in the collection of data and the lack of ability for the Service to insist upon such information being provided.

Ms Korner further confirmed that there was no "blueprint" as to how programs should operate. The different communities with varying levels of success had employed various strategies. The approaches ranged from replacement of petrol supplies with Avgas, initiation of some of the younger members of the community thereby making them amenable to tribal justice, public shaming and, on occasion "flogging". (transcript page 267) Her office is asked for information about what works but there is no "blueprint".

Ms Korner also confirmed the earlier opinion of Doctor Crundall that Alice Springs is a reasonable centre for treatment of persons who are petrol sniffers and who normally live in northern South Australia, central Australia and communities in the extreme east of Western Australia (transcript p.274). Indeed it should be borne in mind that the deceased had in fact travelled north from where he had been residing in South Australia in some sort of attempt by his family to address his petrol sniffing problems.

Ms Marion Dunlop, the Assistant Secretary, Planning and Evaluation Branch in the Office of Aboriginal and Torres Strait Islander Health Services in the Commonwealth Department of Health and Family Services also gave evidence to this Inquest. She acknowledged that the problem of petrol sniffing in the Central Australia area was one that was regarded by her Department as a major issue. She further acknowledged that the issue was a cross border issue for which the Commonwealth with each of the South Australian, Western Australian and Northern Territory governments must share responsibility. (transcript p.608)

From the evidence of Ms Korner and others, it is clear that there has been no concerted effort to coordinate policies, facilities or treatment of petrol sniffers. Ms Korner referred to an administrative model used to better coordinate such efforts in other health areas. She referred specifically to a sexual health tri-state project. Pursuant to that project there is an agreement between Western Australia, South Australia, the Northern Territory and the Commonwealth to enable a team of persons in the area to operate without the restrictions and impediments which would normally follow from the limitations of state and territory borders.

It would appear from the evidence, that given the cross border issues that flow from the petrol sniffing problem, such a model could be employed in this area also. It may be that a coordinating body should be established with appropriate funding from the Commonwealth of Australia. Such a body could also establish a repository of knowledge and lessons learned and also act to disseminate such knowledge to those in need of it.

Ms M. Brady highlighted the need for such a repository of information in the course of her evidence (transcript p.893). She referred to the shifting of responsibility for the problem as between Commonwealth and state and territory governments over the years. This constant shifting of ground resulted in the lack of institutional memory. She lamented the fact that there has not been any attempt by any institution or government authority to keep a definitive updated collection of materials on petrol sniffing. Except for recent efforts, there is still no solid body of updated resource material and good medical literature that has been kept up to date which can then be accessed from anywhere. The creep of the internet to the

outermost reaches of the Northern Territory could be used to good effect in ensuring that communities have good access at all times to appropriate resources.

Recommendations

After reviewing the evidence in these proceedings, it is abundantly clear that it would be well beyond the abilities and proper role of this Inquest to recommend any specific programs or methodology to address the problem of petrol sniffing in Central Australia. It is clear that many attempts have been made in the past in both the Northern Territory and elsewhere to address the problem. Such attempts have met with mixed success and usually the success which was achieved was of relatively short duration.

The factors contributing to the abuse of petrol are many and any solution or partial solution to the problem will no doubt require the contribution of many parts of the community. I do commend, however, Exhibit 9, the d'Abbs Report, for further consideration. Although somewhat dated now it does seem to bring together many of the considerations and options available.

As to the allocation of resources, it would not be appropriate for this Inquest to intrude upon the province of government. It is for the government to allocate scarce resources where it sees fit after taking into account considerations outside the purview of this inquiry.

Nevertheless, there have been matters properly raised during the course of the Inquest consideration of which may assist in both safeguarding those who are most vulnerable and in addressing the future direction of consideration of the problem.

It is Recommended:

1. That steps be taken to ensure that all Death Certificates and Autopsy Reports reflect any connection of a death with the abuse of petrol or other inhalant.

2. That an adequately funded consultative body be established to:

(a) investigate and recommend appropriate means for better preventing the resort to inhalant abuse by those at risk;

(b) investigate and recommend treatment and rehabilitation options for those already suffering from inhalant abuse; and

(c) consider and recommend appropriate legislative change to better assist law enforcement officers and others in addressing the behaviours of those suffering the effects of petrol abuse and of those who assist in the provision of petrol to such abusers.

3. That facilities be established and maintained for the safe detoxification and/or rehabilitation of petrol sniffers. Whether those facilities are located in Alice Springs or in more remote locations, persons should not be admitted unless and until:

(a) each person has been medically examined and assessed as suitable by appropriately qualified personnel;

(b) such establishment has adequate facilities by way of communications and first aid;

(c) such establishment is operated only in circumstances where at all times those present and operating the facility have appropriate first aid qualifications; and

(d) such facility has a program or methodology approved by Territory Health Services or other suitable organization for assisting those for whom they care.

4. That if outstations such as Ilpurla are to continue to be used as places of rehabilitation or respite then it is necessary for such establishments to be regulated.

(a) The "program" or treatment of those sent there must be subject to review and control so that those in a vulnerable position are protected;

(b) In order to operate as places of rehabilitation or respite, they must have appropriate medical safeguards and other services such as communications facilities; and

(c) Before entry to such outstation, each person so admitted should be medically examined.

4. That Northern Territory Health Services monitor and assist petrol sniffers after they return to their communities from any detoxification or rehabilitation facility. Appropriate ongoing care should be provided.

5. That, in consultation with the Commonwealth Government a tripartite strategy be developed by the Northern Territory, South Australia and Western Australia to address the problem of petrol sniffing in Central Australia. Such strategy should include:

(a) a uniform approach to the collection and dissemination of statistical information concerning the extent of the problem and the movement of the problem as between Central Australian Communities; and

(b) the collection and dissemination of research materials and other information for use by those involved in the treatment and rehabilitation of petrol sniffers and in formulating preventive strategies.

(c) The efficient and co-ordinated use of resources available regardless of the physical location of that resource or of the inhalant abuser.

6. That the Commonwealth Government establish and fund rehabilitation facilities for chronic petrol sniffers in Alice Springs. Those facilities should be such as to be able to act as a repository for information and research, and should also be considered for training workers who can then work in communities where petrol sniffing is prevalent. The residential facility known as CAAPS in Darwin may provide an appropriate model and such facilities should be designed to provide the services referred to for persons resident in the Central Australia regions of South Australia, Western Australia and the Northern Territory.

GIVEN under my hand this 2nd day of September 1998 at ALICE SPRINGS.

W. L. DONALD

CORONER