CORONERS ACT, 2003

SOUTH *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 23rd, 24th, 25th, 26th, 27th, 30th and 31st days of May 2011, the 1st and 2nd days of June 2011 and the 20th day of February 2012, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the deaths of David James Wyatt and Jakob James Wyatt.

The said Court finds that Jakob James Wyatt aged 2 years, late of 5 Charlson Street, Davoren Park, South Australia died at Davoren Park, South Australia on the 16th day of March 2009 as a result of stab wounds to neck and chest.

The said Court finds that David James Wyatt aged 24 years, late of 5 Charlson Street, Davoren Park, South Australia died at Davoren Park, South Australia on the 16th day of March 2009 as a result of blood loss due to multiple stab wounds to chest and multiple incised wounds of neck, left arm and lower legs.

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

1. Introduction and cause of death

1.1. David James Wyatt and his son, Jakob James Wyatt, died on 16 March 2009. David Wyatt was 24 years of age and Jakob Wyatt was 2½ years old at that time. Autopsies of both deceased were carried out by Dr John Gilbert, forensic pathologist at Forensic Science South Australia. Dr Gilbert gave the cause of death for Jakob Wyatt as stab wounds to neck and chest[1], and I so find. Dr Gilbert gave the cause of death for

[1] Exhibit C3b

David Wyatt as blood loss due to multiple stab wounds to chest and multiple incised wounds of neck, left arm and lower legs[2], and I so find.

1.2. A police investigation quickly determined that David Wyatt killed his son, Jakob, using a knife. The description of the wounds inflicted upon Jakob as set out in Exhibit C3b, reveal that it was a violent attack. I will not describe the injuries in detail, but they can be summarised as follows: Jakob's throat was cut, resulting in near complete transection of the upper trachea, the left common carotid artery was transected and there was partial transection of the left internal jugular vein. There were six stab wounds over the anterior chest. These resulted in deep penetrating wounds to the right lung, heart and the left lobe of the liver. The stab wounds were inflicted with some force. No defence type injuries were seen on the arms or hands, suggesting that Jakob was asleep at the commencement of the attack, was rapidly incapacitated by his injuries, or was restrained during the attack[3].

1.3. David Wyatt, whom I shall hereinafter refer to simply as 'Wyatt', also inflicted knife injuries on his partner, Naomi Thompson (the mother of Jakob) and on Chloe Thompson, an infant who was the daughter of Wyatt and Naomi Thompson. The investigation showed that Wyatt's injuries were self-inflicted.

1.4. Toxicological analysis of Wyatt's blood samples taken at autopsy revealed the presence of .08 milligrams of methylamphetamine per litre and .04 milligrams amphetamine per litre. It goes without saying that methylamphetamine is an illicit drug, sometimes referred to by street names including 'speed', 'meth' and 'ice'. It cannot be purchased lawfully. The concentrations found were consistent with illicit use[4]. The toxicological analysis also found therapeutic concentrations of quetiapine and risperidone in Wyatt's blood. These were drugs which were administered as part of his treatment for a schizoaffective disorder for which he had been diagnosed.

2. Background

2.1. On 1 March 2005 Wyatt, who was then 21 years old, entered the Parafield Gardens Community Club gaming room with a knife and demanded money from a staff member. He fled on foot having stolen $355 but was apprehended after a short chase.

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[2] Exhibit C3a
[3] Exhibit C3b
[4] Exhibit C4a

2.2. Wyatt was charged with aggravated robbery and was found to be not guilty by way of mental incompetence of that offence on 8 August 2006 in the District Court of South Australia. Wyatt was sentenced by that Court on 15 December 2006 to a limiting term of 4 years and released on licence. The conditions upon which Wyatt was released are set out in the Order for Release on Licence[5], a copy of which is incorporated in this finding. The conditions of licence are not unfamiliar in cases of this kind and include a requirement that Wyatt be under the care and direction of the Clinical Director, Forensic Mental Health Service, and obey that person's directions with regard to medical and psychiatric treatment and reside where directed by that person. It was also a condition that the defendant not use, possess or administer any narcotic or psychotropic drug which was not medically prescribed. It was a condition of the licence that Wyatt submit to weekly urine analysis testing. Additionally, the conditions required Wyatt to participate in drug and alcohol counselling and to attend an anger management course.

2.3. Following his arrest for the aggravated robbery and up until his sentencing in December 2006, Wyatt was granted home detention bail. During that time he breached his home detention bail conditions on six occasions with the result that he was brought into custody and had contact with James Nash House.

2.4. While on home detention bail in 2005 he met Naomi Thompson, with whom he commenced a relationship. At some point Ms Thompson moved into Wyatt's parents' house where he was on home detention. During this time Ms Thompson became pregnant to Wyatt with Jakob, who was born on 22 September 2006.

