CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Lasonya Sheree Dutton
Hearing dates:	10 – 14 February 2025 Wilcannia Courthouse 24 October 2025 State Coroners Court 11 – 12 December 2025 Broken Hill Courthouse
Date of Findings:	10 November 2026
Place of Findings:	Broken Hill Courthouse, Broken Hill, NSW
Findings of:	Judge Teresa O'Sullivan, State Coroner of NSW
Catchwords:	CORONIAL LAW – First Nations Death – police investigation – Barkindji woman – intimate partner violence – suicide or homicide – adequacy of support services in Wilcannia – grief, loss and healing
File number:	2022/91077
Representation:	Counsel Assisting the Coroner: Ms Kirsten Edwards SC and Ms Rebecca McMahon, instructed by Ms Bronwyn Lorenc and Ms Camilla Blome, Crown Solicitor's Office Commissioner of the NSW Police Force: Mr Anders Mykkeltvedt, instructed by Ms Lisa Lewis and Mr Craig Norman, Office of the General Counsel Detective Senior Constable Madeleine Fleming: Mr William Bruffey, instructed by Mr Dominic Longhurst, Longhurst and Associates Inspector Matthew McCarthy: Mr Darien Nagle, instructed by Mr David Kennedy, David Kennedy and Associates Inspector Thomas Aylett: Mr Robert Deppeler, instructed by Mr Michael Jaloussis, McNally Jones Staff Lawyers Far West Local Health District: Mr Jake Harris, instructed by Mr Marcus Anderson, Hicksons Lawyers

	Maari Ma Aboriginal Health Corporation: Dr Peggy Dwyer SC, instructed by Ms Judith Alderson, Avant Legal Keith Dutton Senior: Mr Josh Brock, instructed by Ms Danielle Captain-Webb, Legal Aid NSW Glenn Wilson: Mr Jonathan Cooper and Mr Paul Crean, instructed by Nadia Karim, Karim and Nicol Lawyers
Non-publication orders:	The Court has made orders for non-publication of certain evidence, pursuant to section 74 of the Coroners Act 2009. Details of these orders can be obtained upon request from the Registry.
Findings:	***Identity of the deceased*** The person who has died was Lasonya Sheree Dutton ***Date of death*** Lasonya died between 26 and 29 March 2022 ***Place of death*** Lasonya died in Wilcannia, NSW ***Cause and manner of death*** The available evidence does not enable me to make a finding as to the cause and manner of Lasonya's death.
Recommendations:	**To the Commissioner of the NSW Police Force** 1. The NSW Police Force is to review supervision and support processes at Barrier Police District, including the Officer in Charge (OIC) allocation processes, taking into account the issues raised in Detective Senior Constable Fleming's evidence and her suggestions for improvements to practice, including: a. officers having regular rostered days in Wilcannia; b. the need for ongoing and structured case review to support officers;

	c. ensuring that an officer who is allocated as the OIC of an investigation receives adequate support and guidance from a senior officer at the time of allocation including a clear briefing in relation to the status of the matter and any further investigative priorities that need to be attended to; d. that there is appropriate oversight of an investigation by a senior officer in instances where the OIC goes on a period of leave; and e. implementing a higher level of culturally sensitive support, assistance and training within the Barrier Police District. All changes which are currently not in place to support the supervision of junior officers at Barrier Police District should be implemented. This review should also assess the effectiveness of processes recently implemented, including those described by Detective Inspector Thomas Aylett in the inquest and outlined at [192] in these findings. 2. The NSW Police Force is to undertake a review of the strengths of the second homicide investigation and consider how the approach by the Homicide Squad, led by Detective Chief Inspector Paul Smith, could be implemented into core police training for police who are working in regional and remote communities or those who may work in such communities. In particular, consideration should be given to including elements of the approach in the immersive, place-based training led by Inspector Jayde Symons the Manager of

	Aboriginal Strategy & Coordination Team, Crime Prevention Command, NSW Police Force. 3. The NSW Police Force is to: a. undertake a review of the information provided to regional and remote police officers about the support offered by the Homicide Squad in relation to deaths which occur in those areas; and b. strengthen regional and remote police officers' knowledge and understanding of the expertise and assistance provided by the Homicide Squad, where necessary. As part of this recommendation, the following features should be emphasised: i. The 24 hour a day, 7 days a week statewide 'on-call' response provided by the Homicide Squad; ii. The availability of the Homicide Squad to provide specialist advice and investigative support to regional and remote police officers in homicide and coronial matters; and iii. The availability of a 'Homicide Review' service to provide an accountable process to review a current suspicious death investigation and provide independent advice to assist investigators.

	To the Commissioner of the NSW Police Force, Far West Local Health District, Maari Ma Health Aboriginal Corporation and Wilcannia Safehouse 4. The services are to arrange a meeting with the Wilcannia Community Working Party (WCWP), and any other member(s) of the Wilcannia community nominated to express community views, within 12 months, to: a. Explore the possibility of creating and funding an Aboriginal counsellor role or roles. As part of this process, consideration should be given to supporting local community members to train and upskill to provide social and emotional wellbeing or counselling services in Wilcannia; b. Discuss Dr Hovane's recommendations and the 'community hub' proposal and consider how those recommendations may be progressed in the community; c. Discuss the development of a service directory and, in consultation with Wilcannia community members, develop a service directory that can be made available to services and community members in a variety of different ways to enhance the accessibility of the resource; d. Consider mechanisms to enhance their engagement with the Wilcannia community (including the WCWP) including: i. providing structured and transparent opportunities for community members to express their concerns and ideas about potential solutions;

	ii. illustrate to the community how those concerns have been listened to; and iii. how to support efforts by the WCWP executive to advocate for measures to strengthen the WCWP. Far West Local Health District is to be the lead agency responsible for organising this meeting. **To Maari Ma Health Aboriginal Corporation** 5. That Maari Ma work with the Wilcannia community to revitalise the Healing Headstones program and support its delivery, including by assisting with any suitable funding applications.

Table of Contents

Introduction 8
Purpose of an inquest and the role of the Coroner 8
The inquest proceedings 9
Issues at Inquest 11
    Evidence by Community Services 12
    Expert evidence of Dr Victoria Hovane 12
    The Wilcannia Community 13
Sonya's life 13
Wilcannia 15
    Monica Kerwin 17
    Brendon Adams 17
Sonya's Movements 18
    Trip to Adelaide and return to Wilcannia 19
    Thursday 24 March 2022 19
    Friday 25 March 2022 19
    Saturday 26 March 2022 20
    Weekend of 27 and 28 March 2022 21
    Tuesday 29 March 2022 22
ISSUE 1: The statutory findings required under s 81 of the Act 23
    Findings as to identity, date and place 23
    Cause and manner of Sonya's death 23
Evidence referring to self-harm 24
Crime Scene Examination 24
    Was Sonya's death as a result of suicide? 39
    Was Sonya's death as a result of homicide? 40
    Findings as to cause of death 41
ISSUE 2: The adequacy of the initial police investigation and subsequent investigation 42
The police response 42
Briefing at Wilcannia Police Station 42
    Submissions on the first police investigation 53
    Second Homicide Squad Investigation 58
    Police training and ACLOs 59
ISSUE 3: The adequacy of mental health and domestic violence services in Wilcannia, including culturally safe services 61
    Adequacy of service delivery 62
    Aboriginal counsellors based in Wilcannia 65
    Local community programs and Wilcannia Working Party (WCWP) 66
    Service gaps and community hub proposal 69
    Features of service design and delivery 72
ISSUE 4: Whether any recommendations are necessary or desirable in connection with Sonya's death 75
Statutory Findings required by s 81(1) 83
Conclusion 83

Introduction

1. These are findings in relation to the death of Lasonya Sheree Dutton, known to her friends and family as Sonya.

2. Sonya was a proud Barkindji woman. Sonya had two children, Hayley Dutton-Parke (Hayley) and Keith Dutton-Parke (Baby Keith). Sonya was a cherished mother, daughter, granddaughter, sister, cousin and friend. She was born in Broken Hill but lived in Wilcannia her whole life. Sonya was the daughter of Keith Dutton Snr (Keith Snr) and Annette-Marie Johnson. Sonya's mother passed away in 2011. She had two brothers, Keith Dutton Jnr and Kieran Dutton.

3. Tragically, Sonya was located deceased in the backyard of 8-10 Hood Street, Wilcannia on Tuesday 29 March 2022. Sonya was living in this home at the time with her grandmother and step-grandfather. Sonya was 31 years old.

4. I express my condolences to Sonya's family and loved ones.

5. At the outset, I want to acknowledge the passing of Sheena Dutton and Norma Dutton who died after the inquest was heard in Wilcannia. I offer my sincere and respectful condolences to the Wilcannia community for the profound loss of three generations of Barkindji women and the grief you are living with.

Purpose of an inquest and the role of the Coroner

6. Coronial proceedings are an inquisitorial exercise in fact finding, that is, an investigation aimed at discovering the truth, to the extent possible.

7. The inquest hearing is a public examination of the circumstances of Sonya's death. My primary function – as the Coroner presiding – was to explore the circumstances in which Sonya's death occurred, with a view to making specific findings of fact as specified in s 81 of the *Coroners Act 2009* (NSW) (the Act), as to:

    a. The person's identity;

    b. The date and place of the person's death;

    c. The manner and cause of the person's death.

8. Pursuant to s 27(1) of the Act, an inquest is required to be held in certain circumstances including, relevantly if it appears to the coroner concerned that:

a. the person died or might have died as a result of homicide (not including suicide); or

b. the person's identity and the date and place of the person's death have not been sufficiently disclosed; or

c. that the manner and cause of the person's death have not been sufficiently disclosed.

9. This inquest was held pursuant to s 27(1)(a) of the Act in circumstances where the investigation into Sonya's death revealed allegations of intimate-partner violence, and gaps in the evidence of the original investigation which gave rise to a suspicion that Sonya might have died as a result of homicide. This required further investigation as outlined in these findings.

10. Further, a Coroner has the power to make recommendations under s 82 of the Act where it is considered necessary or desirable to do so in relation to any matter connected with the person's death which is the subject of the inquest.

11. Coroners can make recommendations directed at opportunities for systemic improvement including as to matters of public health or safety or with respect to the investigation of the death.

12. Noting this, it was important to consider the surrounding context of Sonya's death, including the community of Wilcannia where she had spent most of her life. Sonya had interacted with several services in Wilcannia in the lead up to her death and the availability and suitability of those services was an important issue to consider and a matter that I will return to later in these findings.

The inquest proceedings

13. The inquest hearing into Sonya's death was held over eight hearing days. The first tranche was conducted from 10 – 14 February 2025 at Wilcannia Courthouse. During this tranche of the hearing, several witnesses were called with respect to the police investigation into Sonya's death which I will refer to in greater detail below.

14. Prior to the commencement of the hearing, a smoking ceremony was conducted on the bank of the Darling River across the road from the Wilcannia Courthouse. This ceremony was led by Keith Snr. I am grateful to Keith Snr for leading this ceremony.

15. During the first tranche of the hearing at Wilcannia Courthouse, the Wilcannia Community Hall was also used to provide Sonya's family, friends and members of the community with the choice of watching the hearing via a live stream without having to attend the courthouse. This option proved to be a supportive environment. Community members were able to attend with young

children, share meals together and talk to each other about the evidence.

16. On 10 February 2025, a view was conducted at 8-10 Hood Street, the location where Sonya was found. The process of that view was described during the inquest:[1]

> *Yesterday when Court adjourned, of course, your Honour, along with your assisting team, Mr Brock and Ms Captain-Webb, Detective Surplus and Chew, we went on a view to 8-10 Hood Street, Mr Keith Dutton Senior was present, as was Ms Norma Dutton. There were also a number of other family members who were present at the home. Whilst we were at Ms Dutton's home, Keith Dutton Senior pointed out the kitchen window near the sink to your Honour, which looks out to where Sonya's memorial now stands, which of course [was] where her body was located.*
>
> *The group then went outside and we stood for some time by Sonya's memorial, and whilst we were there, Detective Chew showed your Honour where the fence post once stood, which Detective Chew referred to in his evidence as A, which is on exhibit 2. And your Honour saw, of course, that fence post no longer stands in that location. Whilst in the backyard area, Keith Dutton Senior pointed out Ingrid Bugmy's house to your Honour, and also the outside window of the bedroom where Sonya slept when she was with us at 8-10 Hood Street. Your Honour was also shown the location of the property, which corresponded to the blue and red lines, which appear on exhibit 2, relating to the paths taken by Benita Kennedy and also by Paul Murray and Doris Mills. Your Honour, that was the completion of the view.*

17. The second tranche of the inquest occurred in the latter part of 2025; a single hearing day on 24 October 2025 held at the State Coroners Court in Sydney and two further hearing days from 11 – 12 December 2025 at Broken Hill Courthouse. On both occasions, the Wilcannia Community Hall was used to allow members of the community to watch the proceedings via live stream.

18. During the inquest, the Court had the privilege of hearing from Sonya's loved ones, Keith Snr, Hayley and Baby Keith. Baby Keith wrote a letter to his mum which Keith Snr read to the court. Hayley prepared a slideshow of photos of her mum accompanied by a pre-recorded song which she wrote and sang. Baby Keith and Hayley's contributions to the inquest were heartfelt and showed their deep love and connection to their mum.

19. On the final hearing day, Keith Snr provided a moving family statement about his Sonya. I am very grateful for the time and care which Keith took in preparing that statement and for his generosity in sharing this letter with the Court and the community.

[1] Transcript Day 2, 11.2.25, T74.39-75.8.

Issues at Inquest

20. As is the usual practice, an issues list was distributed to the parties in advance of the commencement of the inquest to provide structure to the proceedings.

21. The issues that were the focus of the inquest hearing were as follows:

    1. What was the manner and cause of Sonya's death, in particular:

        a. was Sonya's death a result of suicide?
        b. was Sonya's death a result of homicide?
        c. if the death was a result of homicide, is there sufficient evidence to satisfy the elements of s 78 of the Coroners Act to refer known person(s) to the DPP for potential prosecution?

    2. Were the mental health and domestic violence services in Wilcannia and provided to Sonya adequate and culturally appropriate?

    3. Were there deficiencies in the initial police response and subsequent investigation? If there were deficiencies, what caused or contributed to that? If there were improvements in the subsequent investigation, what were they?

    4. Whether any recommendations are necessary or desirable, including examination of whether the mental health services and family and domestic violence services in Wilcannia are currently adequate and culturally appropriate and safe.

22. A brief of evidence comprised of 11 volumes of material (Exhibits 1 and 3) was tendered, containing evidence compiled by the police and material obtained by those assisting me. Further additional material was tendered throughout the course of the hearing (Exhibits 2, 4-7).

23. A schedule identifying the witnesses that gave oral evidence at the inquest, their role and title is outlined at **Annexure A**.

Evidence by Community Services

24. An important part of the inquest into Sonya's death was the evidence given by representatives of community services which support the Wilcannia community. The evidence was given in the form of a roundtable discussion.

25. The inquest heard from the following witnesses who participated in this roundtable on 11 December 2025 during the second tranche of the hearing:

    a. Mary Ronayne – Community and Culture Manager, Domestic Violence Service Management, Wilcannia Safehouse;

    b. Richard Weston – Chief Executive Officer, Maari Ma Aboriginal Health Corporation;

    c. Inspector Jayde Symons – Gadigal and Buronga woman – Aboriginal Strategy & Coordination Team, Crime Prevention Command, NSW Police Force;

    d. Denise Jack – Director Mental Health Drug and Alcohol Violence and Neglect Services, Far West Local Health District; and,

    e. Dr Shannon Nott – Executive General Manager Health & Clinical Services; and Chief Medical Officer, Royal Flying Doctor Service South Eastern Section.

26. A lot was learned from listening to the witnesses during the inquest into Sonya's death. The evidence given by witnesses, in particular, representatives of services and organisations providing support to the Wilcannia community, has provided a basis to make recommendations aimed at ensuring the health and safety of the Wilcannia community and preventing a similar tragedy occurring in the future.

Expert evidence of Dr Victoria Hovane

27. In addition to the valuable evidence provided by the representatives of community services referred to above, an expert report was requested from Dr Victoria Hovane, a Ngarluma, Jaru, Gooniyandi Psychologist. Dr Hovane travelled from Western Australia to give evidence at the inquest. As part of the preparation of her report, Dr Hovane visited Wilcannia. Dr Hovane explained in her evidence how important it was to spend time on Barkindji Country in the preparation of her report. During the second tranche of the hearing, Dr Hovane travelled to Wilcannia and spent time at the community hall, where members of the Wilcannia community were watching the inquest.

28. Dr Hovane's expert report identified service gaps in Wilcannia and recommendations for how those gaps could be addressed in a culturally appropriate way and I will refer to her evidence

throughout these findings.

The Wilcannia Community

29. At the outset, it is important to acknowledge the significant impact that Sonya's death had on those who loved her, and on the wider Wilcannia community. I echo the submission of counsel assisting in expressing my gratitude to the members of the Wilcannia community who met with the team assisting, who engaged in interviews and provided statements, attended to give evidence, and who participated or watched the inquest proceedings.

30. This extensive community engagement would also not have been possible without the work of Nicolle Lowe, who during the inquest provided ongoing extensive support to the Wilcannia community in her role as an Aboriginal Coronial Information Support (ACISP) officer. I concur with the submission of counsel assisting that Ms Lowe's advice and assistance in this matter has been absolutely invaluable.

31. I also acknowledge the assistance provided by the legal parties to this inquest and note that for non-contentious matters these findings draw on the extensive and detailed submissions of Counsel Assisting.

Sonya's life

32. Sonya was born on 17 May 1990 in Broken Hill to Annette-Maree Johnson and Keith Snr. Sonya has an older sibling from this relationship, Keith Thomas Dutton (Keith Junior). The relationship between Keith Snr and Ms Johnson ended shortly after Sonya was born in 1990.

33. After Sonya's parents separated, Sonya and Keith Junior were placed in the care of their paternal grandmother, Norma Dutton and her partner Trevor Jones who was also known as Poppa Footer. They resided at 8-10 Hood Street, Wilcannia. Sonya grew up and lived in Wilcannia for almost all of her life within an extensive family and kinship system. Sonya was well liked in the Wilcannia community. She had a lot of friends and made friendships easily.

34. On 9 October 2011, Sonya gave birth to her first child, Hayley. At this time, she was residing in Reynella, South Australia, with Hayley's father, Nathan Parke.

35. On 29 May 2013, Sonya gave birth to her second child, Baby Keith, in Broken Hill. It is not known when Sonya and Mr Parke's relationship ended. Sonya's daughter, Hayley, remained in Adelaide with Mr Parke and her paternal grandparents. Around this time, Hayley's paternal grandmother, Janelle Evans, sought, and was granted, custody of Hayley. At some point, Sonya and Baby Keith returned to live in Wilcannia.

36. In late 2021, Sonya commenced a relationship with Glenn (Kermit) Wilson (**Mr Wilson**).

37. According to Keith Snr, Sonya was greatly affected by losing custody of Hayley. After this, she reportedly began to drink more heavily and on a daily basis, often from the time she woke up until she fell asleep. Over the following years, Sonya reportedly remained her happy-go-lucky self in her day-to-day manner, but losing custody of Hayley appeared to continue to affect her and she continued to drink daily.

38. Sonya was deeply impacted by a number of deaths of family members and close friends throughout her life, which are summarised as follows:

- On 25 January 2007, Sonya's nephews Liam Dutton and Damien Hall, died from suffocation after accidentally being locked in the boot of a car. Liam was 3 years of age and Damien 4 years of age when they died.
- On 18 February 2011, Sonya's mother died.
- On 25 August 2014, Jeffrey Kirby, the ex-defacto of Raelene Hunter and close friend to Sonya, died from a heart attack, aged 32 years.
- In 2016, William ('Winkas') Kennedy, the son of Loretta Dutton and cousin to Sonya, who she considered to be like a brother, died by suicide, by hanging, aged 26 years.
- In April 2018, Loretta Dutton, Sonya's aunt and a motherly figure, died suddenly, aged 52 years.
- On 20 April 2020, Crystal Kennedy, daughter of Loretta Dutton and cousin to Sonya, who she considered to be like a sister, died after she was hit by a motor vehicle.
- In 2019, Sonya's son, Keith, had a motorbike accident and spent three months in hospital, resulting in his foot being amputated.
- On 29 July 2021, Kahlia Blair, the daughter of Owen Whyman and a friend of Sonya, died by suicide, by hanging.
- On 19 November 2021, Mark Whyman, son of Monica Whyman and a friend of Sonya, died by suicide, by hanging, aged 34 years.
- On 20 March 2022, Rene Johnson, a cousin to Sonya, died by suicide, by hanging, aged 17 years.

39. Sonya had 204 recorded incidents requiring police involvement throughout her life, including incidents relating to domestic violence, mental health and traffic matters. At the time of her death, she was listed as the person in need of protection on several current apprehended violence orders (AVOs), with the defendants variously listed as Mr Wilson, Sheena Dutton and Benita Kennedy.

40. In relation to Sonya's mental health conditions, Dr Hovane provided important context:[2]

> *From a holistic, whole of life Aboriginal perspective Lasonya's functioning throughout her life must be understood in an intersectional context, beginning with the context of colonisation, dispossession and displacement of her people; her birth and exposure to ongoing state or structural violence, and racism and systemic discrimination that operate to marginalise Aboriginal people living in remote locations like Wilcannia*.

Interactions with services in the period prior to Sonya's death

41. The evidence at the inquest demonstrated that Sonya experienced mental health concerns and domestic violence. Sonya also suffered the loss of many people who she loved dearly and carried the trauma of deep grief and loss.

42. The evidence indicated that in the year prior to her death, Sonya had several periods of reported suicidal ideation or suicide attempts and several admissions to hospital. The evidence in this regard was outlined by Dr Hovane in her report.

43. Dr Hovane's review of the health records identified that Sonya's history of mental health issues included five separate reported mental health incidents between February 2009 and October 2021 and on at least two occasions, she was scheduled under the *Mental Health Act (2007)* NSW. During these incidents, Sonya was intoxicated and appeared to be distressed, making threats to kill herself. During some of those incidents Sonya disclosed she attempted self-harm including by wrapping things around her neck including a video tape, bra and a medical mask.

44. A summary of Sonya's interactions with local health and mental health services is outlined at **Annexure B**.

Wilcannia

45. Prior to considering the period leading up to the tragic discovery of Sonya, it is important to closely consider Wilcannia, the place where she had spent most of her life. Sonya's experiences and access to support must be considered within the context of the availability of services within the community in which she lived.