3. A plethora of organisations

3.1. Wyatt had contact, during the period of his licence, with a number of different Government or Government funded agencies. In order to bring some clarity to the complicated story that follows, I have thought it desirable to list the organisations with which he had an involvement or connection. They were:

1) Parole Board
2) James Nash House
3) Northern Mobile Assertive Care Team
4) Lyell McEwin Hospital (LMHS)

[5] Exhibit C108t - Annexure A attached to Finding

5) Department for Correctional Services (DCS)

6) Forensic Community Team (an 'outpatient' facility of James Nash House)

7) Drug and Alcohol Services South Australia (DASSA)

8) NEAMI (an organisation that provides 'psychosocial rehabilitation services')

9) Families and Community Services

10) Centrelink

11) SAPOL

4. An overview of Wyatt's compliance with his licence conditions

4.1. The evidence clearly showed that Wyatt was hardly a model licensee. Detective Sergeant Webber, who investigated this matter, observed in his report[6] that:

> 'Evidence obtained by police indicates that whilst the deceased was on release on licence he would engage in behaviour which would amount to a breach of that licence almost daily. Examples of this behaviour were: taking alcohol and a variety of illicit drugs on a regular basis. He also failed to take prescribed medications as per his treatment order. He failed to keep appointments with counsellors, mental health staff and DCS[7]. He failed to undergo urinalysis testing as required and failed tests when he did take them. During the almost 3 years that he was under licence, and notwithstanding the prolific nature of his breaching, he was in fact, only formally breached once. He had other periods of detention but these resulted from incidences of acute mental health episodes where he came back into the system via hospital. DCS caseworker Karen Carlton was in the process of submitting documentation to have him once again remanded at the time of his death. Evidence suggests that it could take as long as 2 months for a breach to be processed through all of the stages to have an individual brought back into custody.' [8]

4.2. Having heard the evidence presented at this Inquest, and having considered the nearly 150 documentary exhibits, some of them lengthy documents in themselves, I agree with those observations. Wyatt was non-compliant with drug and alcohol counselling. He was a serial abuser of drugs, and was in a situation where he was known to be a serial abuser of drugs. It was also known that when he abused drugs he relapsed into psychotic behaviour. It was also known that he was living with a vulnerable woman and a young child.

[6] Exhibit C108a
[7] Department for Correctional Services
[8] Exhibit C108a, page 31

5. Urinalysis

5.1. I will have more to say about this later in this finding, but probably the single most striking demonstration of Wyatt's failure to comply with licence conditions is his record with respect to urine testing. During the Inquest it was calculated that between the date of his release on licence and his death, Wyatt would have been expected to submit to approximately 90 urine tests. In fact, he submitted to a total of 7 tests only[9].

6. Wyatt's interactions with the various services

6.1. I will now set out, under the subheadings of the various services, my findings as to Wyatt's interactions with those services. This will also serve to outline the events as they unfolded between his release on licence and his death.

6.2. Department for Correctional Services - Karen Carlton

The Court heard evidence from Karen Carlton, a corrections officer with the DCS. She holds the qualification of social worker and her duties include the supervision of offenders on parole, probation and bail. Her duties also include the supervision of persons who have not been convicted in a Court by reason of mental impairment and who are placed on orders under the mental impairment provisions of the Criminal Law Consolidation Act (CLCA). Part of her duties are to keep the Parole Board informed of the progress of her charges. She was assigned the supervision of Wyatt in December 2006. Ms Carlton stated that Wyatt failed to attend for his weekly urine testing on multiple occasions. On 7 June 2007 Ms Carlton advised the Parole Board that Wyatt was in breach of his conditions of licence. She was requested by the Parole Board to forward documentation to the DPP[10] requesting that the DPP make an application to the Court for an order reviewing the original supervision order. The application was to be made under section 269U of the CLCA. On an application for review the Court has power to confirm the present terms of the supervision order or to amend the order so that it ceases to provide for release on licence and provides instead for detention or to amend the various conditions of the licence.

6.3. On 5 July 2007 Ms Carlton made a request to the DPP for a review to be sought. In consequence of that, the DPP made an application to the District Court on 26 October

[9] Transcript, pages 334-335
[10] Office of the Director of Public Prosecutions

2007. The application sought a review of Wyatt's supervision order on the grounds that he contravened conditions of his release on licence in the following ways:

a) Condition 2(e) in that he had consumed an illicit substance, namely cannabis;

b) Condition 2(f) in that he had not attended appointments with Drug and Alcohol Services of South Australia;

c) Condition 2(h) in that he had not obeyed the lawful directions of his Community Corrections Officer to attend appointments for supervision, urine testing and programs as directed, namely the Breakeven Program.

The application came before the District Court on 11 December 2007. The breaches were admitted by counsel for Wyatt. The Court had before it a report dated 30 November 2007 from Dr Nambiar[11], a consultant forensic psychiatrist at James Nash House, which had been prepared for the purposes of the application before the Court. Surprisingly, Dr Nambiar said that:

> '…Wyatt had made substantial gains in regards to his rehabilitation.'

and that:

> 'Although there were a number of negative prognostic factors currently in play, including illicit use of substances, conflict with his partner and other family members and his lack of motivation with regards to organising his life and attending appointments, on balance it would appear that there are a number of positives that can be continued to be improved upon if he remains in the community.' [12]

Dr Nambiar went on to recommend that Wyatt remain in the community. The Judge acted on that report stating as follows:

> 'As I am satisfied, from his report, that there is not presently any safety issue for the community, I am, on balance, persuaded to give you an opportunity to comply with the conditions. When I say that, I mean all of the conditions.' [13]

6.4. The Judge then adjourned the application to April 2008 requesting further reports by Ms Carlton and Dr Nambiar.

6.5. In the meantime, the Forensic Community Team received a telephone call from Eastern Mental Health Services advising that Naomi Thompson had contacted them to