46. The Wilcannia Community Working Party (**WCWP**) 2019 Community Action plan sets out important information about Wilcannia: [3]

[2] Exhibit 1, Volume 1A, Tab 7, Expert report of Dr Victoria Hovane at [60], p 17.
[3] Exhibit 1, Volume 1B, Tab 64B, Statement of Monica Kerwin, Annexure B, Wilcannia Community Working Party Community Action Plan, p.20 – 22.

HISTORY

The traditional owners of Wilcannia are the Barkindji river people. Wilcannia is in the heart of the Central Darling Shire and is surrounded by some of the most significant known sites of Aboriginal occupation in Australia. These sites include some finds relating to Aboriginal culture and heritage that are of national importance. In June 2015, the High Court of Australia handed down a declaration recognising the Barkandji Native Titles Rights. Around the same time, Steamer's Point on the Darling River was declared a significant Aboriginal Place.

LOCATION

Wilcannia is situated in Far Western New South Wales on banks of the Darling River. Located in the Central Darling Shire, Wilcannia is approximately 200kms from Broken Hill and 260kms from Cobar. The Paroo Darling National Park is 120 kms to the north. During the summer months it is not unusual for temperatures in Wilcannia to reach over 35°C, while the average minimum temperature in winter is 4°C. Wilcannia's average annual rainfall is 264.8mm.

47. Dr Victoria Hovane's expert report provided information about the history of Wilcannia including colonisation, displacement, reserves, mission and Stolen Generations.

48. Dr Hovane states that as a result of this history, Aboriginal People have expressed similar experiences to those reported during the Royal Commission into Aboriginal Deaths in Custody including an overwhelming sense of being constantly monitored and surveilled by police, which causes unnecessary stress to people already experiencing crushing poverty, disadvantage and stress. In her report, Dr Hovane detailed the impact of unresolved intergenerational trauma and its adverse impacts on Aboriginal and Torres Strait Islander social and emotional wellbeing.

49. The inquest was fortunate to hear from Wilcannia community members about the strength of culture, community, and relationships within Wilcannia. One community member reflected that Wilcannia is a "little family community… we all know one another, all look out for one another."[4]

50. It was identified that the Wilcannia community would benefit greatly from investment and improvements in health, housing, employment and education.[5] Dr Hovane agreed that these four priorities are "foundational to preventing downstream issues such as the removal of

[4] Transcript Day 4, 13.2.25, T250.36-37.
[5] Transcript Day 5, 14.2.25, T292.45-49; Exhibit 1, Volume 1B, Tab 64B, Statement of Monica Kerwin, [12] – [13].

children into state care and juvenile justice, and health and wellbeing issues.... working at an individual level only, reflects a band-aid approach to addressing the complex needs of local community members".[6]

51. There is also a clear need to build the capacity of Aboriginal controlled organisations and community members to deliver services, including mental health services, family violence support and grief, loss and trauma counselling services. Such services would offer critical support to a person experiencing the vulnerabilities which Sonya lived with.

Monica Kerwin

52. The inquest was fortunate to hear evidence from Monica Kerwin, a highly respected member of the Wilcannia community who was born and raised in Wilcannia. Ms Kerwin has held many roles in Wilcannia including as a former Chair of the WCWP, which is a volunteer role. Ms Kerwin was involved in the development of the WCWP Community Action Plan, referred to above.

53. Ms Kerwin is currently employed as a consultant with Yilabara, which is an Aboriginal organisation that delivers a range of Aboriginal employment, consulting and training services. Yilabara has been operating in Wilcannia since October 2024 to help local members of the community upskill and find employment opportunities.

54. Ms Kerwin gave oral evidence focusing on her experience and opinions in relation to the support services available in Wilcannia. Ms Kerwin reflected on how her community came together during the COVID-19 pandemic, and that this was one of Wilcannia's biggest strengths. Ms Kerwin emphasised, as noted by the WCWP, that the Wilcannia community would benefit greatly from investment and improvements in health, housing, employment and education.[7]

55. The Wilcannia community needs assistance to support its members in times of grief and loss and to heal. Ms Kerwin led the Healing Headstones program which is a grassroots community project which involves teaching community members to make a ceramic mosaic headstones for their deceased loved ones.[8] I will return to the Healing Headstones Program later in these findings.

Brendon Adams

56. The inquest also heard evidence from Brendon Adams, the local Aboriginal Community Liaison Officer (ACLO) in Wilcannia, working alongside fellow ACLO, Ike Williams.

[6] Exhibit 1, Volume 1A, Tab 7, Expert report of Dr Victoria Hovane at [1113], p.3.
[7] Tab 64B, Statement of Monica Kerwin, [12] – [13].
[8] Exhibit 1, Volume 1B, Tab 64B, Statement of Monica Kerwin, [24], [43].

57. Mr Adams and Mr Williams have dedicated significant time and effort to developing and delivering support programs to the Wilcannia community. For example, Mr Adams spoke about the Men's Hub and 'Brothers by the Baaka', an initiative which they started involving a support group centred around the Baaka (Darling River) to assist men struggling with experiences of incarceration.

58. Mr Adams has been in Wilcannia for 23 years and made an important point regarding service delivery in Wilcannia, which all the community service representatives later agreed with at the inquest, that:

> *Wilcannia has its own local ways and local solutions on how services need to be delivered and designed and that's the most important thing because it's about ownership, it's about self-determination and it's about how our... community [grows and improves] and become a better place for our youth*.

59. Mr Adams and Mr Williams created an image representing a "community hub" which represents a response to the support service needs of the Wilcannia community. I will refer to this hub later in these findings when discussing the evidence of Dr Hovane, however, it is notable that this model has been created with a close eye on the specific needs of Wilcannia.

60. Mr Adams expressed that it is important that the hub include culture, as that is central to identity,[9] and should be flexible so that people can just walk in when they are ready.[10]

61. A diagram of the Wilcannia community hub was tendered in evidence at the inquest and is replicated at **Annexure C**.

Sonya's Movements

The days leading up to 26 March 2022 and 26-29 March 2022

62. To consider the evidence regarding the cause and manner of Sonya's death, it is necessary to outline the evidence regarding her movements in the lead up to 29 March 2022 when she was discovered deceased in the backyard of 8-10 Hood Street, Wilcannia.

63. It is acknowledged that the description of how Sonya was found on 29 March 2022 may be distressing to read, in particular for Sonya's family and loved ones, however it is necessary to accurately outline this evidence given the statutory findings that I am required to make and the issues for consideration in the inquest regarding Sonya's manner of death.

[9] Transcript, Day 4, 13.2.25, T261.20.
[10] Transcript, Day 4, 13.2.25, T262.45.

Trip to Adelaide and return to Wilcannia

64. On 11 March 2022, Sonya travelled to Adelaide with Baby Keith to have his prosthetic leg fitted (as noted above, Baby Keith lost part of his leg in a motorcycle accident).

65. On 18 March 2022, Sonya returned to Wilcannia, assisted by Melissa Kennedy.[11]

66. On Wednesday 23 March 2022, Sonya attended Marjorie Whyman's house.[12]

Thursday 24 March 2022

67. On Thursday 24 March 2022, Sonya attended Aunty Glennis' house and spent time with her and her family playing bingo. She was 'real happy', laughing and drinking. Later that day she attended a social basketball game and was seen to be heavily intoxicated.[13] Christopher Hunter was present.[14]

68. Baby Keith said that the last time he saw his mum she was playing bingo at Aunty Glennis' place.[15] He said he went home alone to his grandparents' house and that Sonya went to Mr Wilson's house. Baby Keith later stated that he thought 'Kermit' (Mr Wilson) had killed his mother. He said this was because 'that's the last person mum was with.'[16]

69. The last time Trevor saw Sonya was in the afternoon of Thursday 24 March 2022, when she returned home to shower and said she was going to go and get cash out. Trevor said that Sonya 'seemed fine, happy and her usual self'.[17] He did not think anything of the fact that Sonya was not home after this as she often spends time at different addresses. Over the following days Baby Keith went looking for Sonya and said he had been told that his mum had gone to Cobar.[18]

Friday 25 March 2022

70. On Friday 25 March 2022 over the course of the day:

    a. Joy-Ann Williams saw Sonya at around 8:30am or 9:00am, looking for Merle Dutton.[19]

[11] Exhibit 1, Volume 1A, Tab 12, Statement of PCSC Madeline Fleming dated 6 April 2022 at [27], p 7.
[12] Exhibit 1, Volume 1A, Tab 12, Statement of PCSC Madeline Fleming dated 6 April 2022, p 32 (Transcript of interview with Marjorie Whyman).
[13] Exhibit 1, Volume 1A, Tab 12, Statement of PCSC Madeline Fleming dated 6 April 2022 at [29], pp 7-8, 30.
[14] Exhibit 1, Volume 1A, Tab 12, Statement of PCSC Madeline Fleming dated 6 April 2022, p 41 (Transcript of interview with Christopher Hunter).
[15] Exhibit 1, Volume 1A, Tab 9, Transcript of BWV interview with Keith 'Baby' Dutton, p 4.
[16] Exhibit 1, Volume 1A, Tab 9, Transcript of BWV interview with Keith 'Baby' Dutton, p 8.
[17] Exhibit 1, Volume 1A, Tab 11, Statement of Trevor Jones at [12], p 2.
[18] Exhibit 1, Volume 1A, Tab 11, Statement of Trevor Jones at [13], p 4.
[19] Exhibit 1, Volume 1A, Tab 12, Statement of PCSC Madeline Fleming dated 6 April 2022, p 22 (Transcript of interview with Joy-Ann Williams).

b. Glen Williams saw Sonya at about 9am or 10am, walking through'. This is the last time he claims to have seen her. She drove past him and gave him 'a big wave'.[20]

c. Ike Williams (ACLO) saw Sonya at 27 Barkindji Drive at about 3:50pm. Sonya asked Mr Williams to drive her and Ariah Dutton to get some cigarettes. Sonya did not have enough money to buy cigarettes and asked to be driven back to Barkindji Drive, where family members refused to give her money. She asked to be taken to her Uncle Merles' House who also refused to give her money. Mr Williams then drove her to Joyce Hunter's house at Barkindji Drive. Ike Williams saw Sonya at about 5:00pm, drinking with Tina Hunter, Johnathon (JoJo) Whyman and Stephen Harris. Sonya gave Mr Williams her bank card and requested that he hold onto it until Sunday so that she didn't lose it.[21]

d. Joyce Hunter, Tina Hunter, Johnathon (JoJo) Whyman and Stephen Harris all drank with Sonya at Joyce Hunter's House at Barkindji Drive in the evening.[22]

e. Tina Hunter said that Ms Dutton was happy and 'the same how she always was'.[23]

71. At a different location, Christopher Hunter said that there were drinks at which Melissa Kennedy, Sheree Hartnett, Ronald Wilson and Glen Williams were present, but Sonya did not attend.[24]

Saturday 26 March 2022

72. On Saturday 26 March 2022, Dale Harris saw Sonya at 1:40am walking past the water tanks towards 8-10 Hood Street. She was walking side to side and seemed to have her head down in a sad manner. She was holding her head, and he asked her where she was going "and she said like, she couldn't talk and she said, over nan's."[25] Dale reported that about 5 minutes before this, he saw Glen at the same location with something resembling a little speaker on his shoulder. Dale asked Glen where he was going and Glen said, "down to where he live."[26]

---

[20] Exhibit 1, Volume 1A, Tab 12, Statement of PCSC Madeline Fleming dated 6 April 2022, p 37 (Transcript of interview with Glen Williams).
[21] Exhibit 1, Volume 1A, Tab 12, Statement of PCSC Madeline Fleming dated 6 April 2022 at [30], p 8.
[22] Exhibit 1, Volume 1A, Tab 12, Statement of PCSC Madeline Fleming dated 6 April 2022 at [30], p 8.
[23] Exhibit 1, Volume 1A, Tab 12, Statement of PCSC Madeline Fleming dated 6 April 2022 at [30], p 8.
[24] Exhibit 1, Volume 1A, Tab 12, Statement of PCSC Madeline Fleming dated 6 April 2022, p 42 (Transcript of interview with Christopher Hunter).
[25] Exhibit 1, Volume 1A, Tab 12, Statement of PCSC Madeline Fleming dated 6 April 2022, p 47 (Transcript of interview with Dale Harris).
[26] Exhibit 1, Volume 1A, Tab 12, Statement of PCSC Madeline Fleming dated 6 April 2022, p 49 (Transcript of interview with Dale Harris); Exhibit 1, Volume 2, Tab 70, Transcript of interview with Dale Harris, p.4, Q.33.

73. At about 4:00am, Call Charge Records (CCRs) show that a phone number believed to be used by Sonya was used to send a Multimedia Messaging Service (MMS) message to Glen. The status of the call says, "MMS delete" and there is no data associated with it.

74. Later that morning, Sonya was seen with Raelene Hunter at her place at Coolabah Creek. Raelene and Steve Harris attended the river near West Tilpa Road with Sonya at around 3:00pm or 4:00pm.

75. Sonya was drinking Victoria Bitter beer. Raelene said she believed that after the river Sonya went to Joy and Jarrod Katters, and that 'she must have walked from there and then she must have went home'.[27] Raelene also said that Sonya 'was happy but like, when she's... she gets a bit drunk and she sort of like fall over and things you know? But she was good'.[28]

76. Steve Harris did not remember much about Sonya on this date because it was his birthday and he was "pretty intoxicated".[29]

77. JoJo Whyman saw Sonya earlier and said that she was "great". He said that he was not at the river, but that Sonya went to the river with "Raelene Hunter, Jarrod Cattermole, Julie and Steve."[30]

78. Joy-Ann Williams said that Sonya went to her address after going to the river.[31] She said that this did not occur late, and that it was usual for Sonya to go to her home. She could not recall the time that Sonya left.

79. Ariah Dutton went to 8-10 Hood Street to use the bathroom at about 5:00pm. She saw Sonya lying on the couch. Ariah used the bathroom, but when she returned Sonya was no longer there.[32] She waited for baby Keith to arrive at the address. Keith arrived and then walked to Glen's residence to play X-Box. Ariah was the last known person to see Sonya.

Weekend of 27 and 28 March 2022

80. Norma and Trevor said they stayed home over the weekend of the 27 and 28 March 2022, they

[27] Exhibit 1, Volume 1A, Tab 12, Statement of PCSC Madeline Fleming dated 6 April 2022, p 16 (Transcript of interview with Raelene Hunter).
[28] Exhibit 1, Volume 1A, Tab 12, Statement of PCSC Madeline Fleming dated 6 April 2022, p 27 (Transcript of interview with Raelene Hunter).
[29] Exhibit 1, Volume 1A, Tab 12, Statement of PCSC Madeline Fleming dated 6 April 2022, p 18 (Transcript of interview with Steven Harris).
[30] Exhibit 1, Volume 1A, Tab 12, Statement of PCSC Madeline Fleming dated 6 April 2022, p 15 (Transcript of interview with Johnathon (JoJo) Whyman).
[31] Exhibit 1, Volume 1A, Tab 13, Statement of PCSC Madeline Fleming dated 30 June 2022 at [42], p.7.
[32] Exhibit 1, Volume 1A, Tab 13, Statement of PCSC Madeline Fleming dated 6 April 2022 at [34], p.9.

did not use the backyard[33], and they did not try to contact Sonya over that weekend.[34] Norma said that Sonya mentioned to her, prior to going to Adelaide earlier in March, that she planned to go to Cobar on this weekend.[35]

81. Ingrid Bugmy gave evidence that she was on her porch when it was dark and looked across to 8-10 Hood Street and could see a person standing at a window at the back of the house.[36] She said she saw this the night before Sonya was found.

Tuesday 29 March 2022

82. On the morning of 29 March 2022, Keith Snr went to Broken Hill so that Norma could undergo dialysis.[37] Trevor went to Wilcannia for an appointment he had around 10:00am.[38]

83. At 10:20am that morning, Merle Dutton attended 8-10 Hood Street to visit relatives. He went into the backyard where he observed a dog eating what he thought was a kangaroo, but he later realised was a female body.[39]

84. Merle Dutton notified Joy Williams, who called triple 0 at about 10:23am.[40]

85. Police arrived a short time later and declared a crime scene.[41] Detective Senior Constable Madeleine Fleming (**DSC Fleming**) was among the police to initially respond from Barrier Police District (**Barrier PD**) and later became the officer in charge (**OIC**) of the investigation into the circumstances of Sonya's death.

86. DSC Fleming arrived at 8-10 Hood Street at about 12:10pm that day. She observed:[42]

> *...the deceased to be in the centre on the yard wearing a grey jumper, both legs missing and was in a state of extreme decomposition. ... I observed a black television cord wrapped around the deceased neck. We also observed several frayed noose ties (Anchor*

[33] Exhibit 1, Volume 1A, Tab 12, Statement of PCSC Madeline Fleming dated 6 April 2022, p 34 (Transcript of interview with Ariah Dutton).
[34] Exhibit 1, Volume 1A, Tab 12, Statement of PCSC Madeline Fleming dated 6 April 2022, p 27 (Transcript of interview with Norma Dutton); Exhibit 1, Volume 2, Tab 68. Transcript of BWV interview with Norma Dutton, Trevor Jones, Benia Dutton, Leatta Hunter, p.4.
[35] Exhibit 1, Volume 1A, Tab 12, Statement of PCSC Madeline Fleming dated 6 April 2022, p 28 (Transcript of interview with Norma Dutton); Exhibit 1, Volume 2, Tab 68. Transcript of BWV interview with Norma Dutton, Trevor Jones, Benia Dutton, Leatta Hunter, p.5.
[36] Transcript, Day 4, 13.2.25, T282.45.
[37] Exhibit 1, Volume 1A, Tab 8, Statement of Keith Dutton at [29], p.6.
[38] Exhibit 1, Volume 1A, Tab 8, Statement of Trevor Jones at [16], p.3.
[39] Exhibit 1, Volume 1A, Tab 12, Statement of PCSC Madeline Fleming dated 6 April 2022, pp.23-24 (Transcript of interview with Merle Dutton).
[40] Exhibit 1, Volume 1A, Tab 12, Statement of PCSC Madeline Fleming dated 6 April 2022 at [36], p.9.
[41] Exhibit 1, Volume 1A, Tab 12, Statement of PCSC Madeline Fleming dated 6 April 2022 at [36], p.9.
[42] Exhibit 1, Volume 1A, Tab 12, Statement of PCSC Madeline Fleming dated 6 April 2022 at [39]-[40], p.10.

points) on a couple of trees at the rear of the property near the back fence however these appeared to be old and were not like the cord around the deceased neck.

I could see discoloured brown grass near a corrugated iron fence in the rear yard. It seemed as though something of weight had been on this area of grass for a period of time causing a distinct outline. Near this, was also more discoloured grass near the deceased body.

ISSUE 1: The statutory findings required under s 81 of the Act

Findings as to identity, date and place

87. With respect to the findings required under section 81 of the Act, it was submitted by counsel assisting that the evidence in the brief would enable the following findings to be made which are uncontroversial:[43]

    a. Identity: The person who died was Lasonya Sheree Dutton

    b. Date of death: Between 26 and 29 March 2022

    c. Place of death: Wilcannia NSW

88. The Commissioner of the NSW Police Force (**the Commissioner**) agrees with the submissions of counsel assisting regarding these aspects of the s 81 findings.[44]

89. Maari Ma did not wish to be heard in relation to the formal findings to be made by the Court with respect to Sonya's death.[45]

90. No submissions were made with respect to the formal findings to be made with respect to Sonya's death on behalf of DSC Fleming.

91. I accept the submission of Counsel Assisting regarding these three findings to be made with respect to Sonya's death, namely that Sonya died in Wilcannia NSW between 26 and 29 March 2022.

Cause and manner of Sonya's death

92. As noted at the outset, the manner and cause of Sonya's death was a focus of the inquest.

93. In considering whether there is sufficient evidence to enable findings to be made with respect to

[43] Submissions of Counsel Assisting, [18].
[44] Submissions on behalf of the Commissioner of NSW Police Force, [3].
[45] Submissions on behalf of the Maari Ma Health Aboriginal Corporation, [6].

the cause and manner of Sonya's death, it is necessary to closely consider the available evidence relating to the cause and manner of her death, including evidence that might be considered to be consistent with her death being self-inflicted (suicide) or consistent with her death involving another person (homicide).

Evidence referring to self-harm

94. In addition to the evidence outlined at **Annexure B** regarding Sonya's interactions with mental health services, there was evidence from witnesses that she had previously made threats of self-harm.

95. While many witnesses described Sonya as happy, and did not think she was capable of suicide, there was evidence that Sonya's grief would sometimes lead her to make threats of self-harm. Majorie Whyman stated that after three tragic losses (the death of Aunty Loretta, Cridie and 'Winkas'), Sonya would get really drunk and say that she was going to hang herself. [46] Veronica Hunter said that Sonya made a threat to hang herself once with a medical mask but also that Sonya said she would never actually do anything to herself. Paul Murray stated that he 'sometimes heard Sonya threaten to kill herself, this usually would happen when she was drunk and I think it was to try and get attention or when she wasn't getting her way'. [47] Katrina Hunter stated that she had never seen Sonya try to hurt herself or threaten to hurt herself before, however, a few nights before the last time she saw Sonya, she made a comment like 'if anything ever happens to me, I want my sisters to carry me'. [48]

96. JoJo Whyman said that on occasion she heard Sonya say things like 'I am going to kill myself' but had never known her to try and hurt herself. [49] Melissa Kennedy said that when Sonya got upset with someone and was drinking, she often said she was going to hang herself. [50] Allan (AB) Carroll stated he had heard Sonya say she was going to kill herself when she was in a bad mood. [51]

97. Dr Hovane also referred to the series of tragic losses and associated grief which Sonya experienced through her life, as outlined at [37].

Crime Scene Examination

98. In addition to references to self-harm, the crime scene examination at 8-10 Hood Street

[46] Exhibit 1, Volume 1A, Tab 28, Transcript of BWV interview with Marjorie Whyman; Exhibit 1, Volume 1A, Tab 29, Statement of Marjorie Wyman at [17]-[18], p.3.
[47] Exhibit 1, Volume 1B, Tab 60, Statement of Veronica Hunter at [26], p.4.
[48] Exhibit 1, Volume 1A, Tab 27, Statement of Katrina Hunter at [31], p.5.
[49] Exhibit 1, Volume 1A, Tab 23, Transcript of BWV interview with JoJo Whyman; Exhibit 1, Volume 1A, Tab 24, Statement of JoJo Whyman at [13], p.3.
[50] Exhibit 1, Volume 1B, Tab 30, Statement of Melissa Kennedy at [15], p.3.
[51] Exhibit 1, Volume 1A, Tab 18, Statement of Alan Carroll at [11], p.2.

identified certain features that may be consistent with Sonya's death being due to self-harm.

Use of a cord

99. Crime Scene Officer Melissa Mertens (**CSO Mertens**) attended the scene at 8-10 Hood Street and observed a cord around Sonya's neck.[52] This was a black HD AV cable with an Xbox label. There appeared to be a knot on the cable on the right side of Sonya's neck.[53] Whilst the placement of the cord in this position may be consistent with suicide, the placement of the cord may equally be attributable to third party involvement.

The cord may have derived from 8-10 Hood Street

100. CSO Mertens located an Xbox console with the cover removed and no cords located on the table in the entrance to 8-10 Hood Street.[54]

Examination of the round timber post

101. CSO Mertens observed fencing in the backyard which ran across the middle of the backyard met at a corner where there was a round timber post.[55] Sonya was located 2.94 meters from this timber post,[56] between the post and the house. CSO Mertens saw three separate areas of dark staining on the grass in front of the corner fence and timber post.[57] CSO Mertens stated that these 3 areas of dark staining which 'appeared to be decomposition fluid on the grass in front of the corner of the fence'. These areas of staining were marked with markers B, C and D.[58] D was near the corner of the fence, C was in a straight line away from the stain at marker D (0.41m) and B was an irregular shape with heavy staining further away from the fence (0.5m) from the corner of the fence. CSO Mertens formed the opinions that:

    a. the stains could have been caused by the deceased in a seated position near the fence for a period of time while decomposing; and

    b. the stains were made by the lower torso of the deceased while decomposing.

102. There were no other drag marks or evidence of decomposition fluids located in other areas of

[52] Exhibit 1, Volume 3A, Tab 101, Statement of Senior Constable Melissa Mertens, Crime Scene Officer, at [63], p 25.
[53] Exhibit 1, Volume 3A, Tab 101, Statement of Senior Constable Melissa Mertens, Crime Scene Officer, at [63.10] and [99], p 27 and p.44.
[54] Exhibit 1, Volume 3A, Tab 101, Statement of Senior Constable Melissa Mertens, Crime Scene Officer, at [81.1], p.38.
[55] Exhibit 1, Volume 3A, Tab 101, Statement of Senior Constable Melissa Mertens, Crime Scene Officer, at [59], p 24.
[56] Exhibit 1, Volume 3A, Tab 101, Statement of Senior Constable Melissa Mertens, Crime Scene Officer, at [62], p 25
[57] Exhibit 1, Volume 3A, Tab 101, Statement of Senior Constable Melissa Mertens, Crime Scene Officer, at [73]-[75], p 36.
[58] Exhibit 1, Volume 3A, Tab 101, Statement of Senior Constable Melissa Mertens, Crime Scene Officer, at [70], p 32.

the yard.[59]

103. CSO Mertens also identified that the timber post had two steel beams attached (lower and upper) which ran in a southwest direction away from the timber post, parallel to the ground. The top steel beam was approximately 1.36 meters from the ground and was attached to the timber post with the steel screws. She observed a black rub mark angled across the top steel beam. The black rub mark was consistent with the Xbox cord found around Sonya's neck.

Anchor Points

104. Crime Scene Officer Michael Murphy (**CSO Murphy**) tested four possible anchor points on the timber post and the fence railings.[60] Using an Xbox cable which matched the one found at the scene, CSO Murphy applied downward pressure to the cable by grasping it and transferring his body weight. All anchor points withstood the force of his body weight, and 3 anchor points withstood a jerking motion and did not slip, falter or unravel.[61] Whilst there may be reliability issues with respect to this experiment (for example the reconstructions were not repeated or reviewed and it is speculative as to what actions may have been used and therefore that could not be replicated), I accept the submission of counsel assisting that there is no evidence that it was not possible for the timber post to be an anchor point.

Presence of dogs around Hood Street

105. A number of police officers observed dogs in the vicinity of 8-10 Hood Street on 29 March 2022. Detective Sergeant Sharon Neil (**DS Neil**) saw unleashed dogs roaming[62] and another police officer had to use OC spray and punch a dog several times after the dog latched onto his forearm.[63] The observations of dogs in the vicinity of 8-10 Hood Street gives rise to the possibility that Sonya's body may have been dragged from the timber post towards the house. However, this possibility is equivocal as Sonya's body may also have been dragged by dogs if there had been third party involvement and her body had been left in the backyard of 8-10 Hood Street.

Time frame

106. At the time of CSO Merten's attendance at 9-10 Hood Street on 29 March 2022 at 2:20pm (3 days after Sonya was last seen) the conditions were clear and the temperature was 32.5 degrees. The

[59] Exhibit 1, Volume 3A, Tab 101, Statement of Senior Constable Melissa Mertens, Crime Scene Officer, at [70], p 32.
[60] Exhibit 1, Volume 3A, Tab 101, Statement of Senior Constable Melissa Mertens, Crime Scene Officer, at [63], p 25
[61] Exhibit 1, Volume 3A, Tab 100, Statement of Michael Craig Murphy at [10]-[15], pp.2-3.
[62] Exhibit 1, Volume 4, Tab 108, Statement of Detective Sergeant Sharon Neil at [7], [17], pp.2-6.
[63] Exhibit 1, Volume 1A, Detective Chief Inspector Paul Smith, Homicide Squad, NSW Police at [82], p.16.

temperature for the previous 3 days was 30.3, 29.7 and 30.9 degrees.[64] I agree, as submitted by counsel assisting, that the degree of decomposition is neutral evidence because the level of decomposition could be attributable to her death occurring close in time to Sonya's last sighting whether it was by self-harm or the actions of a third party.

Capacity to observe the backyard

107. During the view undertaken as part of this inquest, it was apparent that there was a clear view of where Sonya's body was located from the kitchen window of her home. It was understandable that community members struggled with how Sonya could have been in her backyard in the days leading up to when she was found on 29 March 2022 without anyone seeing her from the kitchen or dining room window.

108. CSO Mertens observed sometime after 2:20pm on 29 March 2022 that the dining room had an external window facing the rear yard with a sliding pane and a maroon curtain hanging from above the window. At the time of her examination, the sliding windowpane was open and the curtain was partially open at one end and the deceased was visible when standing parallel to the open curtain.[65] CSO Mertens also observed in the kitchen, behind the sink, an external window which had a maroon coloured piece of material covering the window obstructing the view of the rear yard. If the curtains had remained in this position between 26-29 March 2022, it is possible they obscured the view from the kitchen and dining room.

109. DS Neil, a member of the NSWPF Homicide Squad who attended the scene, observed that depending on where somebody may have been standing or what vision they had, there were areas from within the house that provided a view to the backyard. DS Neil expressed this view to CSO Mertens.[66] Despite the fact that the curtain was in the position observed by CSO Mertens, I accept that the investigation should remain open to the fact that there is a possibility that Sonya's body would have been visible to an observer in the dining room or kitchen, if it was there prior to her body being found by Mr Dutton.

110. Doris Mills gave evidence that Trevor would sit in the chair close to the kitchen when he was having a cigarette and a cup of tea. He would tie up the curtain and when he was finished, he would bring it down again. While drinking his tea Trevor would look outside.[67] If Trevor adhered to his routine, it is likely that he would have seen Sonya's body in the backyard, if her body was in the place where she was found. Sonya was a very petite person which may have some bearing

[64] Exhibit 1, Volume 3A, Tab 101, Statement of Senior Constable Melissa Mertens, Crime Scene Officer, at [31], p 10.
[65] Exhibit 1, Volume 3A, Tab 101, Statement of Senior Constable Melissa Mertens, Crime Scene Officer, at [44], p 15.
[66] Transcript, Day 2, 11.2.25, T79.13.
[67] Transcript, Day 3, 12.2.25, T219-220.

on whether she was observed by others inside the house.

111. Working against the theory that Sonya's body was in the backyard from 26 March to 29 March 2022, is that there is no evidence that anyone saw anything unusual in the backyard or noticed any smell that one would expect if Sonya's body was decomposing in the backyard. Paul Murray[68] and Doris Mills[69] stated that they observed the backyard of 8-10 Hood Street on Monday 28 March 2022 and did not smell anything unusual, they also gave evidence that they did not see any dogs or see any remains.

Psychological opinion

112. Dr Hovane was not asked[70] to express an opinion as to whether Sonya died by suicide but did observe that a person expressing a generally positive attitude to life is not necessarily inconsistent with that person engaging in self-harm.[71] Dr Hovane also observed that medical and police records indicate that Sonya was not coping well with her life, irrespective of how she presented to others. Dr Hovane reports:[72]

> *Events can arise at any given moment and can trigger changes in a person's mental state and behaviour. If a person is able to make sense of such events that arise with a clear mind, they are better placed to process what has happened in a balanced way. This in turn can influence their resultant feelings and behaviours. If a person's mind is not clear as a result of substance use or being in a stress state to begin with, then this can impact on their ability to make sense of the events that arise, and process what has happened in a balanced way. Substance use is well known as impairing interpretation and making sense of events, and to impair decision making based on those impaired interpretations. Impulsive non rational decision making and behaviours could occur as a result.*

113. This passage identifies that substance use is known to be associated with an increased risk of suicide.[73] Loss and grief are also key vulnerabilities which can cause an increased risk of self-harming and suicide.[74] Sadly, as noted above, Sonya's life had been marked by a series of devastating events causing loss and grief and that may have increased her use of alcohol as a coping mechanism.

[68] Transcript, Day 4, 13.2.25, T232-233.
[69] Transcript, Day 3, 12.2.25, T214.
[70] See questions outlined in Exhibit 1, Volume 1A, Tab 7, Expert report of Dr Victoria Hovane, pp.10-11.
[71] Exhibit 1, Volume 1A, Tab 7, Expert report of Dr Victoria Hovane at [73], p 21.
[72] Exhibit 1, Volume 1A, Tab 7, Expert report of Dr Victoria Hovane at [76], p 22.
[73] Exhibit 1, Volume 1A, Tab 7, Expert report of Dr Victoria Hovane at [75], p 21.
[74] Exhibit 1, Volume 1A, Tab 7, Expert report of Dr Victoria Hovane at [81], p 23.

DSC Fleming's opinion

114. In her statement dated 6 April 2022 (less than 2 weeks after Sonya's body was discovered), DSC Fleming formed the opinion that Sonya had died by suicide.[75] Some aspects of DSC Fleming's opinion are consistent with the observations outlined above including Sonya's history of self-harm, the presence of the cord around her neck and the possibility of Sonya having anchored the cord to the wooden pole and restrict her airways, causing her death. However, there were other aspects of DSC Fleming's opinion that were problematic, which I will refer to later in these findings with regard to the initial police investigation.

Possible third-party involvement

115. As noted above, from sometime in late 2021, Sonya had commenced a relationship with Mr Wilson. Mr Wilson was known in the community by the nickname "Kermit" and had lived in Wilcannia in the early years of his life and parts of this adult life.

116. In early 2021, he moved into the Wilson family home at 44 Myers Street, Wilcannia.[76] It is unclear exactly when Sonya's relationship with Mr Wilson started, but it is understood by police to have commenced in late 2021.[77]

117. There was evidence which demonstrated that Mr Wilson had a history of charges and convictions for violence, including domestic violence. Evidence in the inquest supported the probability that Sonya experienced intimate partner violence when she was in a relationship with Mr Wilson and that there was a background of violence between Mr Wilson and Sonya.

118. Veronica (Bon) Hunter stated that she noticed a change in Sonya when Sonya commenced her relationship with Mr Wilson in 2021, that she was quieter and not herself. She thought Mr Wilson was obsessed with Sonya and controlling her.[78] Veronica said that Sonya privately showed her bruises and bite marks to her upper left arm, shoulder and back area and shortly after this she saw Sonya's arm in a sling, but Sonya would not tell her what happened.[79]

119. During the time Mr Wilson and Sonya were together, Leatta Hunter reported that Mr Wilson would get jealous and tried to control Sonya. Sonya showed Leatta bruises on her body including one on her back, one on the top of her arm and one on the calf of her leg.[80] A couple of weeks

[75] Exhibit 1, Volume 1A, Tab 12, Statement of PCSC Madeline Fleming dated 6 April 2022 at [80], pp.56-58.
[76] Exhibit 1, Volume 1A, Tab 14, Statement of DCI Paul Smith at [179], p.44.
[77] Exhibit 1, Volume 1A, Tab 12, Statement of PCSC Madeline Fleming dated 6 April 2022 at [10], p.3.
[78] Exhibit 1, Volume 1B, Tab 60, Statement of Veronica Hunter at [21], p 3.
[79] Exhibit 1, Volume 1B, Tab 60, Statement of Veronica Hunter at [24]-[25], p 4.
[80] Exhibit 1, Volume 1B, Tab 44, Statement of Leatta Hunter at [13]-[15], p 3.

before Sonya was found deceased, she said that she saw Mr Wilson wake Sonya up by pulling her off the lounge and hitting her to the face with his hand a number of times.[81]

120. Coralee Kerwin recalls Mr Wilson being 'bad' towards Sonya and said he would yell at her and grab her by the shirt. Coralee also said that Mr Wilson had broken Sonya's leg. There is no evidence of Sonya having broken her leg, but she had broken her arm. It is possible Coralee's recollection was not correct in this regard.[82]

121. Other friends and community members reported observing positive interactions between Mr Wilson and Sonya or not witnessing any violence. For example, Raelene Hunter stated that she often saw Mr Wilson and Sonya together and they were happy with not much arguing.[83] Katrina Hunter also said that Sonya seemed happy around him.[84] She also said that Sonya showed her bite marks and bruising on her body. Chris Hunter (Mr Wilson's cousin) and Jonathon Whyman both reported they did not observe any 'dramas' or 'major issues' between them, only small arguments.[85]

122. The only *reported* incident of violence was on 12 February 2022, when Sonya presented to hospital with pain in her left forearm that she attributed to an assault by her ex-partner. The police holdings note that it was alleged that sometime between 3am and 4am, Mr Wilson became upset and punched Sonya to the face and then kicked her causing her to fall from the bed and on to her left forearm.[86] Sonya did not participate in a Domestic Violence Evidence in Chief (DVEC) recording or provide a statement, however police proceeded to charge Mr Wilson with assault occasioning actual bodily harm[87] and applied for an ADVO which was granted. The charge was listed for hearing on 21 April 2022; however the charge was withdrawn by police due to Sonya having passed away.

123. Following the ADVO being granted, Sonya's son, Baby Keith, continued to go to Mr Wilson's address at 44 Myers Street. He would go there to play Xbox. The extent of contact between Sonya herself and Mr Wilson following the service of the ADVO is unclear.

124. The brief of evidence refers to witness accounts of this period including:

    a. Raelene Hunter stated that Mr Wilson was Sonya's partner 'but they was like having a

[81] Exhibit 1, Volume 1B, Tab 44, Statement of Leatta Hunter at [16], p 3.
[82] Exhibit 1, Volume 1B, Tab 37, Statement of Coralee Kerwin at [6], pp 2-3
[83] Exhibit 1, Volume 1A, Tab 27, Statement of Katrina Hunter at [13], p 3.
[84] Exhibit 1, Volume 1A, Tab 27, Statement of Katrina Hunter at [14], p 3.
[85] Exhibit 1, Volume 1A, Tab 19, Statement of Christopher Hunter at [14], p 3; Exhibit 1, Volume 1A, Tab 24, Statement of Johnathon Whyman at [16], p 3.
[86] Exhibit 1, Volume 1A, Tab 14, Statement of DCI Paul Smith dated 25 June 2024 at [204], p 50.
[87] Exhibit 1, Volume 1A, Tab 12, Statement of PCSC Madeline Fleming dated 6 April 2022 at [24], p 7.

little bit of a break away'.

b. Steven Harris stated that Sonya had not seen her ex-partner recently.

c. Joy-Ann Williams stated that about two weeks before Sonya passed away, Sonya told her that Mr Wilson would bash her on the chest.

d. Trevor Jones referred to Sonya and Mr Wilson's relationship as an 'on again off again relationship'.

Timeline of Mr Wilson's movements

125. The available CCTV footage from Mr Wilson's home, along with accounts provided by Mr Wilson and his brother Ronald Wilson, who he lived with at the time, were relied on by police to establish a timeline of Mr Wilson's movements. This timeline between 24 March 2022 and the time Sonya was located on 29 March 2022 was examined in detail in the subsequent investigation into Sonya's death and is outlined in the statement of Detective Chief Inspector Paul Smith (**DCI Smith**).

126. The available evidence does not establish that Mr Wilson had any contact with Sonya after 5pm on 26 March 2022. However, and unfortunately, there are lengthy gaps in the CCTV footage from 44 Myers Street which was obtained from Mr Wilson's home, as follows:[88]

a. Thursday 24 March 2022 from 4:06am to 11:59pm (20 hours);

b. Friday 25 March 2022 from 12:00am to 11:59pm (whole day);

c. Saturday 26 March 2022 from 12:00am to 12:07am (7 minutes);

d. Saturday 26 March 2022 from 4:12am to 12:05pm (7 hours and 53 minutes);

e. Saturday 26 March 2022 from 8:40pm to Sunday 27 March 2022 12:01am (3 hours and 21 minutes); and,

f. Sunday 27 March 2022 from 9:35pm to 9:42pm (7 minutes).

127. Critically, the following gaps exist between when Sonya was last seen by Ariah Dutton at around 5pm on 26 March 2022:

[88] Exhibit 1, Volume 1A, Tab 14, Statement of DCI Paul Smith dated 25 June 2024 at [209], p 52.; Exhibit 1, Volume 5, Tab 152, CCTV Synopsis of 44 Myers Street, Wilcannia.

a. Saturday 26 March 2022 from 8:40pm to Sunday 27 March 2022 at 12:01am (3 hours 21 minutes).

b. Sunday 27 March 2022 from 9:35pm to 9:42pm (7 minutes)

128. Police have not been able to ascertain whether the gaps in the footage are the result of some external involvement that has led to the corruption of the footage or merely a problem with the hard drive. Detective Senior Constable Patrick Chew (**DSC Chew**) stated that Mr Wilson and Ronald Wilson did not refuse any police direction or request at any time.

CCTV 26 March 2022

129. The available CCTV footage has the following events of note on the afternoon of 26 March 2022:

a. At 3:37pm, Mr Wilson returning to 44 Myers Street.

b. At 5:21pm, Baby Keith is seen walking into the driveway of 44 Myers Street, holding what appears to be an Xbox game.

c. At 5:45pm, Baby Keith and an unknown male leave 44 Myers Street.

d. At 5:46pm, Mr Wilson walks out the main entrance door of 44 Myers Street.

e. At 6:11pm, Baby Keith returns to 44 Myers Street with an unknown male.

f. At 7:22pm, Mr Wilson, Ronald Wilson, Baby Keith and an unknown male leave 44 Myers Street.

g. At 8:13pm, Mr Wilson walks into 44 Myers Street.

Gap in CCTV from 8:40pm – the following morning (27 March 2022) at 12:01am.

130. This gap in the footage represents a potential opportunity for Mr Wilson to have left the house and have some involvement in Sonya's death. The gap commences 3 hours and 40 minutes after Sonya was last seen by Ariah Dutton and the level of decomposition may be broadly consistent with her passing away on 26 March 2002. However, there is no evidence in the brief that Mr Wilson was sighted outside of 44 Myers Street during this time period.

131. This gap in footage is a significant limitation in the investigation, and an aspect I will refer to further below.

132. Police review of the CCTV identified that Mr Wilson was at 44 Myers Street most of the day noting:[89]

a. At 1:21pm, Baby Keith entered 44 Myers Street.

b. At 3:27pm, Mr Wilson and Baby Keith left the house. Baby Keith left the property on a scooter. Mr Wilson did not leave the property and returned back inside.

c. At 11:18pm Mr Wilson had a torch and left 44 Myers Street. This was the first time he left the property on 27 March 2022. Mr Wilson stood outside the side gate of the premises then returned to 44 Myers Street at 11:28pm.

Alleged admissions

133. There were reports in the Wilcannia community that Mr Wilson had admitted he was involved in Sonya's death. On 23 May 2022, DSC Fleming conducted a body worn interview with Thomas Whyman and had conversations with Ingrid and Sheena Bugmy (sometimes referred to as Sheena Dutton) which were not recorded. With respect to alleged admissions:

a. Thomas Whyman: he had not heard Mr Wilson say anything but had heard people around the town 'saying it'. He was drunk and didn't know or hear what was said. He heard 'it' was sent through text. He didn't know who had the text messages.

b. Ingrid Bugmy: she did not hear anything from Mr Wilson but had heard the 'yarn what was said about it'. Ingrid said that Sheena Bugmy had an argument with Mr Wilson and she had heard Mr Wilson talk about his involvement in the deceased passing. Ingrid confirmed that she had a party on 20 May 2022 at her house and 'Kermit' walked past, 'swearing and carrying on but he didn't mention anything like that'.[90]

c. Sheena Bugmy: On 20 May 2022, she walked along Myers Street, Wilcannia after having drinks during the night at her uncle's house. Mr Wilson came up to her and wanted to have a physical fight. Sheena said Mr Wilson yelled out to her, "I'm guilty, I done it".[91] Sheena gave evidence and said she had been drinking at her uncles that day. She said Mr Wilson was fighting[92] and a bit later said, "I'm guilty, I'm guilty" and kept throwing his

[89] Exhibit 1, Volume 1A, Tab 14, Statement of DCI Paul Smith dated 25 June 2024 at [240], p 59; Exhibit 1, Volume 5, Tab 151B, CCTV Synopsis, 44 Myers Street, Wilcannia, pp.3-4.
[90] Exhibit 1, Volume 1A, Tab 22A, Transcript of interview with Ingrid Bugmy, p.3.
[91] Exhibit 1, Volume 1B, Tab 57, BWV interview of Sheena Dutton, pp 2-3.
[92] Transcript, 11.2.25, T270.27.

hands up and saying it.[93] The police were there but she is not sure if they heard Mr Wilson. She said he hit her that night. The reliability of the alleged admission is affected by the apparent intoxication of the witness and Mr Wilson. It is noted that Mr Wilson is not alleged to say *what* he is guilty of and, given the context of saying the words in a public place with police around, it could be inferred that it is unlikely he is making a genuine confession to homicide. However, the timing of the words 'I am guilty' may be inferred to link Mr Wilson to being involved in Sonya's death. The strength of the evidence is also affected by the lack of any other witnesses who were present to state that they heard Mr Wilson make the alleged admissions.