[11] Dr Nambiar is a Consultant Forensic Psychiatrist at James Nash House and is also the Clinical Director, Forensic Mental Health Service. He was the person whose care and direction Wyatt was subject to under the conditions of his release on licence.
[12] Exhibit C120, page 148
[13] Exhibit C120, page 69

allege that Wyatt had tried to strangle her. She had left the house with Jakob and was seeking refuge in a women's shelter. Wyatt had used amphetamines on 11 December 2007 and had not slept that night. On 13 December 2007 Wyatt had presented to the Lyell McEwin Hospital seeking treatment. He was found to be in a psychotic state with auditory hallucinations and delusions to the effect that his partner was being tortured. He reported ideas of reference from the television and that he had attempted suicide. He was detained under the Mental Health Act 1993 by a doctor at LMHS and subsequently transferred to James Nash House. His mental state was assessed as one of acute psychosis with auditory hallucinations, paranoid delusions and delusions of reference. His insight and judgment were poor. It was concluded that his psychotic relapse was precipitated by poor adherence to prescribed medication and intermittent amphetamine and cannabis abuse.

6.6. In consequence of that admission to James Nash House, the matter was brought before the District Court again on 27 December 2007 and the Court varied Wyatt's conditions of licence to authorise his detention in James Nash House until 21 February 2008 or such earlier time as the Director, Forensic Mental Health Services, might see fit to release him[14].

6.7. In the event, the matter next came before the District Court on 4 March 2008. The Chief Judge was provided with a copy of a progress report prepared by Dr Nambiar which was dated 25 February 2008. There was also a progress report prepared by Karen Carlton. Ms Carlton's report[15] is expressed in non-committal language. Dr Nambiar's report on the other hand advised that Wyatt was released from James Nash House on 21 February 2008. Dr Nambiar suggested that the Court permit Wyatt to remain on his current licence conditions and advised that James Nash House would continue to monitor the situation.

6.8. Dr Nambiar also advised that because of Wyatt's non-compliance in taking his medication, a decision had been made by Dr Nambiar to change his risperidone consta from an oral form to an injectible form. An application had been sought and obtained from the Guardianship Board authorising a community treatment order for the prescription of risperidone consta at a dose of 50mg by injection every two weeks. Dr Nambiar advised that, in addition to this, Wyatt had been prescribed sodium valproate

[14] Exhibit C120, page 56
[15] Exhibit C120

at 1000mg twice per day. Of course, his compliance with the sodium valproate would still be a matter for his own discipline (or lack thereof).

6.9. In consequence of this information the Chief Judge confirmed that the then present terms of the supervision order would continue on 4 March 2008.

6.10. According to Ms Carlton[16] Wyatt attended at her office as required on 21 February 2008. He kept further appointments on a weekly basis until 26 March 2008 when he failed to attend. He kept appointments during April and, on 4 April 2008, returned a positive urine test for cannabis. He kept his appointments during May and June 2008. He failed to attend an appointment in July 2008 and again on two occasions in August 2008. In September 2008 he missed three psychiatric appointments. On 23 September 2008 Ms Carlton was advised that Wyatt had been detained at Woodleigh House at Modbury Hospital. In October 2008 the Parole Board recommended action to revoke Wyatt's licence and, accordingly, Ms Carlton contacted the DPP to make appropriate arrangements.

6.11. On 23 October 2008 the DPP made an application pursuant to section 269U of the CLCA for a review of Wyatt's supervision order on the grounds that he had been non-compliant with some medications, that he had consumed illicit substances, namely cannabis, methylamphetamine and buprenorphine and that he had not been reporting for supervision as required.

6.12. The DPPs' application for review came on before a District Court Judge on 28 October 2008. The transcript forms part of Exhibit C119. It is instructive to consider the transcript from that occasion. Wyatt was unrepresented and some of his remarks on transcript are quite instructive. They reveal his lack of willingness to accept responsibility for his own actions. When he was informed by the Judge that the Crown was applying for him to be sent to James Nash House to be assessed by Dr Nambiar because he had not been reporting as he had been required to do, he responded as follows:

> 'I've been in hospital. I was in and out of hospital. When I went out of hospital I went to Corrections. I had my medication, I couldn't find it for a couple of days and when I found it I got my depo injection. They told me to be at Court yesterday. I was having it yet. Lucky it's my fiancée's 21st tomorrow. I've only just got back with her. I'm trying to get everything in order. I've just got my own house. I'm just trying to sort through

[16] Exhibit C138

> everything. I'm trying to do - I was trying to get help and then I was really unwell. Every day I was asking for people to help me and now I'm trying to sort myself out and I don't want to be in James Nash House. I don't know what's going on.' [17]

6.13. The Judge explained that the Court was not considering making an order that he remain in James Nash House indefinitely, but simply to be reviewed by Dr Nambiar for a period of time. On the matter of reporting Wyatt responded as follows:

> 'No I was in hospital. They told me I didn't have to report when I got out of hospital. When I got out of the hospital I went and reported.'

When the Judge asked him who told him that, he responded:

> 'That was Karen. I got workers that come to my house - I ring them up, they tell me they'll come visit, they don't come and visit. I've been trying to get back on the community thing but that don't help me. I'm feeling unsafe in my own environment. I'm hearing voices that people are trying to kill me, and they won't help me and now I'm trying to sort these things out myself, like, take more medication and dealing with all the problems and stuff and all of a sudden they want to chuck me in James Nash House. I was looking for a lot of help, I was really unwell, I was going out of my way every day to get help and they wouldn't help me. Now I've patched things up with my ex and we are back together and its her 21st tomorrow and I don't know why they are doing this to me now. Why would they do it to me now?'

6.14. The responses set out above are consistent with the evidence of a number of witnesses that Wyatt consistently refused to take responsibility for his own actions. He would frequently assert that he was being denied help when he sought it. In fact, what emerges from the evidence is a clear pattern that whenever Wyatt wanted something from his various workers, he would get in touch with them to request whatever it was he wanted. However, when he was required to keep an appointment, to exercise some initiative of his own or maintain some level of responsibility, he failed to do so. Many times his failure was due to his consumption of illicit drugs contrary to his licence conditions.

6.15. Returning to the application for review, the matter was finally dealt with on 2 December 2008 when a Judge of the Court noted that Dr Nambiar had provided a report advising that in September 2008 and early October 2008 Wyatt had been consuming illicit substances including IV methylamphetamine, cannabis and buprenorphine. In addition he had failed to comply with his medication regime and his requirement to attend at Elizabeth Community Corrections. In a report dated 1

[17] Exhibit C119, pages 29-30

December 2008, Dr Nambiar advised that Wyatt's mental state had stabilised during his admission to James Nash House. The report stated that there had been a recent case review which had 'identified a number of destabilising factors in Mr Wyatt's situation, and a new plan has been devised'. Dr Nambiar went on to say that with this in mind he would ask the Court to consider releasing Wyatt back into the community on his previous licence conditions. Dr Nambiar advised that Wyatt would be followed up in the community by Northern Mobile Assertive Care and that Ms Thompson had indicated that she wished to have Wyatt home with her and that they would undergo marital counselling with Anglicare. Furthermore, Wyatt had been referred to a psychologist associated with Forensic Mental Health Services to assist him to deal with stress. A Guardianship Board order had been obtained to restrict Wyatt's access to money to prevent him from gambling and spending on illicit drugs. It was reported that Ms Thompson had been assured that she would be supported through domestic violence crisis services in the event that the relationship broke down. Dr Nambiar reported that Wyatt had been reminded of his obligations with regard to his licence conditions and that he would be referred again to DASSA.

6.16. On the strength of that report a Judge affirmed Wyatt's existing conditions of licence on 2 December 2008 and he was released into the community.

6.17. There were no further applications by the DPP to the District Court. As we now know, the assurances provided to Ms Thompson by Dr Nambiar and the team at James Nash House with regard to domestic violence were to be of little comfort when Wyatt commenced his brutal rampage on 16 March 2009.

6.18. Ms Carlton said that she was disappointed with the outcome of the application to the District Court because Wyatt had been non-compliant in relation to drug and alcohol counselling from the beginning[18]. She said that Wyatt refused to take a urine test on 15 December 2008 and failed to attend an appointment on 22 December 2008. He kept an appointment on 19 January 2009 but failed to keep his next appointment on 27 January 2009, advising the following day that he had not reported because 'it was too hot'. He was directed to attend on 30 January 2009 but failed to do so. On 4 February 2009 Ms Carlton submitted a further report of non-compliance by Wyatt. In that report she stated that Wyatt had divulged that he had used amphetamines on 2 December 2008, the day he was released from James Nash House and the day of the

[18] Exhibit C138

hearing in the District Court, when his licence conditions were confirmed. Ms Carlton summarised the position as follows:

> 'The writer has been supervising Mr Wyatt since mid December 2006. Mr Wyatt's reporting continues to be problematic and unsatisfactory. Mr Wyatt signed the acknowledgement of supervision conditions form, a copy of which is annexed hereto and marked with the letter B agreeing to comply with all licence conditions. It has been virtually impossible to address Mr Wyatt's criminogenic needs as he fails to report and he is not attending any services in relation to alcohol and drugs, and gambling. All referrals have been made but Mr Wyatt lacks motivation and commitment to addressing his problems, which makes his risk of reoffending quite high. This is the third time a breach has been submitted, which shows that Mr Wyatt continues to disregard his obligations to this order. The writer believes that Mr Wyatt would not benefit from continued supervision, as he has not complied with his corrections officer's directions thus far.'

6.19. Ms Carlton did not see Wyatt after 19 January 2009. She spoke to him by phone on 12 March 2009 when he contacted her. She told him that he had to report because he had not presented himself for almost two months. She also told him that there would be a Parole Board interview in the near future.