134. After receiving the above information, DSC Fleming attended Mr Wilson's address and questioned him, recording her questioning on body worn video. Mr Wilson was not cautioned. Mr Wilson confirmed there were rumours that he was involved in Sonya's death. When asked about confronting Sheena Bugmy, Mr Wilson said he did not say the words Sheena Bugmy alleged and said she approached him and called him a murderer, stating "You killed my sister" and "Don't talk to me you murderer".[94]

Glenn Wilson's accounts to police – no admissions

135. When interviewed by police on 29 March 2022, Mr Wilson said the last time that he spoke to Sonya was Thursday night after the basketball and that he saw her with Ike Williams on Friday morning, but he did not speak with her. He stated that things were alright between him and Sonya. He stated he went to Chris Hunter's house on the Friday night and that over the weekend, Baby Keith had been at his house playing games.

136. At 4:20pm on 30 March 2022, Mr Wilson spoke to police at 44 Myers Street, and it was recorded on body worn video. He said he spoke to Sonya on Thursday at the basketball then she came to his place. He said he last saw her with Ike Williams on the Friday. In addition to providing information to police, Mr Wilson said he would arrange for his brother to download CCTV footage that was available.

137. At 5:05pm on 30 March 2022, Mr Wilson and Ronald Wilson spoke to police at 44 Myers Street, and it was recorded on body worn video. He again mentioned that Sonya may have stayed at his house on Thursday night.

[93] Transcript,11.2.25, T270.47.
[94] Exhibit 1, Volume 1A, Tab 12, Statement of PCSC Madeline Fleming dated 6 April 2022 at [43], p 7; Exhibit 1, Volume 2, Tab 75, Transcript of BWV of PCSC Madeline Fleming of interaction with Glenn Wilson at 44 Myers Street, pp 9-10.

138. At about 10:57am on 4 April 2022, Mr Wilson and Ronald Wilson spoke to police at 44 Myers Street, and it was recorded on body worn video. He mentioned a fight Sonya had with Veronica Hunter and said that '…suicidal is to do with a lot of things as well'.[95]

139. At about 12:15pm on 23 May 2022, police attended 44 Myers Street and spoke to Mr Wilson, and this was recorded on body worn video. He identified that members of Sonya's family were accusing him of killing Sonya. When asked whether he had been in an argument the previous Friday, he said he had argued with Sheena Dutton who called him a murderer.

140. On 5 June 2024, Detective Sergeant Nathan Surplice (**Detective Surplice**) requested a formal interview with Mr Wilson and this request was declined, through Mr Wilson's solicitor.[96]

141. It is submitted by counsel assisting that the various interviews do not reveal any admissions to being involved in Sonya's death or any particular inconsistencies or proven lies which would lead to a conclusion that Mr Wilson was being dishonest with police on the topics he discussed.

<u>Aspects of the investigation not implicating Mr Wilson/exculpatory evidence</u>

142. Further evidence in the investigation which did not link Mr Wilson to the death, or which may be considered inconsistent with third party involvement or exculpatory evidence includes:

    a. CSO Mertens did not observe any injuries to Sonya's head, chest, abdomen or back, nor did she observe any defensive wounds to Sonya's hands.[97] DSC Chew confirmed[98] that:

        i. there was a ligature mark on Sonya's left neck area;

        ii. there were puncture wounds consistent with dog bite wounds;

        iii. there was no defensive wounds or blunt force trauma (but an accurate assessment was precluded due the degree of decomposition); and,

        iv. there were no identifiable stab wounds, skull fracture or bruising of the skull (noting limits of examination).

[95] Exhibit 1, Volume 2, Tab 74, Transcript of BWV of PCSC Bridie Hutchens of interaction with Glenn Wilson and Ronald Wilson at 44 Myers Street, p 5.
[96] Exhibit 1, Volume 4, Tab 113, Statement of Detective Sergeant Nathan Surplice at [105], p 25.
[97] Exhibit 1, Volume 3A, Tab 101, Statement of Senior Constable Melissa Mertens, Crime Scene Officer, at [63.5], [63.9], pp 26-25.
[98] 10.2.25, T32.

b. CSO Mertens conducted DNA and fingerprint testing on various items at 8-10 Hood Street, and none were linked to Mr Wilson (confirmed in evidence by DSC Chew).[99]

c. There were no signs of a struggle in Sonya's room.[100]

d. On 17 October 2023, the large shed located in the backyard of 44 Myers Street and the vehicle associated with 44 Myers Street (White Mitsubishi utility vehicle, WZD700) were examined and various areas and items were tested for human blood. None of the areas or items tested detected human blood.[101] It is noted that the testing of these items occurred some 19 months after Sonya was found.

e. Mr Wilson was remanded in custody on 24 May 2023 in relation to an unrelated matter. A review of his gaol calls did not lead to any significant information being obtained.[102]

f. Call charge records were obtained for Mr Wilson's phone which did not indicate any unusual activity.[103]

g. Extensive analysis of mobile phone records and social media activity were undertaken, none of which identified any evidence of telecommunication contact between Sonya and Mr Wilson between 26 March and 29 March 2022.[104]

h. There were several rumours circulating in the community which police followed up, including:

    i. Mr Wilson often used a pram and that he may have used this pram to take Sonya's body to 8-10 Hood Street. A pram was never sighted by police at Mr Wilson's address and there's no evidence of a pram being located or discarded in the Wilcannia area following Sonya's death.[105]

[99] Transcript Day 1, 10.2.25, T45.33.
[100] Transcript Day 1, 10.2.25, T45.40.
[101] Exhibit 1, Volume 1A, Tab 14, Statement of DCI Paul Smith dated 25 June 2024 at [250]-[251], p 61.
[102] Transcript Day 1, 10.2.25, T31.13.
[103] Exhibit 1, Volume 1A, Tab 14, Statement of DCI Paul Smith dated 25 June 2024 at [314], p 78.
[104] Transcript Day 1, 10.2.25, T43.48-44.4.
[105] Exhibit 1, Volume 1A, Tab 14, Statement of DCI Paul Smith dated 25 June 2024 at [295], p 72.

ii. Rhonda Hinch and Mikayla Knight located a light blue blanket at the Wilcannia tip which had red staining on it. Wilcannia police seized the blanket and had it forensically testing. The testing indicated there was no human blood on the blanket.[106]

iii. That following Sonya's death, a knife was located near Wilcannia oval and that this knife had blood on it. Marlene Hunter told police that in June 2022 she was with her brother walking along the footpath of Wood St near the intersection of the Barrier Highway. She said she saw a large kitchen knife on the footpath. Her brother took the knife and put it in the bin outside the school and did not think anything further of this.[107] DSC Chew confirmed that there was never any reference to blood being on the knife by witnesses and the knife has never been located so it is not possible to test the knife.[108]

iv. Keith Snr had a concern about a blanket found in the backyard of 8-10 Hood Street. DSC Chew confirmed that the blanket had been tested and there was no presence of human blood identified.[109]

v. That Mr Wilson admitted to Blake Parke that he killed Sonya in his shed at 44 Myers Street. Police spoke to Blake Parke on 7 August 2023, and he indicated that no such admissions had been made to him.[110]

Post Mortem Examination

143. A post mortem examination of Sonya was undertaken by Dr Donovan Paul Loots on 4 April 2022, and a report was produced dated 6 February 2023.

144. The extent to which Sonya's body had decomposed did not allow for a determination of the cause of death. In his report, on the basis of the reported circumstances and findings of the examination, Dr Loots expressed an opinion that the direct cause of death was

[106] Exhibit 1, Volume 1A, Tab 14, Statement of DCI Paul Smith dated 25 June 2024 at [296], p 73.
[107] Exhibit 1, Volume 1A, Tab 14, Statement of DCI Paul Smith dated 25 June 2024 at [297], p 73.
[108] Transcript, 10.2.25 T30.43.
[109] Transcript, 10.2.25, T31.22.
[110] Exhibit 1, Volume 1A, Tab 14, Statement of DCI Paul Smith dated 25 June 2024 at [298], p 74.

'unascertained'.[111]

145. It was noted in the submissions of counsel assisting that the circumstances of the death were summarised by Dr Loots and he expressed the opinion that '[a]lthough police were of the opinion that the circumstances of death may be in keeping with hanging, third party involvement could not be excluded. The circumstances of the death were thus considered to be of a suspicious nature and were treated as such'.[112]

144. It was submitted on behalf of the Commissioner that the 'framing' of the extract of the autopsy report of Dr Loots by counsel assisting as a statement of Dr Loots' "opinion" seemed to be incorrect.[113]

145. It is submitted by counsel for the Commissioner that the extract of the autopsy report instead appeared to provide Dr Loots' summary of the information provided to him by police, the status of the police investigation at the time of the post mortem examination and that the wording of the relevant paragraph supports this and also that the quote is not contained in the section of Dr Loots' report referring to the "Results of examination and discussion of findings."[114]

146. It is ultimately submitted on behalf of the Commissioner that this section of Dr Loot's report and the conclusion section of the report include very little explanation of Dr Loots' conclusion that the direct cause of death should be recorded as "unascertained".

147. It is submitted on behalf of the Commissioner that against that backdrop and noting that, for reasons not apparent on the face of the post mortem report, it was not prepared for almost a year after Sonya's death – it is submitted that it is appropriate to record that Dr Loots made a number of observations to DS Neil during the post mortem examination itself.[115]

148. Counsel on behalf of the Commissioner submits that given the paucity of reasoning set out in Dr Loot's report and the delay in its preparation, DS Neil's notes of the observations made by Dr Loots during the post mortem examination serve to provide some potentially useful insight into Dr Loots' thought processes.[116]

149. It is submitted on behalf of the Commissioner that these notes (which are set out in detail in the submission) suggest that there were a number of features noted during the autopsy that were

[111] Exhibit 1, Volume 1, Tab 5, Autopsy Report by Dr Donovan Loots dated 6 February 2023, p. 2.
[112] Submissions of Counsel Assisting, [47].
[113] Submissions on behalf of the Commissioner of NSW Police Force, [6].
[114] Submissions on behalf of the Commissioner of NSW Police Force, [7]-[11].
[115] Submissions on behalf of the Commissioner of NSW Police Force, [12]-[14].
[116] Submissions on behalf of the Commissioner of NSW Police Force, [12]-[13].

supportive of a conclusion that Sonya died by suicide, including:[117]

a. the absence of defensive injuries;
b. the absence of blunt force trauma injuries;
c. the absence of bruising or fractures to the head;
d. the apparent absence of a break to the hyoid bone; and
e. the absence of injuries to the back of a kind that would typically be seen in cases where a second person was applying a ligature from behind and placing pressure on the rear of the person to keep the ligature tight.

150. It was submitted on behalf of the Commissioner that none of the matters conveyed by Dr Loots to DS Neil was inconsistent with, or even tended against, a finding of suicide and against that backdrop, Dr Loots observed to DS Neil that "all features quite suggestive of hanging" and that he was "inclined to say hanging" on the basis of the images taken at the scene such that while the cause of death would "[l]ikely remain undeterm[ined]" he would "point [the] coroner in [the] direction of suspected hanging".[118]

Was Sonya's death as a result of suicide?

151. It is submitted by counsel assisting that there is evidence which may be considered consistent with the cause of Sonya's death being suicide. However, the possibility of third-party involvement in Sonya's death and the limitations of the evidence (some of which may be attributable to the initial police investigation), mean that there is insufficient evidence, on the balance of probabilities, to make the finding that Sonya died as a result of suicide.[119]

152. Submissions on behalf of Mr Keith Dutton indicate that he accepts the analysis of counsel assisting on the reasons preventing the Coroner from reaching a finding about the cause of Sonya's death. Ultimately, it is submitted on behalf of Mr Dutton that the evidence is obscure as to whether Sonya's last moments may have been marked by emotional distress leading to self-harm or may have involved a third party.[120]

153. It is submitted on behalf of Mr Dutton that considering Sonya's experience of grief and loss, in the context of a community history of intergenerational trauma, he respectfully acknowledges the effort during the inquest to identify possible improvements in health services for Wilcannia. Nonetheless, is it submitted on behalf of Mr Dutton that he asks for caution that this aspect of

[117] Exhibit 1, Tab 198, Third Statement of D/Sgt Neil, pp. 7-9.
[118] Submissions on behalf of the Commissioner of NSW Police Force, [17].
[119] Submissions of Counsel Assisting, [49].
[120] Submissions on behalf of Keith Dutton, [10].

the inquest's work should not be taken as an implicit endorsement that Sonya's death was at her own hands and for the reasons set out by counsel assisting, such a finding is not open.[121]

154. On behalf of the Commissioner of NSWPF it is submitted that while the determination of Sonya's death is a matter for the State Coroner, it is appropriate to observe that it cannot sensibly be said that a finding of suicide is one that is not reasonably "open" on the evidence (nor can it be said that such a finding would otherwise be contrary to law).

155. Counsel for the Commissioner submits, with reference to the *Briginshaw* standard, that in view of the various indicia suggestive of suicide and the absence of evidence that is, in a real and persuasive sense, inconsistent with suicide, it is difficult to see how it could be said that a finding of suicide is not one that would be open to the Court to make.[122]

156. I have closely considered the evidence and the detailed submissions, in particular on behalf of the Commissioner, including the reference to the *Briginshaw* standard.[123]

157. I find that the available evidence is insufficient for a finding to be made that Sonya's death was as a result of suicide.

Was Sonya's death as a result of homicide?

158. Counsel assisting submitted that whilst there is evidence which gives rise to the possibility that a known person was involved in Sonya's death, the possibility of suicide, and the limitations of the evidence, mean that there is insufficient evidence to satisfy the elements of s 78 of the Act to refer any person to the DPP for potential prosecution in relation to Sonya's death.[124]

159. The Commissioner submitted that it would not be necessary for the court to positively exclude the possibility of homicide before it could conclude, on the balance of probabilities, that Ms Dutton died as a result of suicide.[125]

160. Maari Ma did not wish to be heard in relation to the formal findings to be made by the Court with respect to Sonya's death.[126]

161. No submissions were made with respect to the formal findings to be made with respect to Sonya's death on behalf of DSC Fleming.

[121] Submissions on behalf of Keith Dutton, [11].
[122] Submissions on behalf of the Commissioner of NSW Police Force, [24].
[123] Submissions on behalf of the Commissioner of NSW Police Force, [21]-[24].
[124] Submissions of Counsel Assisting, [50].
[125] Submissions on behalf of the Commissioner of NSW Police Force, [22].
[126] Submissions on behalf of the Maari Ma Health Aboriginal Corporation, [6].

162. Submissions were not made on behalf of Mr Wilson or Al McCarthy.

163. As noted above, whilst Mr Dutton accepts the analysis of counsel assisting regarding Sonya's manner of death, it is submitted on behalf of Mr Dutton that he feels many in the community would share his unease that a third party may have been involved given the following factors:[127]

    i. A relationship involving domestic violence that was possibly escalating at the time of Sonya's death;

    ii. Lost information about the movements of an obviously relevant person;

    iii. The improbability of Sonya self-harming without being found prior to 29 March 2022;

    iv. Assessing the possibility of Sonya taking her own life; and

    v. Reports of admissions and other information following Sonya's death.

143. I find that the available evidence is insufficient for a finding to be made that Sonya's death was as a result of homicide. I accept the submission of counsel assisting that there is insufficient evidence to satisfy the elements of s 78 of the Act to refer any person to the DPP for potential prosecution in relation to Sonya's death.

Findings as to cause of death

144. Whilst it is acknowledged that there is evidence indicating the presence of a cord around Sonya's neck, noting the evidence outlined above, in particular the level of decomposition of Sonya's body, the conclusion of Dr Loots and my findings regarding the insufficiency of the evidence as to the manner of Sonya's death, it is not possible to make a finding as to the cause of Sonya's death.

145. As was the case with respect to manner of death, I find that the evidence is insufficient for a finding to be made as to the cause of Sonya's death.

146. In making findings regarding the insufficiency of the evidence as to the cause and manner of Sonya's death, I accept the submission of counsel assisting as to the limitations of the evidence available, as outlined above, some of which may be attributable to the initial police investigation.

147. Noting this, I now turn to consider Issue 2 in the inquest regarding the adequacy of the initial

[127] Submissions on behalf of Keith Dutton, [12]-[36].

police investigation into Sonya's death and the subsequent investigation that followed.

ISSUE 2: The adequacy of the initial police investigation and subsequent investigation

The police response

148. Sonya's death was first investigated by Barrier Police District (Broken Hill Detectives) and DSC Fleming later became the OIC. The initial police response to Sonya's death, and the investigative steps that took place following her discovery were examined as part of the inquest. A summary of the police response that follows incorporates the evidence obtained during the coronial investigation into Sonya's death and the inquest.

Initial investigation by DSC Fleming

149. DSC Fleming provided three statements in relation to her involvement in the investigation of Sonya's death and also gave evidence at the Inquest on 11 and 12 February 2025.

150. At the time of her attendance at the scene at Hood Street on 29 March 2022, DSC Fleming held the rank of Plain Clothes Senior Constable, and she had just under a year of experience at Broken Hill. DSC Fleming had never investigated a matter in Wilcannia and her only exposure to the town was driving through it. DSC Fleming had attended a number of matters involving deceased persons but had not been the OIC of any cases involving deceased persons.

151. At the time of her attendance at the scene, DSC Fleming did not think she was the OIC, at least in part because she was not the most senior police officer on scene. At the inquest, DSC Fleming's evidence was that she awaited direction from her superiors, then Detective Sergeant Matthew McCarthy, now Acting Inspector McCarthy (**AI McCarthy**) and Detective Inspector Thomas Aylett (**DI Aylett**).

152. At the time of Sonya's death, AI McCarthy was DSC Fleming's team leader within the Detectives' office at Barrier PD[128] and DI Aylett was the Crime Manager of Barrier PD.[129] Both attended the scene at Hood Street where Sonya was located on the afternoon of 29 March 2022.

Briefing at Wilcannia Police Station

153. A briefing took place at Wilcannia Police Station at 2:30pm on 29 March 2022 with the main investigative steps identified as securing the crime scene and speaking to members of the Wilcannia community who had recently seen Sonya. DSC Fleming recalled in oral evidence that DI Aylett instructed her and Constable Robert James (**Cst James**) to obtain accounts from

[128] Exhibit 1, Volume 1A, Tab 13A, Third Statement of DSC Fleming, [11].
[129] Exhibit 1, Volume 4, Tab 112, Statement of Detective Inspector Thomas Aylett, [4].

community members and record them on body worn video. The rationale explained by DSC Fleming was that it was the best form of evidence at that point in time and the most efficient way to get versions considering the time frame and that she felt a strong sense of urgency to obtain body worn video accounts as soon as possible.

154. On 30 March 2022, the day following the discovery of Sonya's body, DSC Fleming did not consider herself to be the OIC. She then went on leave between 30 March and 5 April 2022, at a time when she remained of the view that she did not consider herself to be the OIC.

155. Whilst on leave, DSC Fleming assumed that in the days that followed, others in her team would continue to work on the case relating to Sonya's death. DSC Fleming did not attend the post mortem examination of Sonya which took place on 4 April 2022.

156. DSC Fleming realised she was the OIC on her return from leave on 5 April 2022 when AI McCarthy forwarded a brief notification to her via email.[130]

157. As noted above, DSC Fleming prepared a statement dated 6 April 2022 where she formed the opinion that Sonya had died by suicide, an opinion which is discussed further below.

Involvement of the Homicide Squad

158. The Homicide Squad, led by DS Neil, was involved in the investigation between 29 March 2022 and 4 April 2022. DS Neil was briefed in relation to Sonya's case at 11:15am on 29 March 2022 after which DS Neil arrived in Wilcannia with Detective Surplice at about 5:30pm on the same day. Homicide left Wilcannia on 31 March 2022, by that stage identifying certain investigative priorities.

159. Two of the key investigative priorities were taking formal statements from witnesses and obtaining the CCTV from 44 Myers Street. DS Neil believed those tasks would be followed up in a timely manner.[131]

160. DSC Fleming said that she recalls a whiteboard with notes on it which indicated body worn versions were to be taken from witnesses but can't recall other investigative priorities on that board. She said the priorities were not conveyed to her on 29 March 2022 in any other way.[161] She cannot recall any other advice from the Homicide Squad in those early days.[162] As at 5 April 2022, DSC Fleming did not think that the investigative priorities identified by homicide were conveyed to her.[163]

[130] Exhibit 1, Volume 1A, Tab 13A, Third Statement of DSC Fleming, [21]; T170.5.
[131] Transcript, 11.2.25, T84.6.

161. I will consider each of these two key investigative priorities in turn.

Formal witness statements

162. DS Neil gave evidence that she had made it clear on multiple occasions to the local police that after any initial interactions recorded on body worn camera, the preference would be to follow up with witness statements. DS Neil explained while 'body worn accounts' are valuable, typed statements were important because:

    a. they are the most reliable and admissible forms of evidence;

    b. police learn a lot more about a witness when obtaining a typed statement than a body worn informal conversation. Police spend more time with the witness in statement taking which provides an opportunity to obtain further detail;

    c. witnesses are provided an opportunity throughout and at the end of making the statement to read through it and make sure they are comfortable with it or have somebody read it to them and make sure they understand what they have said. A body worn recording at a person's doorstep or in an outside environment doesn't give the witness the same opportunity to take their time or correct or clarify their account.

163. DSC Fleming agreed that, as at 5 April 2022, she was not considering going back to Wilcannia to take formal statements any time soon. There was no plan, as at that date, as to when statements would be taken.

164. AI McCarthy stated that on 5 April 2022, he met with officers Plain Clothes Senior Constable Bridie Hutchens (**PCSC Hutchens**) and DSC Fleming regarding 'progress of enquiries' and noted a number of outstanding enquiries were to be completed however, at that time 'there was nothing to suggest the involvement of another person in the death'.[132] As noted above, DSC Fleming went on leave in mid-April until early May 2022. DSC Fleming transferred to Goulburn in July 2022 and retained carriage of the investigation into Sonya's death.

165. The initial brief of evidence was submitted to the Coroners Court on or about 19 December 2022. After a further period of leave in October 2022, DSC Fleming conceded that at that point she considered the brief to be a coronial brief, rather than an active investigation.

166. On 22 August 2023, a formal request was made by the State Coroner for the NSW Police Force

[132] Exhibit 1, Volume 4, Tab 111A, Supplementary Statement of Acting Inspector Matthew McCarthy, [27].