6.20. Naomi Thompson reports domestic violence to SAPOL

This matter was covered in the evidence of Constable Shaw[19]. It will be recalled that Wyatt had attempted to strangle Ms Thompson in December 2007. On 8 February 2008 a police incident report was allocated to Constable Shaw in relation to that alleged offence. Constable Shaw contacted Ms Thompson on 22 February 2008. She advised that she was safe and living in a Salvation Army safe house. Contact was again made by Constable Shaw with Ms Thompson on 26 February 2008 and Ms Thompson was feeling safe. No further action appears to have occurred until mid to late April 2008 when Constable Shaw again attempted to contact Ms Thompson. On 8 May 2008 Constable Shaw spoke with Ms Thompson who advised that she had not heard anything from Wyatt and that he had not made contact with her. She also said that she no longer wanted police to proceed with the charges of aggravated assault against Wyatt. On 9 May 2008 Constable Shaw attend Ms Thompson's address. When Ms Thompson answered the door the police could hear a male voice inside the house. They asked Ms Thompson who it was and she replied that it was Wyatt. She advised that she had invited Wyatt around but only to see their son. She reiterated that she did not want further police action to be taken. Constable Shaw told Ms Thompson to tell Wyatt to leave the house. As he left the police spoke to him and

[19] Exhibit C140

found out that he would be returning to his parents' address. The police then spoke to Ms Thompson again and she reiterated that she wished to withdraw the charges against Wyatt. Accordingly, she completed a form to withdraw the charges and Constable Shaw explained to Ms Thompson the process for obtaining a domestic violence restraining order. Constable Shaw returned to Ms Thompson's address a few hours later and again explained the process of obtaining a domestic violence restraining order. Ms Thompson agreed to make an application for such an order and an appointment was made for her to attend at the Elizabeth Police Station on 13 May 2008. Constable Shaw also made contact with the Salvation Army caseworker who had been assigned to Ms Thompson and advised the worker that Wyatt had been at the address. The worker indicated that she would keep in touch with Ms Thompson. On 12 May 2008 Constable Shaw attempted to contact Ms Thompson to remind her of the appointment for 13 May 2008 and left a text message to that effect. Ms Thompson failed to attend the appointment for the following day and Constable Shaw attempted to contact her but without success.

6.21. That was the end of any contact between Ms Thompson and SAPOL about that matter.

6.22. Rayleen Harrington - Northern Mobile Assertive Care Team

Ms Harrington was Wyatt's keyworker. She is a registered nurse and registered mental health nurse working for the Northern Mobile Assertive Care Team (MAC). She first came into contact with Wyatt in April 2008. She would try to make contact with him at least once per week.

6.23. Ms Harrington was the person who was responsible for administering Wyatt's depot injections[20]. She gave evidence that largely reflected the experiences of other key witnesses such as Ms Carlton. Ms Harrington, like Ms Carlton, acknowledged that there had been a lack of communication between them. She observed:

> 'Well, no, I mean David - see this is that lack of communication and inter-agency work that was going on at that time. David could well go to corrections and we wouldn't know that he went to corrections. So he could have gone to corrections during this period and been informed by then that they were going to breach him, but we wouldn't know that because we'd not receive any notification.' [21]

6.24. For her part, Ms Carlton stated:

[20] Transcript, page 506
[21] Transcript, page 523

> 'I think it would have been beneficial if I had met Rayleen Harrington and the two of us should have had a closer working relationship. I tried on many occasions to get in contact with Rayleen without success. I may have spoken to her on the telephone up to 4 times in all the time that I supervised David. We should have been talking at least once a fortnight. This lack of communication did not help me have an understanding of where David was at. Better communication between Rayleen and I would have revealed some of the lies David was telling.' [22]

6.25. Ms Harrington's evidence also reflected a lack of commitment and responsibility on the part of Wyatt in complying with his licence conditions. She did not however regard herself at the time as having a role with respect to Wyatt's non-compliance, stating:

> 'No, I think at the time I would have thought that was Corrections.' [23]

Furthermore, Ms Harrington acknowledged that even if she did not take action in relation to non-compliance by Wyatt with his licence conditions, she did not understand at the time that she should have provided the information to Corrections about that non-compliance[24].

6.26. She gave an example which illustrates very clearly Wyatt's abdication of responsibility. She described an occasion when Wyatt called her by telephone to inform her that he was in Moonta Bay and had forgotten his Webster pack[25]. Wyatt had requested that prescriptions be faxed to the Moonta Bay pharmacy so that he could obtain medication up there. At the same time, it was apparent to her that Wyatt had failed to attend a medical appointment in Adelaide as a result of his presence in Moonta Bay. Ms Harrington said that this behaviour was typical of Wyatt: given an opportunity to go to Moonta on the one hand or keep an appointment with a doctor on the other 'he's always going to go to Moonta Bay. I mean that was part and parcel of him and who he was'[26]. In the result, the prescription was faxed to the Moonta pharmacy but Wyatt did not bother to pick it up[27]. Thus his carelessness in travelling to Moonta without his Webster pack was compounded by his carelessness in not bothering to pick up a prescription faxed through at his request by people trying to help him. No doubt he was under-medicated for some time as a result. All of this

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[22] Exhibit C138
[23] Transcript, page 519
[24] Transcript, page 519
[25] His Webster pack was his prescribed medication that he was required to take on a daily basis as part of his licence conditions
[26] Transcript, page 517
[27] Transcript, pages 520-521

builds a picture of a man who simply failed to take responsibility for himself. This characteristic was also demonstrated in Wyatt's preparedness to blame his situation on others, a characteristic to which I have already made reference.

6.27. Ms Harrington agreed that Wyatt was by no means always psychotic. She agreed that he would have been capable, if he had been willing and if he had taken his medications regularly, of performing normal acts of daily living[28]. She agreed that he did not need to be in a psychiatric ward all the time and, furthermore, that he would have been capable - had he been incarcerated at a time when his mental health was stable - of being incarcerated in a mainstream prison population[29].

6.28. Finally, Ms Harrington gave evidence of her efforts to obtain further assistance for Wyatt through a source of funding referred to as a Strategy 6 package which led to the engagement of the organisation NEAMI, to which I will make further reference shortly.

6.29. Interestingly, Ms Harrington was not aware from the very beginning of her association with Wyatt as to the precise terms of his conditions of licence. She only had a vague understanding that he was supposed to comply with mental health treatment and not take part in criminal activities and to refrain from drug and alcohol use[30]. Ms Harrington's position as part of the mental health team was to avoid hospital admissions. She said:

> 'I think it is current thinking to avoid admissions. When we take on these jobs one of our briefs is to implement hospital avoidance packages. That sort of suggests that we do not actually want these people in hospital. We want to do everything we possibly can to keep them out of hospital. I think I was influenced by that in my case management. Recognising that I needed to keep David on the streets. In retrospect I am thinking that I needed to keep him in the hospital but hindsight is a wonderful thing.' [31]

6.30. <u>Julie Burns - Community Support Rehabilitation Worker - NEAMI</u>

Ms Burns gave evidence. She was assigned by NEAMI to provide community support to Wyatt. Her evidence really established that she was unable, despite considerable effort on her part, to engage with Wyatt. Her efforts spanned the period 11 December 2008 until 10 March 2009. Despite considerable effort on Ms Burns' part, it was not until 10 March 2009 that she finally met with Wyatt. At that point,

[28] Transcript, page 526
[29] Transcript, pages 526-527
[30] Transcript, page 592
[31] Exhibit C143

she found Wyatt to be distressed. She said he was agitated, constantly moving and was sighing heavily. He complained about hearing music in his head that would not stop. She asked him if he would like to see a doctor and he said that he would. In the meantime, Ms Burns called Ms Harrington and the latter spoke to Wyatt on the telephone. During the telephone call he relaxed noticeably and said after speaking to Ms Harrington that he did not require any assistance and no longer wished to see a doctor.

6.31. Ms Burns said that after leaving Wyatt's house on that occasion she called Ms Harrington by telephone. Ms Harrington said that this behaviour was not unusual for Wyatt. Ms Burns could do no more.

6.32. Francis Nelson QC - Parole Board of South Australia

The Court was fortunate to be able to hear from Francis Nelson QC, who is the Chair of the Parole Board. She has held that office since 1983. Ms Nelson made the point that the Parole Board is charged with trying to supervise people who are released on licence under the mental health provisions of the CLCA. However, the Parole Board has no direct power of sanction if someone breaches the conditions of their licence. In this respect, the Parole Board's role is entirely different from the role it assumes in relation to ordinary parolees. The Parole Board can issue a warrant for breach of parole in the case of an ordinary parolee, but has no power to do anything with a licensee who breaches a condition of licence. In that situation the Parole Board is limited to requesting that the DPP apply to the sentencing Court to review the licence. Ms Nelson did note that the Parole Board had the power to require a licensee to attend on a summons before the Parole Board for interview but its powers go no further than that.

6.33. Ms Nelson referred by way of example to an event when Wyatt had been required to attend a Community Corrections centre for a urine test. He was asked to wait for the team that would do the drug testing but, despite being warned not to leave until the tests had been done, he ignored the warning and left. Ms Nelson said:

> 'Can I say, your Honour, if he had been a parolee who did that we would have brought him in on a warrant. We have no power to do that with licensees and they know it.' [32]

I have underlined Ms Nelson's remark that licensees are well aware of the limitations upon the freedom of the Parole Board to act when they breach their licence

[32] Transcript, page 75 (the emphasis is mine)

conditions. In my view Wyatt was well aware that once he was released on licence the circumstances in which he might, at the behest of the Parole Board or the criminal justice system, be brought back into detention were circumscribed. I believe he was well aware that there would be a lengthy delay between behaviour that constituted a breach of his licence condition and any consequence. Furthermore, he was well aware that in many instances no action was taken whatsoever when he failed to comply with a licence condition. His general behaviour, his expectation that services would assist him, and that any setback was the responsibility of one of the services failing to assist him, add weight to this conclusion.

6.34. Ms Nelson made the point that the District Court was essentially acting on the basis of reports provided by Dr Nambiar and some other clinicians. Ms Nelson expressed the view that the psychiatrists are concerned with psychiatric illness and the licensee's health generally. The psychiatrists are not in the business of assessing risk in the community. Ms Nelson commented that:

> 'There were so many risk factors in this man's particular presentation that the Court should have had the benefit of more information than I believe the Court had. This man had a history of being sexually abused as a child which may well have accounted for his drug use; certainly there's quite a strong view that that was the case. He started using marijuana at the age of 13 and his use of marijuana escalated to the point where he was using two or three cones a day on a regular basis.' [33]

6.35. Ms Nelson went on to refer to Wyatt's amphetamine abuse, his first presentation with a psychosis at the age of 18, his emotional immaturity, his disorganisation, his history of violence including domestic violence and the fact that he was dyslexic with the result that, for him, independent living was a challenge. Ms Nelson said:

> 'Now the court for whatever reason never seemed to have had a complete picture about all those other factors and I think that's unfortunate.' [34]

6.36. Ms Nelson also pointed out that the Court also has the difficulty that if it revokes the licence there is a practical issue, namely the place of incarceration. She noted that James Nash House only has 30 beds. Ms Nelson characterised the challenge of supervising a person such as Wyatt as the management of someone who is behaviourally disordered. She commented that, in her opinion, a Court is not especially well-suited to manage such a person and, effectively, the statutory scheme

[33] Transcript, page 77
[34] Transcript, page 78

that now exists requires the Court to do just that[35]. Ms Nelson was of the opinion that a body such as the Parole Board is better placed than a Court to manage such an undertaking[36].