Homicide Squad to conduct further investigations into the death of Sonya. This request was accepted and the Homicide Squad commenced further investigations in October 2023. These investigations were conducted by DCI Smith, DSC Chew, Detective Senior Constable Anne-Marie Buckland (**Detective Buckland**) and Detective Surplice.

167. When DCI Smith's Homicide Squad returned in 2023, they obtained 44 formal witness statements.

168. Counsel assisting submitted that is difficult to identify precisely why DSC Fleming was not fully appraised of the investigative priorities identified by homicide. It may be that lack of professional support from her superiors was the reason why she did not think the priorities were communicated to her. Had her superiors supported her by engaging in regular case reviews and supervision sessions, those investigation priorities would have had to have formed part of those discussions. In any event, obtaining the CCTV and taking formal statements did appear to be matters which DSC Fleming was aware of as being important tasks.

169. It was submitted by counsel assisting that the failure to obtain further typed statements as advised by homicide, in a timely manner, meant that the investigation was incomplete. The impact of time passing inevitably impacts witnesses' memories and thus the reliability and accuracy of their accounts. Community members expressed dissatisfaction with the initial police investigation. It is apparent that the lack of formal statement taking conveyed to the community that the investigation was not being taken seriously. Community dissatisfaction has the potential of causing further stress to the relationship between the community and the police.

Obtaining CCTV from 44 Myers Street

170. By the evening of 29 March 2022, DSC Fleming stated that she knew Mr Wilson had CCTV footage at his residence. DSC Fleming recalled that at least by 30 March 2022, obtaining the CCTV was an investigative priority though it was not conveyed to her that all of the CCTV footage needed to be immediately downloaded that day.

171. In evidence, DSC Fleming made frank concessions that by leaving a USB with Mr Wilson to download the footage himself, there were risks of him tampering with the footage. DSC Fleming accepted that the whole of the footage should have been obtained.

172. DS Neil gave evidence that obtaining the CCTV from 44 Myers Street was a priority. She recalls Detective Surplice and herself indicating the importance of the CCTV and what it could contribute to the investigation and that it was a priority that had to be followed up. DS Neil said it was possible that she provided advice about seizing the hard drive as that is something they

routinely do in their investigations.

173. Regarding the investigative step of obtaining the CCTV footage from 44 Myers Street, it is submitted by counsel assisting that leaving a USB, as DSC Fleming did, with a person of interest is poor policing practice. It was submitted by counsel assisting that the decision taken by police not to seize the hard drive of the CCTV at Mr Wilson and Ronald Wilson's home at a much earlier stage was a serious missed opportunity.

174. It is submitted by counsel assisting that it is very likely that if the hard drive was seized (or police took control of downloading the footage) swiftly, this would have likely resolved whether the footage had been tampered with or if some form of technical failure explained the gaps. If the gaps were determined to be mechanical failure, this would have been fairer to Mr Wilson and it is likely that it may have also reduced the stress of family and other community members associated with not knowing the reason for the gaps in the footage. Of course, if the footage had been obtained earlier, and the footage which has now become unavailable was in the hands of police, it would have informed the investigation one way or the other as to whether Mr Wilson remained home or alternatively was outside of his home at a time when Sonya may have died.

175. For her part, it is submitted on behalf of DSC Fleming that she recognises, with respect to the initial investigation into Sonya's death, that she should have put more information in her coronial OIC brief about Mr Wilson's history of violence.

DSC Fleming's opinion regarding Sonya's death

176. DSC Fleming, as the OIC, prepared the initial brief in relation to Sonya's death and in doing so, expressed an opinion that Sonya had died by suicide by means of hanging herself to the point of suffocation.[133]

177. As noted above, in expressing this opinion, DSC Fleming relied on certain aspects of the crime scene examination. There were also other factors informing her opinion that were problematic.

178. It was submitted by counsel assisting that consideration should be given to implementing training to ensure that assumptions, such as the following, are not carried forward into future investigations involving possible suicide:[134]

    a. First, 'the high prevalence of suicide in Wilcannia'.[135] The high prevalence of suicide in

[133] Exhibit 1, Volume 1A, Tab 12, Statement of DSC Fleming, [80].
[134] Submissions of Counsel Assisting, [71].
[135] Exhibit 1, Volume 1A, Tab 12, Statement of PCSC Madeline Fleming dated 6 April 2022 at [80(II)], pp 56-57.

any location should be used with caution in forming an opinion as to cause of death. Opinions and investigative decisions must be based on the evidence in the individual case. To do otherwise, runs the risk of police too readily reaching a conclusion or applying an unfair bias in an individual case.

b. Second, '....no family member or friend raised any issues or concerns the deceased was involved in foul play. If the community were of the belief foul play was involved, there would be significant unrest within the community'.[136] Wilcannia community members were polite, cooperative and assisted police. It is unclear upon what information or evidence DSC Fleming could have assumed that there would be 'significant unrest' if 'the community' were of the belief foul play was involved. This sort of assumption undermines the importance of appreciating individual accounts. Relying on an expectation of how a community may collectively behave has the undertones of stereotype. Investigations should be evidence-based and assumptions like this are unhelpful. In her evidence, DSC Fleming accepted the shortcomings involved with this opinion as expressed.[137]

c. Third, the statement 'in regard to the smell of the deceased decomposing body, I do not believe the family would recognise this or even consider this smell out of the ordinary. As Wilcannia is remote, there are dead animals along the roadways, the level of cleanliness is not of high standard with rubbish, food scraps and other materials scattered within properties. This smell could have been associated with those factors.'[138] Expressing an opinion in this form risks unnecessarily offending family and community members without proper basis. In assessing whether the smell of decomposition may not have been detected due to other factors, it would be necessary to make a careful assessment of the potential factors in and around 8-10 Hood Street. The observations of Paul Murray and Doris Mills on 28 March 2022 are the most reliable and they did not notice any unusual smells. These witnesses live in Wilcannia, were familiar with the Hood St residence and would have a good understanding of what are usual and unusual smells. Further, DSC Fleming had only been to Wilcannia for this investigation so had no direct experience of 'usual' smells in Wilcannia. Constable Jared Hall worked at Wilcannia for two years and observed that he found it "bizarre" that Sonya would not be detected in the backyard given that the house was often used as a meeting place and the yard was often used as a thoroughfare. He also commented on the "very

[136] Exhibit 1, Volume 1A, Tab 12, Statement of PCSC Madeline Fleming dated 63 April 2022 at [80(IV)], p 57.
[137] Transcript, 12.2.25, T182.46.
[138] Exhibit 1, Volume 1A, Tab 12, Statement of PCSC Madeline Fleming dated 6 April 2022 at [80(VI)], p 58.

strong" and "very noticeable" smell which he clearly considered unusual for the area.

179. It is submitted on behalf of DSC Fleming that it would be accepted that at the time she undertook the initial body worn video statements, she had an open mind as to whether the cause of Sonya's death was suicide or homicide.[139]

180. Regarding her conclusion in her coronial statement, it was submitted on behalf of DSC Fleming that her evidence was, that although she proffered her opinion that the cause of Sonya's death was suicide, this was not a conclusion and at the time she considered that to be a required as part of her OIC statement.[140]

181. In addition, it was submitted that the departure of the Homicide squad led DSC Fleming to believe the investigation into Sonya's death was not being treated as a homicide.[141]

182. Despite this, in submissions made on her behalf, DSC Fleming accepts, as she did in her evidence, that there were aspects of the conclusion that were problematic.[142]

183. It is submitted on behalf of DSC Fleming that her evidence candidly conceded the shortcomings in her investigation and she accepted that it was an oversight that she did not ask follow up questions about Sonya's broken arm and that not following that up was a missed opportunity.[143]

Other aspects of the first police investigation

184. Whilst the evidence outlined above focuses on the initial investigative steps by police, the evidence also revealed further limitations and missed opportunities arising from the first police investigation, specifically, Barrier PD failing to follow up priority investigative tasks and issues in relation to DSC's Fleming's supervision and support.

Supervision and Support

185. As noted above, DSC Fleming had been at Broken Hill for around a year having commenced duties there in April 2021. She had not previously been called out to Wilcannia to investigate a matter. It was the first time that DSC Fleming had been assigned as an OIC of a suspicious death. Further:[144]

[139] Submissions on behalf of Detective Senior Constable Fleming, [22].
[140] Submissions on behalf of Detective Senior Constable Fleming, [23].
[141] Submissions on behalf of Detective Senior Constable Fleming, [24].
[142] Submissions on behalf of Detective Senior Constable Fleming, [25].
[143] Submissions on behalf of Detective Senior Constable Fleming, [28].
[144] Submissions of Counsel Assisting, [111].

a. her training did not include the history of Wilcannia or the Barkindji people;
b. she was unable to give specifics, but had participated in 'some form of training' about Aboriginal people; and
c. she did not know anyone from Wilcannia.

186. DSC Fleming identified that the 2023/2024 homicide investigation led by DCI Smith had many benefits. DSC Fleming acknowledged the benefits of the involvement of Nicolle Lowe and taking statements in a venue away from the police station and in a more flexible way. DSC Fleming also noted the importance of taking time with the community in the course of the investigation and taking the time to research the town and its culture. DSC Fleming reflected on the importance of ACLOs to improve insight and understanding which, in turn, improves an officer's practice and investigations generally.

187. On 29 March 2022, DSC Fleming did not perceive herself as the OIC and was effectively waiting on guidance from her superiors, in particular AI McCarthy and DI Aylett. She considered one of those two senior officers to be the OIC. As outlined above, on 5 April 2022, after a short period of leave and the post mortem (4 April 2022) it became clear to DSC Fleming that she was the OIC. This had been decided in her absence. She was notified that she was the OIC by email. There was no discussion about the allocation of the investigation to her, including whether she had capacity to take it on.

188. DI Aylett agreed that the investigation had been allocated to DSC Fleming by email. However, there was a discussion about the case after the email was sent. DI Aylett stated that by that time, the case was going to be a coronial brief. He said that he had no concerns about DSC Fleming's capacity to be the OIC. When asked whether he knew she had never investigated a suspicious death before he answered, "probably not" and admitted that he never considered whether DSC Fleming was best placed for the case. DSC Fleming went on leave in mid-April until early May 2022. No one had oversight of the investigation at that time.

189. It is submitted by counsel assisting that the allocation of DSC Fleming as OIC to this investigation was done without proper consideration as to whether she had the capacity and experience to be assigned this responsibility. This decision, in addition to the inadequate supervision and support she received, contributed to the unsatisfactory outcome that the investigation was incomplete when the initial brief was submitted to the coroner and distress to the community arising from missed opportunities, including those outlined above.[145]

[145] Submissions of Counsel Assisting, [114].

190. DSC Fleming displayed significant courage when she spoke about the challenges she felt, including:

> *A. I probably would have appreciated to have a sit down with my sergeant and kind of have that conversation as to where, why I was having it, or had that certain case, who potentially would have been allocated or put on there to assist me. Yeah, just - just a conversation would have probably been nice.*
>
> ...
>
> *Q. I know you've said that it's a complex office and it's hard to explain, but doing your best, what was your understanding at that time about what you could do to seek help or guidance with respect to an investigation?*
>
> *A. With - it's very hard to explain that Broken Hill office. To sum it up, we essentially, we only had plain clothes senior constables, none were designated detectives at that time. We essentially - most of our jobs or anything, we generally - our detective sergeant, I would say would be approachable but didn't give much interest in any of our jobs, so a lot of them were kind of we would work together, I guess, between us, just as us PCs, to do jobs. And to seek help, obviously, we would potentially seek help from Mr Aylett. But, you know, only he can do so much, as a crime manager he's crime managing the whole of Barrier PD. And yeah, so it - I guess it is, in that office, it's hard to necessarily seek help because it's - it's not always there and sometimes the people that are sitting in those supervisory roles aren't necessarily doing their job.*
>
> *Q. By that job do you mean oversight and assistance of—*
>
> *A. Yeah, like—*
>
> *Q. --officers like yourself?*
>
> *A. Yeah. This job's - obviously this matter's quite excessive, and yeah, I obviously can concede that I probably should have asked for more help. But it was just kind of, I guess, in that time at that office, it was known to - to just kind of do it.*
>
> *Q. Had you ever made a request for help or extra resources before, in that year you'd been at Broken Hill?*
>
> *A. No.*

Q. Had you seen anyone else do it? So you never seen someone do it and be refused; is that right?

A. No, no.

Q. But there was no culture in which you had observed anyone offering assistance, or anyone seeking it; is that fair to say?

A. I - between us PCs, obviously we'd offer help between each other to - in between our own caseload, but, yeah, it isn't - you know, there's very little help that we can seek necessarily in - at that station. There's, yeah, it's - in Broken Hill there's, you know, people moving and changing, and no one's necessarily set in that position, or someone's relieving somewhere else. It's really hard to seek that stability of support in - in that station.

Q. I don't want to upset you, but what impact does it have on you to work in a police station with that environment?

A. Huge impacts. I work at this police station now and I know that I'm supported and I'm – and I'm supported - I'm supported by my supervisor and she's aware of everything that's going on in our matters. And it's just a stark contrast to what I was faced in Broken Hill and what our office was faced.

191. DSC Fleming, with the benefit of hindsight, stated that as a plain clothes senior constable with one year of experience in a detectives' office, she probably should never have been the OIC of this case. It is submitted by counsel assisting that this candid and thoughtful remark should provide pause for senior officers allocating OICs to serious cases, particularly in unique and complex communities, to consider carefully the capacity and experience of the officer being considered for OIC duties. Further, this comment by DSC Fleming should emphasise the importance of this decision given the impacts that may follow as a result of a junior officer taking on an investigation like this.

192. DI Aylett acknowledged listening to DSC Fleming's evidence at the hearing and said, "that was confronting from someone who was her manager."[146] Some of the reflections DI Aylett had in relation to DSC Fleming's evidence about support and supervision were:

    a. there was a generation gap between the supervisors and younger detectives which was a roadblock in terms of advice and support and guidance;

[146] Transcript 24.10.25, T26.44.

b. he wished he'd been made more aware of the support that DSC Fleming needed because he had the capacity to make that happen;

c. he agreed with the proposition that he had an expectation that DSC Fleming was going to be provided with more supervisory support than she ultimately received;

d. it was AI McCarthy's role to ensure when an OIC goes on leave that there was some continuity and follow-up throughout the investigation;

e. he expected that if there was some difficulty in providing that sort of continuity it would have been raised with him. He would not dive into something unless he was made aware it was an issue.

193. There was a requirement that AI McCarthy report monthly as part of a review process of the investigation. DI Aylett does not believe he received any report in April 2022. He gave evidence that he did receive a report in July 2022 but that he did not otherwise receive monthly reports.

194. DI Aylett informed the court that there had been some improvements at Barrier PD in recent times, including:

a. an additional Detective Sergeant role which has been created and filled;

b. implementation of monthly strike force reviews;

c. the development of an investigation response model which includes a nominated local OIC to oversight community engagement and welfare; and,

d. the introduction of family liaison roles so that families of deceased people can have a direct police contact and be kept informed of the progress of the investigation

195. AI McCarthy did not give evidence at the hearing. The monthly review process appears critical and, by reference to the Terms of Reference, should have been done. It was necessary to support DSC Fleming and most importantly, as a quality control mechanism to ensure proper oversight of this investigation.

Other issues

196. The potential that the physical environment had changed between the time Sonya was found on 29 March 2022 and the homicide squad's more thorough investigation in 2023/2024 meant that the further investigations undertaken, particularly those investigations relating to 8-10 Hood

Street and 44 Myers Steet, were compromised.

197. The passing of time also meant that it became difficult to resolve issues raised by community members. For example, a knife found by Mariene Hunter was very unlikely to be recovered after such a long time and it would be difficult to identify (and test) a pram, if any, that could have been used by Mr Wilson. Quite obviously, the passing of time also meant that witness' capacity to recall what they heard and saw over the course of 26-29 March 2022 was bound to be compromised.

Improvements suggested by DSC Fleming

198. DSC Fleming gave candid evidence, identifying and apologising for deficiencies which, in hindsight, she has identified with the initial investigation. This took courage and it was clear that DSC Fleming was doing her best to assist the court.

199. DSC Fleming made some very helpful suggestions for improvements to practice including:

    a. having regular rostered days in Wilcannia. This would give the officer an opportunity to build relationships with the community;

    b. the need for ongoing and structured case review to support officers;

    c. ensuring a senior officer sits down with officers when they go on leave or are allocated an OIC role and engagement in case reviews; and,

    d. implementing a higher level of culturally sensitive support, assistance and training.

Submissions on the first police investigation

200. In submissions on behalf of the Commissioner, it was conceded that while significant resources were allocated in the aftermath of the discovery of Sonya's body and a large number of investigative steps were undertaken in the early stages of the investigation, there were shortcomings in the original investigation following the departure of the Homicide Squad.[147]

201. In response to the submissions of counsel assisting regarding certain deficiencies in the initial investigation as outlined above, it is accepted by the Commissioner:[148]

    i. That further attempts should have been made promptly to take formal statements from key witnesses

[147] Submissions on behalf of the Commissioner of NSW Police Force, [32].
[148] Submissions on behalf of the Commissioner of NSW Police Force, [33].

ii. Consistent with the evidence of DS Neil, the attempts to obtain the CCTV footage from 44 Myers Street were inadequate; if Mr Wilson was not prepared to surrender the original hard drive voluntarily or allow police to download the footage themselves, steps should have been taken to facilitate the lawful seizure of the hard drive (including by obtaining an appropriate warrant);

iii. The question of whether DSC Fleming was sufficiently experienced to serve as the OIC of the investigation was not the subject of sufficient consideration, and she did not receive sufficient ongoing supervision and support with the conduct of the investigation (including because of a failure to ensure that the monthly review process occurred as required; and

iv. The investigation should have been transferred to another OIC following DSC Fleming's move to Goulburn in July 2022.

202. In submissions on behalf of Keith Dutton, it was noted that the coronial process has provided Mr Dutton with a greater insight into the response to Sonya's death. Whilst the grief from Sonya's death was, and will always be profound, it has been exacerbated by gaps in the initial police investigation, which resulted in lost opportunities to know more about the circumstances of Sonya's last moments.[149]

203. It was submitted on behalf of Mr Dutton that the inquest process was effective in drawing attention to the historical and contemporary circumstances of Wilcannia, that calls for the adaption of investigatory techniques for remote Aboriginal communities in the future. The initial investigation did not respond to that call.[150]

204. It is submitted on behalf of Mr Dutton that the uncertainty and objective reality that no positive finding can be made about the cause of Sonya's death and the evidence during the inquest leads to a submission that uncertainty has been contributed to by decisions made in the first investigation.[151]

205. In submissions on behalf of Mr Dutton, the following aspects of the evidence are emphasised to contribute to an understanding of the context where further harm can flow from deficiencies in an investigation into the tragic loss of a loved family and community member:[152]

[149] Submissions on behalf of Keith Dutton, [3].
[150] Submissions on behalf of Keith Dutton, [5].
[151] Submissions on behalf of Keith Dutton, [35].
[152] Submissions on behalf of Keith Dutton, [37]-[70].

i. There were ambiguities in the leadership of the investigation in the initial days of the investigation;

ii. There was a lack of a strategic or structured handover from the Homicide Squad paving the way for relevant follow up to be missed;

iii. There was an absence of oversight, communication and support once ongoing responsibility was allocated;

iv. There was a premature focus on suicide that contributed to deficiencies in the first investigation that will never be repaired;

v. There was an absence of critical supervision at the time the officer-in-charge was transferred; and,

vi. There was poor communication about the investigation to Sonya's family and the community of Wilcannia.

206. It is further submitted on behalf of Mr Dutton that it is apparent that there has been serious reflection about possible improvements from some members of the first investigation, such as DSC Fleming and DI Aylett.[153]

207. It is submitted on behalf of DSC Fleming that she candidly concedes the shortcomings in her investigation. It is noted in submissions on DSC Fleming's behalf that she has apologised for how the manner of her investigation may have made others, such as Mr Dutton feel, and she maintains that apology unreservedly.[154]

208. I am grateful for the appropriate concessions made on behalf of the Commissioner and DSC Fleming in relation to the initial investigation into Sonya's death. It is regrettable that the deficiencies in the initial investigation into Sonya's death, in particular the approach taken to certain investigative priorities as outlined above, resulted in missed opportunities to gather further evidence regarding the circumstances of her death.

[153] Submissions on behalf of Keith Dutton, [6].
[154] Submissions on behalf of Detective Senior Constable Fleming, [33].

Lessons from the second homicide investigation

Preparation and community engagement

209. It is submitted on behalf of counsel assisting that the Homicide Squad, consisting of DCI Smith, Detective Surplice; DSC Buckland and DSC Chew undertook a professional and thorough investigation. A number of family members and community members expressed their appreciation for their work and the thoughtful and respectful way in which they approached the community.[155]

210. As part of the investigation the team travelled to Wilcannia six times. DSC Chew gave evidence about the preparations he and his colleagues undertook prior to commencing the investigation in Wilcannia. In addition to undertaking a thorough review of the brief of evidence, DSC Chew referred to:

    a. listening to an episode of the Dying Rose podcast about the death of Sonya to get an understanding of the issues and concerns being raised by the community and the media;

    b. engaging in a series of meetings with the solicitors and counsel assisting the Coroner;

    c. meeting with DSC Fleming;

    d. reading the Royal Commission into Deaths in Custody report into the death of Mark Quayle. DSC Chew said that this report outlined the significant disadvantage in the community and lack of services at that time (1987), and he saw some similarities between then and now in relation to the lack of services available;

    e. undertaking research about the Wilcannia community including in relation to population and the make-up of the population, housing and other information which demonstrated how unique and isolated the town was;

    f. engagement with ACLOs including Ike Williams, Brendon Adams (who worked in Wilcannia) and Paul Sloan and Vanessa Tompkins. DSC Chew gave evidence about the many benefits of working with ACLOs including learning how to engage in a more sensitive way with the First Nations community and give reassurances to community members they were talking with;

[155] Submissions of Counsel Assisting, [127].

g. being assisted by Nicolle Lowe, Aboriginal Coronial Information and Support Officer from the Coroners Court. DSC Chew described her assistance and support as invaluable to the investigation and said further:

> *I can't speak highly enough of Nicolle, I think the investigation team shares that as well. She's very motivated and passionate about it and again very similar to ACLOs. Was great in engaging with Keith Senior in the first instance and introducing us to Keith and then as well as the rest of the community. She's just a very positive influence on our interaction with the community and greatly assisted us.*[156]

h. being assisted by Elders and respected leaders in the community, including Monica Kerwin. DSC Chew noted that these members of the community 'knew people's personal experiences, knew where they were, if they were available, and they again, similar to before, they could vouch for us. Once we've made the relationship with those people, explain to them why we're here, they could then pass that information on, and in a sense, vouch for us to provide a reason why we're here looking into Sonya's death.'[157]

211. DSC Chew acknowledged that their team had more time and resources to undertake this sort of preparation compared to local police but that it was beneficial.