6.37. I can do no better than to borrow Ms Nelson's words to summarise the matter as she did in the following passage:

> 'This man went through life not obeying the rules that's why he was, in part, a problem. So you have to develop a responsibility for one's own conduct. You don't do that if you allow people to breach the rules with impunity. But I think your Honour is right, it's a management process as opposed to having the Courts trying to deal with it in a judicial way; it should be a management process. Whether people are guilty or not guilty is a legal matter but it's the end result that we're trying to manage and I just think it's in the wrong place, I don't think it's reasonable to include Courts as part of that management process.' [37]

6.38. Ms Nelson also commented that it is unrealistic to suggest that if you simply look after the illness, you fix the problem[38].

6.39. With respect, there is much value in Ms Nelson's observations. I will return to her observations when I address the question of appropriate recommendations in this matter.

6.40. Karen Stoate - Families SA

I heard evidence from Ms Stoate. She is employed as a Supervisor in Families SA. She gave evidence that Wyatt was first drawn to the attention of Families SA when a notification was made concerning Jakob in September 2006. The intake involved concerns about Wyatt having significant mental health problems and being agitated and delusional. There were concerns that Ms Thompson did not understand the impact of Wyatt's mental health problems. At the time she was thought to be overwhelmed and not responsive to Jakob's needs. After some contact with Ms Thompson and Jakob the case was closed in October 2006. There were one or two other intakes, but most significantly there was an intake on 8 March 2009 in relation to Chloe Thompson.

6.41. I have previously referred to the fact that Chloe was an infant. She was actually born on 1 March 2009, a mere 15 days before Wyatt's murderous rampage of 16 March

[35] Transcript, page 78
[36] Transcript, page 79
[37] Transcript, page 88
[38] Transcript, page 89

2009. The intake was received by Ms Stoate on 10 March 2009, the previous day having been a public holiday. Ms Stoate was at that time acting in the role of Supervisor for Families SA at Elizabeth, a position she has since been appointed to substantively. The report had been received by the Child Abuse Report Line (CARL) and had been classified as a Tier 2 case by the call taker. A Tier 2 case is a case in which the child is considered to be at risk of significant harm and a response is required within 7 days[39]. On the morning of 10 March 2009 Ms Stoate had also received one Tier 1 notification, twelve other Tier 2 notifications and three Tier 3 notifications. One of the other Tier 2 notifications also involved a newborn baby. The Tier 1 had priority as Tier 1 notifications must be responded to within 24 hours. Ms Stoate reviewed the Tier 2 notifications including the notification relating to Chloe Thompson and decided that the office did not have capacity that day to respond to them. She also noted that the issues identified in the notification relating to Chloe were similar to those referred to in the earlier notifications relating to Jakob. She did not believe that the intake required immediate attention as she had no reason to believe that Chloe or Jakob were in imminent danger. On that day, the staff available to Ms Stoate for allocation of work included herself and 4 social workers. One of those workers started at midday. Their caseload at the beginning of that week was 46 cases, not including the 17 intakes received from CARL on the morning of 10 March 2009. On 11 March 2009 Ms Stoate still had 5 staff but that day she received one Tier 1 notification, three Tier 2 notifications and two Tier 3 notifications. On the following day, 12 March 2009, she had 5 workers and received a further three Tier 2 notifications. On Friday, 13 March 2009 she had 5 staff, including herself, and received a Tier 1 notification, six Tier 2 notifications and seven Tier 3 notifications. On that day the whole team was involved in the Tier 1 which involved the emergency removal of two children. In addition to the removal of the children a report for Court had to be prepared. Due to this workload Ms Stoate stated that she was unable to allocate the intake for Chloe Thompson for investigation that week. Her intention was that Chloe Thompson's intake would be followed up during the following week.

6.42. Ms Stoate gave evidence that Families SA has a very high workload and not enough staff to deal with the workload. She pointed out that there were 35 new intakes that week, which was not uncommon for Elizabeth. She said that the workload is

[39] Transcript, page 695

extremely high, the issues are very complex issues and Elizabeth is a particularly disadvantaged socio-economic area. She said:

> 'So I don't know - I don't have any easy quick fix answers.' [40]

6.43. Clearly the notification to Families SA was an opportunity for an agency to assess the situation which was developing in the household occupied by Wyatt and Ms Thompson. The introduction of a newborn baby into the household shortly after 1 March 2009 was a significant stressor.