212. DSC Chew also spoke about the benefits of taking statements in places other than the police station (where community members may have negative associations) and being flexible in terms of when people were able to attend to speak to police. DSC Chew said, 'it was just important for us to find what would be the easiest and best way to try and have people make their statements with us and feel comfortable'.[158] DSC Chew observed that 'there was definitely … a strong willingness to assist police…. With the flexibility, it was important to not be rigid in our approach to taking statements from police. It's very different to Sydney or any other community, I've kind of worked in with that, and often it took multiple times to - just to talk to somebody, to build that rapport before they would finally commit to making a [written] statement'.[159]

213. Monica Kerwin also spoke about being approached by DSC Buckland for advice before the homicide commenced their investigation. Ms Kerwin explained how she helped the police to build trust with community members and how to nurture relationships with the people that they needed to speak to. Ms Kerwin would speak to community members and explain the importance

[156] Transcript, 10.2.25, T23.18-23.
[157] Transcript, 10.2.25, T25.1.
[158] Transcript,10.2.25, T24.32.
[159] Transcript,10.2.25, T27.10.

of telling police what they knew to help put the "puzzle" together.[160] Ms Kerwin saw it as a sign of respect that the investigators reached out to her to help and then continued to call on her for advice.

214. There are important lessons to be learnt for future investigations in remote communities like Wilcannia and I will refer to this further in relation to the recommendations I propose to make.

Second Homicide Squad Investigation

215. Counsel assisting submits that the second investigation conducted by police into the circumstances of Sonya's death was professional and thorough. This characterisation is embraced by the Commissioner.[161]

216. The Commissioner submits that the conduct of the second investigation was exemplary and agrees that lessons can effectively be learned from it. [162]

217. It was submitted on behalf of Keith Dutton that the inquest has been constructive in shining a light on potential improvements to the investigation of deaths in a remote, Aboriginal community. It is apparent that, generally, the community of Wilcannia has consistently been open and committed to find out more about what happened to Sonya. It is further submitted that this commitment was reflected in sustained advocacy by Sonya's family and the broader community, including through engagement with the media – most notably the podcast 'Dying Rose'– as well as their ongoing participation in the coronial process and police investigations.[163]

218. It is submitted on behalf of Mr Dutton that there also arose evidence that the second investigation involved significant effort to adopt investigatory techniques that were culturally informed and responsive to the needs of the Aboriginal community, which in turn, improved the quality of the engagement and the information obtained. It is submitted on behalf of Mr Dutton that effort was complemented by initiatives of the Coroner's Court, including conducting hearings in Wilcannia and adapting courtroom practices, including the availability of the community hall to watch proceedings in a less formal space, aimed at making the process more accessible and less intimidating for community members.[164]

219. However, it is further submitted on behalf of Mr Dutton that the lessons from the original investigation, the efforts of the second investigation and the insight provided by the inquest can

[160] Transcript, 14.2.25, T290.35.
[161] Submissions of Counsel Assisting, [127], Submissions on behalf of the Commissioner of NSWPF, [38].
[162] Submissions on behalf of the Commissioner of NSWPF, [43].
[163] Submissions on behalf of Keith Dutton, [4].
[164] Submissions on behalf of Keith Dutton, [6].

never restore what has been lost by Sonya's family and community. It was submitted that the inquest also resulted in evidence that raises doubt that the improvements identified or implemented by individual officers have been effectively disseminated within the New South Wales Police Force as a state agency and ultimately, there was scant evidence capable of inspiring confidence that, if a similar tragedy were to occur in the future, the investigatory process would not remain vulnerable to the same mistakes.[165]

220. I accept the submission of counsel assisting that the second investigation into Sonya's death was professional and thorough. It is clear that there are lessons that can be learnt from the approach taken by the police investigations in the second investigation.

221. I will refer further to the important lessons in the context of recommendations below.

Police training and ACLOs

222. A further relevant topic to emerge at the inquest, in light of the lessons learnt regarding the police investigation into Sonya's death, was the training regime for NSW Police Force officers that might assist them in approaching investigations in Aboriginal communities in a culturally appropriate way.

223. Inspector Jayde Symons explained the four levels of training that are available to police officers in relation to Aboriginal cultural awareness. Whilst they cover important topics, the first three levels are reasonably short and do not relate specifically to First Nations experience and culture in Wilcannia. The more recent introduction is the Working with Aboriginal Communities training which involves a degree of cultural immersion. As at the time of the hearing, this program had been rolled out in one location, Armidale NSW. Inspector Symons introduced the program as follows:

> *WITNESS SYMONS: Yeah, sure. So then once we go through - well, once we have a community engagement we go really into more of what's like a panel workshop between - so what we would have is elders. We can have people from the local AMS [Aboriginal Medical Service], people from government or non-government organisations that are involved. And then they come in, and we start to go through a lot of the history. So it's open for people to tell the stories about the local area. It's open for police to ask questions as well and vice versa.*
>
> *So some of the things that we also sort of teach in that is we go through things*

[165] Submissions on behalf of Keith Dutton, [7].

like, you know, what's the difference between an acknowledgement and a welcome? Why is that important that people do that, and why do we acknowledge country?

MCMAHON: Yes.

WITNESS SYMONS: Not only just for Indigenous people but for non-Indigenous people as well.

224. It is clear that Inspector Symons is committed and passionate about this program and hopes that the cultural training will assist police to understand the communities they work in on a deeper level. Inspector Symons was asked whether there will be an immersive training program developed and rolled out specifically for Wilcannia:

The one that we've got is actually specific for Broken Hill which is the first one. So then there will be one for Wilcannia because that can be absolutely place-based.

225. As noted above, the role of ACLOs is very important in police investigations.

226. The inquest received evidence about the important role of ACLOs in the Wilcannia community and how they can provide an important bridge between non-First Nations investigators and the community.

227. The ACLO program commenced as a pilot program in 1986 and since that time has expanded to include 58 ACLO positions within the NSW Police Force as at the time of the inquest.[166]

228. ACLOs are civilian members of the NSW Police Force and are located across New South Wales to provide advice and support to police operating within Aboriginal communities, including the ability to provide an Aboriginal cultural perspective to police.

229. Within Barrier PD, where Wilcannia is situated, there are 6 ACLOs, two of which are based in Wilcannia.[167]

230. Wilcannia ACLO, Brendon Adams helped the Court to understand this role in more depth in the context of living and working in Wilcannia: [168]

We are an important link to the police that our community people are protected, their

[166] Exhibit 1, Volume 5, Tab 175A, Statement of Inspector Jayde Symons, [4].
[167] Exhibit 1, Volume 5, Tab 175A, Statement of Inspector Jayde Symons, [17].
[168] Transcript Day 4, 13.2.25, T255.46-50; T256.1-6.

rights are met….[we improve] the relationship….the community, you know, they - they go through their struggles and for us we are that link and we are the vital link to help to make sure our community is safe…

231. ACLOs help to build trust, especially for police coming from urban areas. They help to overcome issues relating to emotions, assist with language barriers, avoid misinterpretation and to make sure there is trust on both sides. ACLOs provide cultural safety. Mr Adams agreed that ACLOs also have an important role in connecting community members to the right services. Inspector Symons expressed her support for Mr Adams and Mr Williams:

MCMAHON: And I just want to start by asking you, in your opinion, how important are the ACLOs, including of course Ike Williams and Brendon Adams in the Wilcannia community?

WITNESS SYMONS: You can't really put a price on it if that makes sense. They know community. They work with community. They are there every day listening and responding to, you know, the things that community need, but working in with them as well. And it's really difficult because, obviously, as an Aboriginal person in the police, whether you're sworn or unsworn, you know, there's a lot of different loads that you carry. And we openly to acknowledge that. So it can be very challenging sometimes working with community and doing police work as well.

232. I make no recommendations in this regard, however it is hoped that the Commissioner's representatives will pass on the relevant parts of the transcript and findings which highlight the important work being performed by the ACLOs in the Barrier PD (and no doubt elsewhere) and that the NSW Police Force will continue to consider ways to best promote and support their critical work.

ISSUE 3: The adequacy of mental health and domestic violence services in Wilcannia, including culturally safe services

233. It is relevant to explore ways in which the services in Wilcannia could be improved to strengthen the supports available for young woman such as Sonya who may experience the same or similar vulnerabilities. Improving those supports may prevent tragic deaths in the future.

234. The evidence of Dr Hovane, Monica Kerwin, Brendon Adams, and the representatives from community services, outlined in my findings, have been central to my consideration of this issue. It is clear from these witnesses' evidence, and the co-operative manner in which the witnesses discussed the complex issues at hand, that there is a willingness to work together and to provide better outcomes for the members of the Wilcannia community.

235. Sonya was generally described as a 'happy-go-lucky' person. She was petite in stature (145cm tall and 35-40kg). Her medical records record a 'failure to thrive' which Dr Hovane noted may be related to her small stature.[169] At the same time, as noted above, records show that Sonya had long standing struggles with her mental health and reported suicidal thoughts to people close to her and health staff. On the times that Sonya was scheduled under the *Mental Health Act (2007)* NSW, Sonya was intoxicated and appeared distressed.[170] Despite her mental health presentations, Sonya did not appear to have a formal diagnosis, engage in regular therapy or be prescribed medication.[171] Sonya had experienced many devastating losses (outlined at [37] of these findings) and commenced drinking at a young age, possibly as a mechanism to soothe her profound and ongoing grief. She was described by community members as a heavy drinker, including around the time of her death. In 2021, Sonya expressed a willingness to undertake rehabilitation, but this did not eventuate.

Adequacy of service delivery

236. The key opinions provided by Dr Hovane in relation to whether Sonya received adequate support are as follows:[172]

> *Q 4.5 Did Sonya receive reasonable and culturally safe mental health care and treatment in the community in the years/months prior to her death, including in relation to:*
>
> *d. Drug and alcohol services*
>
> *e. Mental health services*
>
> *f. Domestic violence support*
>
> *91. A The term 'reasonable' in this question could be viewed from more than one perspective. For example, was the care and treatment Sonya received reasonable in the context of services and responses available at the time? Given the paucity of services available in the community, then one could conclude that the care, and treatment was reasonable based on available services.*
>
> *92. If, however, the question is whether Sonya had received reasonable care and treatment in the community based on her needs, then my response is no, Sonya*

[169] Exhibit 1, Volume 1A, Tab 7, Expert report of Dr Victoria Hovane at [44], p 15.
[170] Exhibit 1, Volume 1A, Tab 7, Expert report of Dr Victoria Hovane at [45]-[46], p 15; see also Appendix B.
[171] Exhibit 1, Volume 1A, Tab 7, Expert report of Dr Victoria Hovane at [47]-[48], pp 15-16.
[172] Exhibit 1, Volume 1A, Tab 7, Expert report of Dr Victoria Hovane at [91]-[92], p 26.

did not receive reasonable and culturally safe mental health care and treatment in the community in the years/month prior to her death.

237. Mr Nott and Mr Weston agreed with the above opinions of Dr Hovane.[173]

238. Ms Jack agreed that the treatment Sonya received based on available services in Wilcannia was reasonable but noted the complexities of concluding that Sonya did not receive reasonable care and treatment in the community based on her needs. In regard to Ms Jack's comment, it was submitted on behalf of Far West Local Health District (**Far West LHD**) that responding to an individual's mental health needs requires more than just health services alone.[174] It was submitted that Ms Jack explained in her evidence that factors such as housing and social issues are involved. Mr Nott of Royal Flying Doctor Service South Eastern Section agreed, saying that there are factors at play which extend beyond mere health needs. He explained that, in approaching a person's health and wellbeing holistically, it is necessary to consider social determinants, underlying factors, and the impact of intergenerational trauma. In that context, non-health responses such as youth programs, housing, police, as well as health services, all play a role. Mr Weston of Maari Ma agreed.[175]

239. It was submitted on behalf of the Far West LHD that any response that seeks to improve the mental health of individuals in Wilcannia will inevitably require a holistic approach.[176] I agree with this submission

240. In relation to current supports in the community, Dr Hovane opined: [177]

> *Q 4.7 Considering the services and supports which are currently available to the Wilcannia community, would those services and supports have the capacity to provide the support that Lasonya required in the years/months prior to her death?*
>
> *94. No. From the information provided and my observations of what is available in Wilcannia, the present service system is unable to provide appropriate supports to those with complex needs like Lasonya*.

241. Mr Weston said it is complex, but he agreed with the above opinion. Mr Nott said he agreed with it but also noted that he thinks that there is good will and that the inquest heard from all providers

[173] Transcript Day 7, 11.12.25, T67.50-68.1-17.
[174] Submissions on behalf of the Far West LHD, [12].
[175] Ibid.
[176] Submissions on behalf of Far West LHD, [14]
[177] Exhibit 1, Volume 1A, Tab 7, Expert report of Dr Victoria Hovane at [91]-[92], pp 26-27.

wanting to work with the community. He said that "when considering the solutions to be able to [provide] wrap around comprehensive care for people with complex, both physical health and mental health needs, there are much broader systemic challenges that mean we're not able to provide that today. So, I agree with that paragraph, and it is through no lack of will or trying."[178] Ms Jack agreed with Mr Nott's response.[179] Mr Nott went on to say: "[a]nd certainly, there is a lot of work I know my colleagues, and certainly internally within the Royal Flying Doctor Service, that we're doing to try and ensure that we can provide the right care for individuals, regardless of where they live".[180]

242. It was submitted on behalf of Far West LHD that Sonya had complex psychological or psychiatric issues, including a history of trauma arising from childhood experiences, frequent loss, grief and ongoing domestic violence, instances of self-harm and substance abuse. It was submitted that the mental health care Sonya received was episodic as a consequence of intersecting factors including her variable presentation, her level of engagement, that she attended different services and that she was at times transient or could not be contacted.[181]

243. Counsel for the Far West LHD outlined in submissions instances where Sonya had engaged with health services in the period preceding her death which it was submitted were similarly episodic.[182] This is consistent with the summary of Sonya's presentations outlined in these findings.

244. Dr Hovane is of the opinion that the present service system available in Wilcannia is unable to provide appropriate supports to those with complex needs like Sonya.

245. Ms Kerwin gave evidence that:[183]

> *We shouldn't be grieving, you know, constantly for our young people, you know, or anyone, really, when we have, you know, so many service provider entering our community with a service that ticks their box, but don't service us on the ground properly and I honestly believe Sonya fell into a system failure.*

246. I accept the evidence of Dr Hovane that the term 'reasonable' needs to be considered from the perspective of the availability of services in the Wilcannia community and Sonya's needs. The

[178] Transcript Day 7, 11.12.25, T68.34-39.
[179] Transcript Day 7, 11.12.25, T68.45.
[180] Transcript Day 7, 11.12.25, T68.45.
[181] Submissions on behalf of the Far West LHD, [6].
[182] Submissions on behalf of the Far West LHD, [9].
[183] Transcript Day 5, 14.2.25, T307.26

evidence available indicates that the services available in Wilcannia at the time Sonya engaged with them were unable to support her complex needs.

247. The court acknowledges the evidence given by the witnesses from the community services and Dr Hovane that to provide appropriate support to people like Sonya, a holistic approach is required and that cultural safety is critical.

Aboriginal counsellors based in Wilcannia

248. A number of witnesses from the community stated that mental health services in Wilcannia are not adequate. Marjorie Whyman said:

> *Q. What about the services if you need help with your mental health?*
>
> *A. No, not very good. No. No. Like, we do have a few services around town, but, you know, people cry out for help, but yeah, they get knocked back, like, most of the time.*
>
> *Q. Where do you go if you need help?*
>
> *A. Well, probably just go and sit with a family member. That's what I'd do.*

249. When asked to nominate a program or service that Wilcannia needs right now, Brendon Adams said that the community needs Aboriginal counsellors. They are so important because they understand community and culture. Mr Adams agreed that it would be ideal if people living in the community were doing that role. Highlighting the local desire for building the capacity of the local workforce. Mr Adams believes there are people within the Wilcannia community who could be trained to do those roles. Ms Kerwin agreed with the need for Aboriginal counsellors based in Wilcannia. Ms Kerwin is in a unique position to assess the capacity of community members for roles in services which are urgently needed in Wilcannia. Ms Kerwin believes that, with training and flexible education, she can envisage some local people undertaking wellbeing roles.

250. Mr Weston highlighted that having Aboriginal people in their workforce is critical for success and Ms Jack and Mr Nott agreed that Aboriginal clinicians are best placed to assist and work with community members.[184]

251. Given the depth of ongoing intergenerational trauma, grief and loss experienced by Sonya and so many Wilcannia community members, counsel assisting submitted that it should be considered a bare minimum that an Aboriginal counsellor position, or positions are created and

[184] Transcript Day 7, 11.12.25, T9.4-29

based in Wilcannia. These positions have been recommended by Ms Kerwin and Mr Adams, who hold leadership positions in Wilcannia. Aboriginal counsellors based in town would overcome some of the drawbacks identified in relation to services which are delivered in a fly-in-fly-out, drive-in- drive-out or zoom-in-zoom-out manner. Such a position or positions would improve cultural safety and could play an important role in the healing or wellness centre, or hub, and the Healing Headstones program, referred to below. It is acknowledged that there are challenges in building a local workforce and recruiting and retaining First Nations health professionals in remote communities. Creating a position which is flexible, however, is an important first step towards meeting a need which has been expressed as pressing by community members. I accept this submission.

Local community programs and Wilcannia Working Party (WCWP)

252. This inquest heard some excellent examples of community led programs. For example, Mr Adams spoke about 'Brothers by the Baaka' (as outlined in these findings at [56]) and the Men's Hub. Ms Ronayne shared the success of an annual prevention program, working with youth, the Dream Bigger event, which involves holding a fashion parade.

253. Ms Kerwin generously shared a successful local program she delivered in Wilcannia, the Healing Headstones program. The program is designed to provide a place of healing for community members experiencing loss whilst they build a headstone for their loved one. This program is of particular significance because Sonya participated in this program, building a beautiful mosaic headstone for her mother's grave. Ms Kerwin supported Sonya through this process which, it is understood, was very important and meaningful for Sonya.

254. This program was embraced by Wilcannia, where so many people experience intergenerational trauma and deep grief and loss:[185]

> *So the program is - speaks for itself through the people that attend it, you know. When we ran our first program, all the families went home and all they talked about was that headstone, "That headstone they're making, youse need to come down". So the families enjoyed that time and each individual is given a safe space to do the headstone, you know, but we can sit in groups. The only time - we sort of - like I said, we sit in groups and we have that conversation about that person they're making it for and the stories you will not read in a eulogy, you know, hear in a eulogy or it will be a story you heard for the first time, you know. When - when Sonya joined, bless her, she - she*

[185] Transcript Day 5, 14.2.25, T299.44.

came in so, you know, "I want to make mum - my mum", you know, and, yeah, she - she said, "What do I do?"

255. Ms Kerwin has demonstrated how to conduct a successful local program – she had 15 people coming for 10 weeks and it is clear they benefitted from the experience. The program worked because it was community led, flexible to meet the complex needs of its participants such as Sonya, and involved local people. Ms Kerwin explained that the program is no longer running but she would like it to be revitalised, to train local people to deliver the program and to find a neutral location where it can run and – "basically, we need to fund it".[186]

256. I make a recommendation in relation to revitalising this successful program in these findings at Issue 4.

257. The inquest heard evidence about how the WCWP is an essential grassroots organisation to provide a voice for local people; to work with government to find solutions to issues affecting the Wilcannia community; and to hold services accountable. Ms Kerwin gave evidence about the need to strengthen the WCWP, in the following ways:[187]

    a. the WCWP has three positions: a secretary, chair and deputy chair (WCWP executive). Only the secretary position is paid. All three roles are important and require a significant amount of work and should be paid roles; and

    b. the WCWP executive should be trained and upskilled to enhance their ability to undertake consultations with community and engage with organisations and government.

258. Mr Weston fully supported the suggestions made above by Ms Kerwin and acknowledged the benefits of strengthening the WCWP:[188]

    MCMAHON: And if that working party was strengthened through the secretariat support, the paid positions, would that benefit service collaboration and service delivery?

    WITNESS WESTON: In my experience, it does because people have to front up to the working party. It forces all of us as service providers into the room at the same time. It forces—

[186] Transcript Day 5, 14.2.25, T301.26.
[187] Transcript Day 5, 14.2.25, T295.32.
[188] Transcript Day 7, 11.12.25, T44.1-50.

MCMAHON: Can I just note nodding by Denise [Jack] and nodding by Shannon [Nott] on this point.

WITNESS WESTON: Yeah. I mean, you know, it's not as if we don't collaborate, but, you know, we have - we all have organisational priorities, a lot of competing priorities. We have to manage staff. We have to schedule people's time. It's not straightforward and easy, but just going back to your reading out that statement by Monica Kerwin, I would wholeheartedly agree with every point that she's made in that statement.

MCMAHON: Richard, and I don't mean to cut you off at all, but I just want to end on this last question. So I give Denise and Shannon some time on this.

WITNESS WESTON: Sure.

MCMAHON: One of the last points you raised was about the benefits of regular meetings. Is that something that your service and I'll ask the same of Shannon and Denise would be willing to talk to one another about re-establishing so that that collaboration with community—

WITNESS WESTON: Are you talking about working party meetings or—

MCMAHON: Yes, essentially, but having regular meetings and I'm not suggesting a particular timeframe, but at least that concept being reintroduced as part of the collaboration process.

WITNESS WESTON: Yeah, look, I would say yes to that question, but just because there are no formal kind of gatherings like that, it doesn't mean we're not talking and collaborating. That's—

MCMAHON: No, no, by no means is that being suggested in the question. It's more of an addition to what's going on.

WITNESS WESTON: Yes. Well, yeah, I look, I think it would be good. I think it has – I think the benefit of it - of doing it more - in a more structured way is it's more transparent for the community. And so people can see that it's happening. You know, everyone's got - you know, community members, not everybody can come to a working party meeting. They've always been quite an open forum. People want to come and air an issue or seek some information. There's no – you know,

it's an open door, but not everybody's - you know, it's not the right forum for everybody, you know, sitting in a meeting all day.

259. There is no doubt that strengthening the WCWP executive in the ways suggested by Ms Kerwin would enhance their capacity to be a strong organisation to engage with services providers in the ways described by Ms Kerwin. It is anticipated that the service providers would greatly benefit from the WCWP being better equipped to express their views and therefore increase the likelihood that the services provided to the community are in line with community expectations and needs. Ms Kerwin said:[189]

> *...but I'd like for your Honour's recommendation to be a priority for this community around listening to grassroots people at grassroots level on what our solutions are.*

260. I accept Ms Kerwin and Mr Weston's evidence that there is a need to strengthen the WCWP. I consider this further in the recommendations at Issue 4 below.

Service gaps and community hub proposal

261. In relation to addressing the service gaps, Dr Hovane recommended 24 hour/7 days a week crisis services and a Healing or Wellbeing Centre. The recommendations are best described by Dr Hovane:[190]

> *For individuals in Wilcannia who are experiencing complex issues like Sonya, there should be 24 hour/7 days a week, crisis services available to respond appropriately to them. This could include a culture-based, trauma based, Sobering Up Shelter in the town to which those in need could be referred. The need for substance use programs and support was identified as part of the safe and healthy communities priority in the CAP in 2019.*
>
> *There is a Safe House already available and which Sonya accessed during her life.*
>
> *To achieve community-level change, Aboriginal people that I worked with extensively in Western Australia (WA) in 2023-2024 during the development of the WA Aboriginal Healing Framework (446 women and men) emphasised the importance of having Healing or Wellbeing Centres in their communities through*

[189] Transcript Day 5, 14.2.25, T306.6-9.
[190] Exhibit 1, Volume 1A, Tab 7, Expert report of Dr Victoria Hovane at [95]-[97], p 27.

which holistic culture-based, community-based, community-led programs can be offered without stigmatisation (e.g., perpetrators and victim labelling) for women, men, youth, children and whole of families. They did not support a fragmented approach to service provision and delivery. They noted that such programs must be offered across prevention, early intervention and tertiary intervention levels, to respond to the complex needs of members of the community. A key element of the work of such centres is to provide positive male and female role-models to work with those who are missing such role models from their family and kinship systems. An important part of a role models' program could be to model what it means to be a strong, respectful man, woman, young person, and child; and to reinforce and teach culture and roles, responsibilities, obligations, rules, boundaries and discipline within culture. Ultimately, they assert that a culture-based approach holds that the safety and wellbeing for all members of the community is central, because that is required by local Aboriginal cultures.

262. The wellness and healing centre recommended by Dr Hovane is similar to a model designed by the local Wilcannia ACLOs (replication was tendered at the inquest as Exhibit 4 and is included at Annexure **C**). Mr Adams made the important point, with which all of the conclave witnesses agreed, that:[191]

> *Wilcannia has its own local ways and local solutions on how services need to be delivered and designed and that's the most important thing because it's about ownership, it's about self-determination and it's about how our… community [grows and improves] and become a better place for our youth*.

263. Other aspects of the hub that were expressed as important by Mr Adams included that the hub must include culture (as that is central to identity) and the hub should also be flexible so that people can just walk in when they are ready).

264. Ms Kerwin and Mr Adams embraced Dr Hovane's recommendations.[192]

265. The witnesses expressed the challenges and opportunities of these models from their perspective. Mr Nott highlighted that this sort of model is needed in nearly every rural and remote community across Australia. There are challenges, however, in relation to funding and he expressed a concern that it may require a redesign of our entire health system.

[191] Transcript Day 4, 13.2.25, T260.35.
[192] Transcript Day 4 13.2.25, T260.17; Transcript Day 5, 14.2.25; T303.9.

266. Those issues aside, however he said:[193]

> *The opportunity presented by the recommendations are to have an ongoing and meaningful engagement with the community around what their needs are and for experts, which includes community, to be able to look at ways that we can try to accomplish the elements that are described here for the Wilcannia community hub*.

267. Mr Weston identified challenges including 'how is it going to happen'. Mr Weston also said that the model was not unfamiliar to him having worked at The Healing Foundation for nine years. He said The Healing Foundation would often ask what the community wanted and the idea of a healing community hub was often presented back. The challenges from his perspective included determining the process of community engagement and the complexities of the issues within the community. Mr Weston also pointed to the practical difficulty of funding a 24-hour 7 day week model. Mr Weston reiterated the importance of taking forward important principles of self-determination, community leadership and community engagement. Mr Weston returned to the important issue of avoiding a deficit narrative: [194]

> *We shouldn't come at the Aboriginal community in Wilcannia as, you know, a set – a bucket load of deficits that have to be fixed. We have to come at it, and say about what's working – what works, and where are the strengths in this community, and they are in the things that Monica listed in other parts of her evidence around, you know, the community has agency*.

268. Mr Weston ultimately said that there is nothing wrong with the healing hub concept, but "you really need to test the waters with the whole community".[195]

269. Counsel for the Far West LHD outlined in submissions that people in Wilcannia need more than a health response and that a hub would ideally provide not only mental health care, but also address the issues that contributed to Sonya's episodes of poor mental health: social, housing, income support, education, employment, family and community issues, trauma, violence and substance use.[196]

270. Ms Jack agreed with Mr Nott and Mr Weston and made further important contributions including acknowledging the reality that crises within the community are being dealt with by the

[193] Transcript Day 7, 12.12.25, T28.
[194] Transcript Day 7, 12.12.25, T73.
[195] Transcript Day 7, 12.12.25, T75.9-10.
[196] Submissions on behalf of Far West LHD, [12]-[15].

community itself after hours. Ms Jack made the point that the 24-hour service is formalising something that the community are already doing. The difference being the crisis centre would create a safe space to do it.

271. Inspector Symons agreed with the others at the table and emphasised that it is about "supporting the community in relation to what they want".[197]

272. Ms Ronayne agreed that 24-hour support is necessary, particularly in the early morning hours when people need urgent assistance. She acknowledged the work the community is already doing to support its people. When asked if the model proposed by Dr Hovane aligns with the Safe House and if the Safe House would be involved with such a model, Ms Ronayne responded "Absolutely".[198]

Features of service design and delivery

273. The evidence from the community service representatives was exceptionally helpful in terms of conceptualising foundational principles and themes arising in terms of service design and delivery. These principles and themes should be included in the development and delivery of services in Wilcannia in the future:

    a. **Services and programs should be community-led**. Ms Ronayne explained the importance of the Safe House being developed by Aboriginal women of Wilcannia. Ms Ronayne has five Aboriginal people working at the Safe House, three of whom are from Wilcannia and two are from Broken Hill. Ms Ronayne said that all of the local knowledge is led by those team members. When asked if there is one piece of advice to non-First Nations controlled organisations, she said:[199]

        > *We have to be led by the locals. We have to be led like the panellists, the ones that we're wanting to engage. There has to be, through the interview process, it has to be not so much mainstream. We need to be doing pre-meetings with the local community to be able to understand their knowledge. Understand their, you know, because it's the lived experience of Wilcannia that's not drawn out. So, for instance, if I'm looking for somebody within the community for mental health, everyone's been trained in regards to first aid and mental health.*
        >
        > ...

[197] Transcript Day 7, 12.12.25, T73.4-6.
[198] Transcript Day 6, 11.12.26, T474.27.
[199] Transcript Day 6, 11.12.26, T54-55.

There is people that's already skilled just through life experiences, unfortunately through traumatic and fatal, you know, times. There's that learning that we have, and there are people in Wilcannia that you go to, and you learn from.... You see it from the cultural - it's already there. It's already in the community.....Wilcannia is so equipped in regards to cultural ways, and we need to be led by them. We need to have them guiding the steps of who's going to be in those roles.

b. **Cultural safety is critical.** Mr Nott talked about engaging with the local Bakindji people and community-controlled organisations to ensure infrastructure is safe and to continually improve services and to create what local people consider to be a safe space for them. He also stated, and all of the witnesses agreed:[200]

I think if you look at the evidence, it is very clear that there's two main things for most people in terms of accessing care, step 1 is that they can access care that they can trust and is right for them and is patient centred and in the context of Wilcannia clearly community centred and culturally appropriate and responsive.

c. **Continuity of care is important.** The second point made by Mr Nott following from the above passage was as follows: [201]

The other component with that continuity of care step is people do not want to see a new person to explain their story over and over again and clearly also from a medical perspective that institutes risk where there are multiple providers.

d. **Service providers in Wilcannia must collaborate with one another and the Wilcannia community**. That collaboration includes collaborating with the WCWP. Mr Weston described the WCWP as a "very important cultural and community governance mechanism".[202] All of the witnesses agreed with the importance of engaging and collaborating with the community.

e. **First Nations peoples are critical to service delivery in Wilcannia**. Mr Weston provided an example in the context of Maari Ma: [203]

WITNESS WESTON: People, you know, if you do get a mental health - a GP mental health plan, there's nothing wrong with them. Some people need that

[200] Transcript Day 6, 11.12.26, T48.
[201] Transcript Day 6, 11.12.26, T11.36-12.7.
[202] Transcript Day 7, 12.12.25, T42.48-49.
[203] Transcript Day 6, 11.12.26, T48.

sort of level of intervention but they take a long time. Sitting down and asking - answering a lot of questions with a general practitioner. You know, allowing - enabling people to just access an Aboriginal social emotional well-being team who understand where that person's coming from, and, you know, people can just start yarning, and start talking.

MCMAHON: So removing that step, essentially?

WITNESS WESTON: Well, it's really just giving people more of an option. It's not just - you know, it's allowing them to access the people they need in that moment for how they're presenting. It doesn't require a person who's relatively okay to go through a horrendous process with a general practitioner. It just allows people to, well, to have that yarn, but build a connection and a relationship with the, you know - the people running - you know, delivering the services.

MCMAHON: So you're talking about flexibility. You're talking about options?

WITNESS WESTON: Yeah, and I think we're able to do that. I'm talking about this from an Aboriginal community-controlled perspective.

f. **Services and programs must be flexible**. Ms Kerwin explained that part of the success of the Healing Headstones program was that it allowed people time and space to engage at their own pace. Mr Weston also emphasized the importance of flexibility. Flexibility also involves collaborating with other services to overcome challenges with providing services in remote communities. Mr Nott gave the example of the RFDS and Maari Ma working together to engage in record sharing to improve continuity of care. Mr Nott also spoke about having flexible points of entry when accessing mental health and drug and alcohol services, incorporating a stepped model of care.

g. **Grouping services together allows for a community member to connect to services (such as counselling) in a more subtle way**. Ms Ronayne provided a good example of this namely having a laundromat at the Safe House, a person can come to the Safe House to do their washing and then they can connect to other services and supports offered there. This can avoid stigma and allows someone to have a softer introduction to much needed services.

274. These foundational principles must be central to the delivery of services identified in the

recommendations, which I consider in Issue 4.

ISSUE 4: Whether any recommendations are necessary or desirable in connection with Sonya's death

275. The evidence in these proceedings gives rise to the potential to make recommendations aimed at ensuring the health and safety of the Wilcannia community and preventing a similar tragedy occurring in the future.

276. In this regard, at the conclusion of the hearing, counsel assisting proposed seven recommendations arising out of the evidence.

277. Noting the importance of these recommendations, I am going to go through them each individually.

Proposed recommendation 1

278. Counsel assisting proposed that the NSW Police Force review supervision and support processes at Barrier PD, including the OIC allocation processes, and implement changes to support the supervision of junior officers. Counsel assisting submitted that this review should also assess the effectiveness of processes recently implemented.

279. The Commissioner did not oppose a further review to assess the implementation of the improved processes and consider any aspects of DSC Fleming's suggestions that have not adequately been addressed via the improvements already made.

280. Keith Dutton supports this recommendation.

Proposed recommendation 2

281. Counsel assisting proposed that the NSW Police Force undertake a review of the strengths of the second homicide investigation and consider how the approach by the homicide squad, led by DCI Smith, could be implemented into core police training for police who are working in regional and remote communities or those who may work in such communities (for example, the on-call homicide squad). In particular, consideration should be given to including elements of the approach in the immersive, place-based training led by Inspector Symons.

282. The Commissioner supports this recommendation.

283. Keith Dutton supports this recommendation.

284. The significance of this proposed recommendation is two-fold. Firstly, the second homicide

investigation into Sonya's death demonstrated the value of connecting with community in the process of the investigation. Secondly, the availability of the expertise of the Homicide Squad in supporting local investigations cannot be overstated and is likely to greatly assist police in the critical first stages of an investigation and provide important guidance as the investigation continues.

285. I agree with counsel assisting that it is important that police officers who are investigating suspicious deaths, in particular in regional and remote communities, are aware that they can access expert assistance from the Homicide Squad.

286. I propose to expand the proposed recommendation of counsel assisting. I consider that as part of the recommendations, it is important that steps be taken by the NSW Police Force to strengthen the knowledge and understanding by regional and remote police officers about the services offered by the Homicide Squad in relation to suspicious deaths which occur in regional and remote communities.

Proposed recommendation 3

287. Counsel assisting proposed that Maari Ma and the Far West LHD should work together, consulting with the WCWP, to explore the possibility of creating and funding an Aboriginal counsellor role or roles. As part of this process, consideration should be given to supporting local community members to train and upskill to provide social and emotional wellbeing or counselling services in Wilcannia.

288. Maari Ma endorses this recommendation.[204]

289. It is submitted on behalf of the Far West LHD that it understands and respects the community's desire to have counselling services provided by Aboriginal people, who are best placed to provide culturally safe care, as expressed by Mr Adams, Ms Kerwin and Ms Whyman in evidence.[205]

290. It was submitted by Far West LHD that Ms Jack's evidence highlighting the reference to a "counsellor" may be problematic, and that the requirements for becoming a counsellor are stringent, including the need to do a 4-year degree. Far West LHD submits that it has worked with TAFE in the past to identify courses which can be accessed more easily. There could also be alternatives to counsellors, such paid roles for people in the community with lived

[204] Submissions on behalf of the Maari Ma Health Aboriginal Corporation, [17].
[205] Submissions on behalf of Far West LHD, [18].

experience, or peer workers.[206]

291. The legal representatives for Far West LHD submitted that this proposal should not be directed at Maari Ma and Far West LHD alone, as this will limit its prospects of success.[207] I acknowledge that funding for counselling services is often sourced from the non-government sector, and that it is therefore important to have discussions about establishing these roles with non-government organisations. I agree with the Far West LHD submission that this proposal should form part of the wider discussions reflected in the proposed recommendations 4, 5 and 6 and I address this issue below.

Proposed recommendation 4

292. Counsel assisting proposed that the services represented at the conclave arrange a meeting with the WCWP, and any other member(s) of the Wilcannia community nominated to express community views, within 12 months to discuss Dr Hovane's recommendations and the 'community hub' proposal and consider how those recommendations may be progressed in the community.

293. Maari Ma endorses this recommendation.[208]

294. Far West LHD supports this recommendation, but notes Ms Jack's evidence that there are likely to be funding and logistical issues to overcome. Those representing Far West LHD consider that it is probable that other agencies will need to be involved in the future to resolve issues, however they consider that given the support the proposal received from the services involved in the inquest, that it would be sensible to start with a meeting as proposed.

295. The Commissioner supports this recommendation and considers that it is appropriate that a NSW Police Force representative attend the contemplated meeting to discuss community views in relation to the possible progression of the 'community hub' proposal.

Proposed recommendation 5

296. Counsel assisting proposed that representatives of the services represented at the conclave meet within 12 months to discuss the development of a service directory and, in consultation with Wilcannia community members, develop a service directory that can be made available to services and community members in a variety of different ways to enhance the accessibility of

[206] Submissions on behalf of Far West LHD, [20].
[207] Submissions on behalf of Far West LHD, [17].
[208] Submissions on behalf of the Maari Ma Health Aboriginal Corporation, [6].

the resource.

297. Maari Ma endorses this recommendation.[209]

298. Far West LHD supports this recommendation and is committed to meeting with other services and the Wilcannia Working Party to discuss how this project can progress. Those representing Far West LHD suggest that the Western NSW Primary Health Network would have an important role to play in the creation of a service directory, given many of the relevant services would fall within its remit.[210]

Proposed recommendation 6

299. Counsel assisting proposed that the services represented at the conclave meet within 12 months to consider mechanisms to enhance their engagement with the Wilcannia community (including the WCWP) including:

    a. providing structured and transparent opportunities for community members to voice their concerns and ideas about potential solutions;

    b. illustrate to the community how those concerns have been heeded; and

    c. how to appropriately support efforts by the WCWP executive to advocate for measures to strengthen the WCWP including those outlined in these findings.

300. Maari Ma and the Commissioner support this recommendation.[211]

301. The legal representatives for Far West LHD note the existing processes of engaging with the Wilcannia Community, including that the current Director for Aboriginal Health already engages with the WCWP, and takes feedback from the community to Far West LHD, to inform service delivery. Far West LHD already has a Health Action Plan for Wilcannia, which has been developed with the WCWP, which identifies local health priorities for the community. Far West LHD recognises that there would be opportunities to improve engagement with the Wilcannia community and supports this recommendation. I note that the inquest received into evidence a copy of the Health Action Plan Progress Update dated March 2025 demonstrating that this is a working document.[212]

302. In addition to considering proposed recommendations 3, 4, 5 and 6, Far West LHD submitted

[209] Submissions on behalf of the Maari Ma Health Aboriginal Corporation, [6].
[210] Submissions on behalf of Far West LHD, [24]-[26].
[211] Submissions on behalf of the Maari Ma Health Aboriginal Corporation, [6].
[212] Exhibit 7, Bundle of five health documents including Wilcannia Aboriginal Health Action Plan.

that a combined recommendation could be made on the following terms:[213]

The services represented at the conclave arrange a meeting with the WCWP, and any other member(s) of the Wilcannia community nominated to express community views, within 12 months, to:

a. Explore the possibility of creating and funding an Aboriginal counsellor role or roles. As part of this process, consideration should be given to supporting local community members to train and upskill to provide social and emotional wellbeing or counselling services in Wilcannia.

b. Discuss Dr Hovane's recommendations and the 'community hub' proposal and consider how those recommendations may be progressed in the community

c. Discuss the development of a service directory and, in consultation with Wilcannia community members, develop a service directory that can be made available to services and community members in a variety of different ways to enhance the accessibility of the resource;

d. Consider mechanisms to enhance their engagement with the Wilcannia community (including the WCWP) including:

    i. providing structured and transparent opportunities for community members to voice their concerns and ideas about potential solutions;

    ii. illustrate to the community how those concerns have been heeded; and

    iii. how to appropriately support efforts by the WCWP executive to advocate for measures to strengthen the WCWP.

303. I accept this proposal from Far West LHD to combine recommendations 3, 4, 5 and 6 in these terms.

304. With respect to proposed recommendations 3, 4, 5, and 6, Counsel for Maari Ma submitted that it would be appropriate for there to be a lead agency to make the logistical arrangements to gather representatives of the services, so that there is no room for confusion as to who has that responsibility.[214] I accept that submission.

[213] Submissions on behalf of Far West LHD, [30].
[214] Submissions on behalf of the Maari Ma Health Aboriginal Corporation, [17].

305. Following the conclusion of the inquest, the team assisting made enquiries with community members and legal representatives for the services about this submission made by Maari Ma. As a result of these enquiries, Far West LHD, via their counsel, indicated a willingness to be the lead agency for purposes of the implementation of this recommendation. I thank Far West LHD for their willingness to undertake that role.

306. The evidence at inquest clearly established the WCWP as enabling local members of the Wilcannia community to have a voice about the services required in the community and how those services should be delivered.

Proposed recommendation 7

307. Counsel assisting proposed that Maari Ma work with the Wilcannia community to revitalise the Healing Headstones program and support its delivery, including by assisting with any suitable funding applications.

308. This recommendation is endorsed by Maari Ma. The representatives for Maari Ma note that the actual delivery of this program will be dependent on the availability of funds. Mr Weston gave compelling evidence about the value of this program and the commitment of Maari Ma to supporting it.[215]

Recommendations

309. Having considered the above, I make the following recommendations pursuant to s 82 of the Act:

To the Commissioner of Police

1. The NSW Police Force is to review supervision and support processes at Barrier Police District, including the Officer in Charge (OIC) allocation processes, taking into account the issues raised in DSC Fleming's evidence and her suggestions for improvements to practice, including:

    a. having regular rostered days in Wilcannia;

    b. the need for ongoing and structured case review to support officers;

    c. ensuring that an officer who is allocated as the OIC of an investigation receives

[215] Submissions on behalf of the Maari Ma Health Aboriginal Corporation, [17].

adequate guidance and handover from a senior officer as to the status of the matter and any further investigative priorities at the time of allocation;

d. that there is appropriate oversight of an investigation by a senior officer in instances where the OIC goes on a period of leave; and

e. implementing a higher level of culturally sensitive support, assistance and training within the Barrier Police District.

Any and all changes to support the supervision of junior officers at Barrier Police District should be implemented. This review should also assess the effectiveness of processes recently implemented, including those described by Detective Inspector Thomas Aylett in the inquest and outlined at [192] in these findings.

2. The NSW Police Force is to undertake a review of the strengths of the second homicide investigation and consider how the approach by the Homicide Squad, led by Detective Chief Inspector Paul Smith, could be implemented into core police training for police who are working in regional and remote communities or those who may work in such communities (for example, the on-call homicide squad). In particular, consideration should be given to including elements of the approach taken in the immersive, place-based training led by Inspector Jayde Symons.

3. The NSW Police Force is to:

   a. undertake a review of the information provided to regional and remote police officers about the support offered by the Homicide Squad in relation to deaths which occur in those areas; and

   b. strengthen regional and remote police officers' knowledge and understanding of the expertise and assistance provided by the Homicide Squad, where necessary.

As part of this recommendation, the following features should be emphasised:

   i. The 24 hour a day, 7 days a week statewide 'on-call' response provided by the Homicide Squad;

   ii. The availability of the Homicide Squad to provide specialist advice and investigative support to regional and remote police officers in homicide and coronial matters; and

iii. The availability of a 'Homicide Review' service to provide an accountable process to review a current suspicious death investigation and provide independent advice to assist investigators.

To the Commissioner of Police, Far West Local Health District, Maari Ma Health Aboriginal Corporation and Wilcannia Safehouse

4. The services are to arrange a meeting with the Wilcannia Community Working Party, and any other member(s) of the Wilcannia community nominated to express community views, within 12 months, to:

    a. Explore the possibility of creating and funding an Aboriginal counsellor role or roles. As part of this process, consideration should be given to supporting local community members to train and upskill to provide social and emotional wellbeing or counselling services in Wilcannia.

    b. Discuss Dr Hovane's recommendations and the 'community hub' proposal and consider how those recommendations may be progressed in the community

    c. Discuss the development of a service directory and, in consultation with Wilcannia community members, develop a service directory that can be made available to services and community members in a variety of different ways to enhance the accessibility of the resource;

    d. Consider mechanisms to enhance their engagement with the Wilcannia community (including the WCWP) including:

        i. providing structured and transparent opportunities for community members to voice their concerns and ideas about potential solutions;

        ii. illustrate to the community how those concerns have been heeded; and

        iii. how to appropriately support efforts by the WCWP executive to advocate for measures to strengthen the WCWP.

    Far West Local Health District is to be the lead agency responsible for organising this meeting.

To Maari Ma Health Aboriginal Corporation

5. That Maari Ma work with the Wilcannia community to revitalise the Healing Headstones program and support its delivery, including by assisting with any suitable funding applications.

Statutory Findings required by s 81(1)

310. As a result of considering all the documentary and the oral evidence heard at the inquest, I make the following findings:

Identity

The person who has died was Lasonya Sheree Dutton

Date of death

Lasonya died between 26 and 29 March 2022

Place of death

Lasonya died at Wilcannia, NSW

Cause and manner of death

The available evidence does not enable me to make a finding as to the cause and manner of Lasonya's death

Conclusion

311. I thank the members of the assisting team, Kirsten Edwards SC, Rebecca McMahon, Sarah Crellin, Bronwyn Lorenc, Camilla Blome and Rebecca Hubbard for their extraordinary work during this inquest.

312. I thank Nicolle Lowe, Simone Kubeca and Kristy Knight, the Aboriginal Coronial Information and Support Program (ACISP) workers from the Coroners Court whose assistance is always so greatly appreciated.

313. I thank Detective Chief Inspector Paul Smith and the members of the Homicide Squad (Detective Sergeant Nathan Surplice, Detective Senior Constable Patrick Chew and Detective Senior Constable Ann Marie Buckland) for their dedication and commitment to their investigation of Sonya's death.

314. I also wish to acknowledge the legal representatives of the interested parties in this Inquest, who worked constructively and collaboratively to assist the Court, in particular in relation to the resulting recommendations which I hope reflect the significance of the lessons learnt from Sonya's tragic death.

315. I acknowledge the significant contribution made by members of the Wilcannia community to this Inquest and to one another as the circumstances of Sonya's death have been closely examined. Aboriginal Community Liaison Officers, Brendon Adams and Ike Williams have been central to assisting with this engagement, extending to their liaison with Paul Sutton and his colleagues of Essential Energy to ensure that the community could view the delivery of the findings from Wilcannia.

316. Finally, I wish to acknowledge and pay my respects to Mr Keith Dutton. Mr Dutton's advocacy and strength despite the tragic circumstances of his daughter's death have been remarkable. I also offer Lasonya's children and her extended family my personal condolences. Your loss is profound and ongoing.

317. In the words of Monica Kerwin, Wilcannia is resilient and full of hope.[216] I have been so impressed by this community. I hope that the close examination of Sonya's death and the recommendations I have made will provide a meaningful pathway forward for the Wilcannia community as they continue to heal from the tragedy of her loss.

318. I close this inquest.

Judge Teresa O'Sullivan
State Coroner of NSW
10 November 2026

[216] Exhibit 1, Volume 1B, Statement of Monica Kerwin, [29].

ANNEXURE A: Inquest into the death of Sonya Sheree Dutton Table of Witnesses called during inquest			
TRANCHE 1			
WILCANNIA COURTHOUSE	**Day 1** 10 February 2025	Detective Senior Constable Patrick Chew	Homicide Squad, NSW Police Force
	Day 2 11 February 2025	Detective Sergeant Sharon Neil	Homicide Squad, NSW Police Force
		Detective Senior Constable Madeleine Fleming	NSW Police Force
	Day 3 12 February 2025	Dorothy Mills	Witness
	Day 4 13 February 2025	Allan Brian Carroll	Witness
		Paul Murray	Witness
		Ronald Murray	Witness
		Marjorie Whyman	Witness
		Brendon Adams	Aboriginal Community Liaison Officer, Wilcannia, NSW Police Force
		Sheena Dutton	Witness
		Sheree Harnett	Witness
		Ingrid Bugmy	Witness
	Day 5 14 February 2025	Monica Kerwin	Witness
TRANCHE 2			
LIDCOMBE	**Day 6** 24 October 2025	Detective Inspector Thomas Aylett	NSW Police Force
		Ronald Wilson	Witness
BROKEN HILL	**Day 7** 11 December 2025	**Institutional Conclave**	
		Mary Ronayne	Community and Culture Manager, Domestic Violence Service Management, Wilcannia Safehouse
		Richard Weston	Chief Executive Officer, Maari Ma Aboriginal Health Corporation
		Inspector Jayde Symons	Aboriginal Strategy & Coordination Team, Crime Prevention Command, NSW Police Force
		Denise Jack	Director Mental Health Drug and Alcohol Violence and Neglect Services, Far West Local Health District
		Dr Shannon Nott	Executive General Manager Health & Clinical Services; and Chief Medical Officer, Royal Flying Doctor Service South Eastern Section
	Day 8 12 December 2025	Dr Victoria Hovane	Ngarluma, Jaru, Gooniyandi Psychologist, Expert Witness
		Glenn Wilson	Witness

ANNEXURE B: Inquest into the death of Sonya Sheree Dutton Summary of Admissions to hospitals and health services				
1.	29 May 2007	Sonya had an argument with family members while significantly intoxicated. She yelled "I'm going to kill myself" before wrapping a shoelace around her neck and attempting to tie it to a tree. Her Uncle, Billy Dutton, called police. She was transported to Wilcannia Hospital, then flown to Broken Hill Base Hospital for psychiatric assessment.	• NSW Police Force (**NSWPF**) • Wilcannia Hospital • Broken Hill Base Hospital	Sonya scheduled under the *Mental Health Act*.
2.	3 February 2009	Sonya called "000" due to experiencing suicidal thoughts and was taken to Menindee at 3.45pm. She had been drinking alcohol since the morning. She informed staff at hospital that she wanted to die and intended to hang herself with her bra. She also reported past suicide attempts, including by cutting her wrists 2-3 months prior, and by attempting to hang herself after an argument with her brother. She stated that she felt bad after an argument with her older brother. She stated that feelings of depression and suicidality were precipitated by the deaths of her two nephews who suffocated in a car. She was transferred to Broken Hill Base Hospital at about 6pm.	• NSWPF • Menindee Hospital • Broken Hill Base Hospital	Sonya transferred by ambulance to Broken Hill Base Hospital, where she was scheduled under the *Mental Health Act*.
3.	27 December 2010	Sonya had an argument with her step-grandfather, Trevor Jones. She called the police and stated that she felt unsafe and had suicidal thoughts. She said that she had self-harmed by cutting her arms and that she had previously attempted suicide by wrapping a video tape around her neck. Hospital records indicate that about three months prior to this incident, she had miscarried at 6 months pregnant.	• NSWPF • Wilcannia Hospital	Sonya was given a provisional diagnosis of "situational crisis due to intoxication". Police took her home, and she declined to have follow up with the community mental health team.
4.	17 April 2013	Sonya attended an appointment at Wilcannia Hospital with a midwife at 32 weeks pregnant and was referred to Mental Health by Midwife. Mental Health triage notes from that appointment record concerns that she was suffering from an eating disorder and depression, noting her reluctance to discuss her diet.	• Wilcannia Hospital	Plan to follow up on 1 May 2013.
5.	14 April 2016	Sonya was brought in by ambulance to Wilcannia Hospital with small wound to her elbow. She presented as distressed. Wound care, dressing and infection care for elbow completed on multiple occasions in April-May 2016.	• Wilcannia Hospital	
6.	9 May 2016	Sonya presented to Wilcannia Hospital with severe abdominal pain. She reported blood in vomit and urine daily for several weeks. She was offered chlamydia and gonorrhoea tests. Given paracetamol after consultation with RFDS doctor.	• Wilcannia Hospital • Royal Flying Doctor Service (**RFDS**)	
7.	4 September 2016	Sonya brought in by ambulance to Wilcannia Hospital after a fall. She had sustained injuries to both knees and her head. Observations were taken. RFDS doctor was not concerned about injuries – given paracetamol/ibuprofen and told what red flags to monitor.	• Wilcannia Hospital • RFDS	

8.	16 September 2016	Sonya presented to Wilcannia Hospital with burns to her cheek, hand and leg. She reported that she had fallen into a fire at a party, reaching for a drink while intoxicated. Her burns were dressed, but Sonya did not wish to stay for observations. She was advised to return for review by Maari Ma or RFDS medical officer on Monday.	• Wilcannia Hospital	
9.	17 September 2016	Sonya was brought in by ambulance to Wilcannia Hospital for burns from previous day. Her burns were dressed. There are records of several presentations for burn care and dressing changes in the following month.	• Wilcannia Hospital	
10.	12 November 2016	Sonya presented, reporting having been unwell for the fortnight preceding. She described being unable to tolerate food or water. Her complaint was discussed with RFDS doctor and she was given an anti-emetic (Ondansetron) and advised to return for review on Monday.	• Wilcannia Hospital • RFDS	
11.	26 November 2016	Sonya presented feeling nauseous. She was mildly intoxicated and coughing up phlegm. She also reported having experienced a fall. Minor wounds dressed.	• Wilcannia Hospital	
12.	27 November 2016	Sonya presented following a fight with her sister with "very small cuts" to second, third and fourth fingers. Band-Aids were applied and she was given paracetamol.	• Wilcannia Hospital	
13.	13 December 2016	Sonya presented for dressing change after abscesses drained the day prior.	• Wilcannia Hospital	
14.	17 January 2017	Sonya presented with 2 underarm abscesses.	• Wilcannia Hospital	
15.	24 February 2017	Sonya presented with a laceration on her right calf muscle after trying to jump over a fence.	• Wilcannia Hospital	
16.	27 March 2017	Sonya presented, reporting that she was unable to bear weight on her left knee following a fall. This is reported to have occurred during an altercation with her mother. Sonya presented twice in March 2017 for this injury.	• Wilcannia Hospital	
17.	18 June 2017	Sonya was brought in by ambulance following an alleged assault by a female. She was given a heat pack and paracetamol.	• Wilcannia Hospital	Sonya stayed in hospital overnight.
18.	27 June 2017	Sonya presented with a burn to her shoulder, sustained several days prior. Given paracetamol for back pain and advised to return for wound review.	• Wilcannia Hospital	
19.	30 October 2017	Sonya was brought into Wilcannia Hospital by friends/family. She presented with decreased level of consciousness. Medical record indicates that Sonya was heavily intoxicated, and medical staff were concerned that she might have hit her head. Antiemetics were administered orally and dextrose fluid was administered intravenously. She was kept for observations, before the RFDS doctor discharged her.	• Wilcannia Hospital • RFDS	
20.	22 November 2017	Sonya presented with multiple abrasions to upper and lower limbs, and torso, after being hit by a car while lying on the side of the road. Sonya reported having been drinking alcohol for some hours. She was reviewed by RFDS doctor. Morphine was administered intravenously.	• Wilcannia Hospital • RFDS • RAH	Transferred to Royal Adelaide Hospital.

21.	28 January 2018	Sonya was brought into Wilcannia Hospital by police, having been found lying outside police station. Sonya reported pain in her left ankle, where she sustained an injury in November 2017 (**see above**). Progress notes indicate that her surgical scar from the same injury was fully healed. RN discussed with RFDS doctor. Sonya was given paracetamol only, due to alcohol consumption, and tubigrip applied to ankle.	• Wilcannia Hospital • RFDS • NSWPF	
22.	19 July 2018	Sonya presented having coughed up/vomited blood. She had also had a physical altercation and had a bruise on her cheek. The RFDS doctor was contacted. Sonya was given pantoprazole and booked for RFDS follow up.	• Wilcannia Hospital • RFDS	Booked for RFDS follow-up.
23.	31 July 2018	Sonya presented having been kicked in the forehead and elbow and stomped on the back of the head by her father. She was reviewed by RFDS doctor. She was provided paracetamol, provided head injury advice.	• Wilcannia Hospital • RFDS	Booked for RFDS follow-up. Offered appointment with D&A but did not wish to engage at this time.
24.	1 August 2018	Sonya presented with a deep cut to middle finger on right hand, sustained when she fell on glass on the footpath. Her bone was exposed. There are several presentations in August 2018 for dressing changes to the same wound. Medical staff queried if this was sustained due to an assault, given Sonya's presentation the previous day. Sonya denied that this was caused by an assault.	• Wilcannia Hospital • RFDS • RAH	Transferred to Royal Adelaide Hospital for surgical washout and clean.
25.	12 September 2018	Sonya presented for an alleged assault during which she was pulled to the ground by her hair at her grandmother's house. Her wounds were cleaned and dressed, and Sonya was taken to her Auntie's house, as she did not wish to return to her grandmother's.	• Wilcannia Hospital	
26.	5 December 2018	Sonya presented with pain in the side of her diaphragm, having fallen over the night before while intoxicated. She also stated that partner punched her there two days prior. She was given Panadeine Forte. Sonya was kept for observation and advised to attend morning RFDS clinic. RFDS doctor requested x-rays.	• Wilcannia Hospital • RFDS • Maari Ma • BHBH	Due to lack of remote operators of radiology equipment, required to travel to Broken Hill – travel and accommodation organised by Maari Ma.
27.	18 March 2019	Sonya presented having been feeling unwell for several weeks. She was experiencing stomach cramps, nausea, vomiting and loose stools. RFDS reviewed her and recommended she be transferred to Broken Hill Base Hospital. Hartmann's and Ondansetron given intravenously. Paracetamol and morphine were given as needed for pain management.	• Wilcannia Hospital • RFDS • BHBH	RFDS recommended that Sonya be transferred to BHBH.
28.	5 April 2019	Sonya presented with a laceration to the back of her right leg, sustained shaving while intoxicated. Wound was cleaned and dressed.	• Wilcannia Hospital	
29.	13 April 2019	Sonya presented with report of having been struck on head with an unknown object by her "ex". She was given paracetamol and the RFDS doctor required hourly observations for four hours, and recommended transfer to Broken Hill if there was a deterioration. Sonya decided to leave prior to the completion of four hours and was given head injury advice/instructions.	• Wilcannia Hospital • RFDS	

		RFDS records state that Sonya was hit in the head by "husband…unclear what she was hit in head with".		
30.	7 May 2019	Sonya presented having fallen while intoxicated. She had sustained a 2cm tear below her patella (left or right not recorded).	• Wilcannia Hospital	
31.	27 May 2019	Sonya presented with sore knee following a fall several days prior. She was reported to be heavily intoxicated.	• Wilcannia Hospital	
32.	7 December 2019	Sonya presented following an altercation with her cousin, during which she was thrown to the ground. She sustained an injury to her forehead, from which she was bleeding, and an injury to the right elbow. Sonya was advised to wait in ER for observation due to head injury but decided to return to her grandmother's house. She was given head injury information.	• Wilcannia Hospital • RFDS	
33.	11 December 2019	Sonya was brought in by police following an altercation with her cousin. She had sustained a laceration to the back of her left ear from a pocket knife. Sonya was described in the Progress Notes as being intoxicated. Sonya was provided analgesia, and her wound was cleaned and dressed. RFDS doctor gave remote consultation.	• Wilcannia Hospital • RFDS	Note made that Sonya would follow up with Maari Ma about possibly engaging with the D&A Team
34.	15 December 2019	Sonya was brought in by police having been assaulted with a "big stick". She presented with several small lacerations and contusions. Medical records indicate a significant level of intoxication. This assault opened several existing injuries from 7 December 2019 (**see above**). RFDS were contacted and Sonya given IV fluids and Ondansetron.	• Wilcannia • RFDS	
35.	1 January 2020	Sonya attended hospital heavily intoxicated and informed staff that she had been punched in the mouth and chest by her uncle.	• Wilcannia Hospital • Wilcannia Safe House	Spoke to Wilcannia Safe House who said that Sonya could not be house while intoxicated, but they may be able to organise motel room for the night. Sonya walked out of hospital at 8.46pm.
36.	18 February 2020	Sonya attended hospital intoxicated with an injury to her thumb caused by a fight with "another girl". Sonya informed staff that she drinks alcohol every day to dull pain from a leg injury, and that she finds it hard to sleep.	• Wilcannia Hospital • Broken Hill Base Hospital	Sonya was to get the bus to Broken Hill Base Hospital on 19 February for an X ray. Sonya indicated that she was open to engaging with D&A staff
37.	23 May 2020	Sonya was brought to hospital by ambulance after hitting her head on cement due to falling whilst intoxicated.	• Wilcannia Hospital	Sonya stayed the night at hospital, and transport was arranged to Broken Hill Base Hospital for a scan but declined to go and signed a discharge at own risk form.
38.	18 August 2020	Sonya attended hospital with an injury to her eye from walking into a door whilst intoxicated.	• Wilcannia Hospital • Maari Ma	Transfer was arranged to Royal Adelaide Hospital for an eye operation, but was ultimately transferred to Broken Hill Base Hospital
39.	18-19 August 2020; 7 September 2020	Sonya was transferred to Broken Hill Base Hospital with a facial fracture from the above incident involving a door frame. She denied assault. 7 September was a follow-up.	• Wilcannia Hospital • Broken Hill Base Hospital	Sonya was referred to, and attended, Broken Hill Base Hospital

40.	3 November 2020	Sonya presented to Wilcannia Hospital with pain to her left neck and torso, after having been allegedly assaulted by a male cousin. RFDS and BHBH doctors consulted regarding analgesia.	• Wilcannia Hospital	
41.	19 February 2021	Sonya was transferred to Broken Hill Base Hospital from RFDS base for ongoing treatment of septic left elbow from an injury due to a fall the week prior.	• RFDS • Broken Hill Base Hospital	Sonya was transferred to Broken Hill Base Hospital
42.	7 March 2021	Sonya completed a remote consultation with the RFDS at Wilcannia Hospital after being assaulted with a bottle and dragged on the floor by her hair. Nursing progress note says assault was by sister. She was conveyed to the hospital by ambulance staff. The perpetrator of the assault was taken into custody by police in Wilcannia. RFDS doctors were consulted re observations.	• Ambulance • RFDS • Wilcannia Hospital • NSWPF	Review after four hours, discharge "with safety net … find out if Sonya has a place of safety if fit for discharge". Discharged to Aunty Milly's house
43.	26 October 2021	Sonya called Wilcannia Police and reported that she wanted to kill herself. Police attended and observed minor lacerations of Sonya's arms. She reported that she felt depressed following an argument with family and was taken to hospital. At hospital, Sonya stated "I'm going to kill myself tonight". Wilcannia Hospital called RFDS. Initially, the Mental Health Team would not assess Sonya due to intoxication. Plan recorded was to keep Sonya under observation until sober enough to consult with Mental Health Emergency Care – schedule under *Mental Health Act* if she decided to leave.	• NSWPF • Wilcannia Hospital • RFDS • Broken Hill Community Mental Health and Drug and Alcohol Service	Sonya scheduled under the *Mental Health Act*, and referred to Broken Hill Community Mental Health and Drug and Alcohol Service on 27 October 2021. On that date they made contact and a plan was made to meet for an assessment on 4 November 2021.
44.	31 October 2021	Sonya had an argument with family regarding her son, became upset and attempted to hang herself from a tree with a mask. She called Wilcannia Police and reported suicidal thoughts. At Wilcannia Hospital she stated "I just don't want to be here anymore", and when asked if she had a plan said "yes I will go and hang myself again". She said that she would like to go to the Broken Hill Base Hospital inpatient unit because she felt unsafe. Wilcannia Hospital contacted RFDS. The next day the Mental Health Emergency Care Team consulted with Sonya and determined that they were happy for her to go home, noting she had an appointment with the Broken Hill Community mental health and Drug and Alcohol Service on 4 November 2021.	• NSWPF • Wilcannia Hospital • RFDS • Mental Health Emergency Care Team • Maari Ma	Sonya scheduled under the *Mental Health Act* and stayed the night at Wilcannia Hospital. On 1 November 2021 she was discharged with a plant to follow up with Broken Hill Community mental health and Drug and Alcohol Service. Sonya walked home.
45.	4 November 2021	Sonya attended assessment with the Broken Hill Community Mental Health and Drug and Alcohol Service where it was recorded that she has "self harming behaviour and suicidal ideation in the context of alcohol intoxication and family conflict".	• Broken Hill Community Mental Health and Drug and Alcohol Service	Rehab options were discussed with Sonya including Wyla rehab facility. Follow up appointment booked for 11 November 2021.
46.	11 November 2021	Sonya cancelled her appointment at Broken Hill Community Mental Health and Drug and Alcohol Service.	• Broken Hill Community Mental Health and Drug and Alcohol Service	Broken Hill Community Mental Health and Drug and Alcohol Service called Sonya on 1 December 2021 to follow up

47.	1 December 2021	Broken Hill Community Mental Health and Drug and Alcohol Service called Sonya on 1 December 2021 to follow up, but she indicated that she was in Broken Hill and would prefer an appointment when she returned to Wilcannia.	• Broken Hill Community Mental Health and Drug and Alcohol Service	Broken Hill Community Mental Health and Drug and Alcohol Service called Sonya on 18 January 2022 but the call went to an unidentified message bank. No further contact was made.
48.	5 February 2022	Sonya presented to Wilcannia Hospital with a laceration on her left big toe, sustained when her son dropped a piece of wood on her foot. Sonya also advised Hospital staff that a week prior she had been hit in the head, sustaining a lump and a laceration above and behind her left ear. She indicated that this incident was not reported to police but she wanted it looked at. Wounds on head and foot cleaned.	• Wilcannia Hospital	Sonya discharged to her home.
49.	12 February 2022	Sonya presented to Wilcannia Hospital with a painful left forearm she attributed to an assault by her ex-partner who she would not name. Police attended hospital. She had various superficial injuries including bruises and swelling of her left forearm.	• Wilcannia Hospital • NSWPF • Broken Hill Base Hospital • Maari Ma	Sonya discharged from hospital. Police charged Glenn Wilson with assault occasioning actual bodily harm. Sonya had a follow up appointment with a doctor on 14 February 2022. On 17 February 2022 Sonya attended Broken Hill Base Hospital for an Xray.

ANNEXURE C: Inquest into the death of Sonya Sheree Dutton

Mind Map of Wilcannia Community Hub[217]



[217] Exhibit 4.