6.44. Leanne Pilichiewicz - LMHS Home Visiting Midwifery Service

Ms Pilichiewicz was a registered nurse and midwife who performed home visits as part of the Women's Health Unit at LMHS for newborn children. On 2 March 2009 she received notice that a normal postnatal visit would be required for Ms Thompson. The first visit took place on 3 March 2009 and a second visit was arranged on 6 March 2009. On that occasion Ms Pilichiewicz had some concerns. Wyatt informed her that he was concerned about a potential conflict with Ms Thompson's father. Ms Thompson's father wanted Ms Thompson to go and live with him. Wyatt was also concerned that he would report them to Families SA. Wyatt kept walking around the room while the baby was being assessed and seemed uninvolved and a bit distant. However, Ms Thompson seemed to be relaxed and happy and expressed the view that she was happy to be staying in the house with Wyatt. The baby appeared to be well. Ms Pilichiewicz thought the environment was stressful because of Wyatt's behaviour and that these matters should be addressed by other agencies. Shortly after her visit a mandatory notification was made to Families SA in which concerns were expressed about Ms Thompson's intellectual disability and the mental health issues suffered by both Wyatt and Ms Thompson. The notification was made as a result of the situation in the home generally and the way in which Wyatt presented. Ms Pilichiewicz also contacted Rayleen Harrington, who it will be recalled was Wyatt's mental health worker. Ms Harrington advised Ms Pilichiewicz about Wyatt's mental health history and, in turn, Ms Pilichiewicz advised Ms Harrington that there was a newborn child in the house and that she was concerned about Wyatt's behaviour.

6.45. Conclusions

It is plain that stress and tension would have been building in Wyatt's household with

[40] Transcript, page 730

the introduction of a newborn child shortly after 1 March 2009. It appears also that Wyatt was resentful that he had not been informed by Ms Thompson's family of the delivery of Chloe and had not been present at the birth.

6.46. A number of organisations had reason to be concerned. It is plain that there was a lack of communication and coordination between the various agencies.

6.47. In the very early hours of the morning on 16 March 2009 this stressful situation reached its culmination. That morning Wyatt had telephoned the Mental Health Triage Service based at South Australia Ambulance Service headquarters at Greenhill Road, Eastwood. It is part of the Central North Adelaide Health Service. He spoke to a call taker, Mr Terrance McGinn, a registered nurse who gave evidence in this matter[41]. Mr McGinn had access to a computer-based information system showing all previous contacts between Wyatt and mental health services. Wyatt informed Mr McGinn that he had had a cone of marijuana. Mr McGinn asked Wyatt who else was in the home and he advised that his partner was there and the children. Mr McGinn asked him where they were and he said they were in bed. Mr McGinn asked if Ms Thompson had used any substances. Based on what Wyatt told him, he concluded that Ms Thompson had not used any substances and was in bed asleep, as were the children. Wyatt told Mr McGinn that he was frightened and thought he was going to die. Mr McGinn thought this was a delusional comment. Mr McGinn established from the computer system the identity of one of Wyatt's mental health workers at that time, Mr Bill Monger. He also established the residential address. He satisfied himself (by questioning Wyatt) that Wyatt was sufficiently alert to remember his keyworker. The purpose was to check Wyatt's cognitive function. Mr McGinn said that as a result of what he heard from Wyatt, he did not think it was an actual emergency. He left an entry in the system to let Wyatt's team know the next morning that Wyatt had been in touch with the Triage Service. Mr McGinn said that he did not think that Wyatt was suicidal or homicidal and Wyatt did not threaten harm to himself or anyone else. Mr McGinn thought that Wyatt could be followed up by the Mobile Assertive Care Team the following day.

6.48. That was the last contact Wyatt had with any service prior to embarking upon the violent rampage that culminated in injuries to Ms Thompson and Chloe, and the death of Jakob and Wyatt himself.

[41] Exhibit C144

6.49. I think the case clearly shows that there was a significant lack of coordination between the various agencies involved in Wyatt's case.

7. Domestic Violence - The Family Safety Framework

7.1. A particular aspect of this case is the element of domestic violence that was apparent to many of the agencies involved, including DCS, James Nash House, all of the health services and Families SA. The only intervention that focussed upon the case from a domestic violence viewpoint was that of SAPOL after the assault upon Ms Thompson in December 2007. That intervention resulted in Ms Thompson eventually withdrawing her complaint against Wyatt. She was encouraged to seek a domestic violence restraining order but did not do so.

7.2. The Coroners Court has the benefit of the assistance of the Senior Research Officer (Domestic Violence), who has drawn my attention to the Family Safety Framework. The Framework is intended to establish a commonality of approach and practice across various services. The Family Safety Framework includes a common risk assessment process. It has been implemented across the metropolitan area of Adelaide and in a number, but not all, of regional areas of the State[42]. I quote from the Strategic Overview:

> 'Research indicates that the existence of certain behaviours or indicators such as jealousy, strangulation, sexual assault and separation pose a higher risk for victims. Previous research has observed that a history of domestic violence is common in intimate partner homicides and that in some cases the homicide incident is the culmination of numerous prior incidents of domestic violence.'

One of those behavioural indicators was, I note, strangulation. It will be recalled that strangulation was a feature of Wyatt's assault upon Ms Thompson in December 2007. Indeed, Constable Shaw had drawn conclusions that the Family Safety Framework (had it been in place) would have necessitated a risk assessment in the high risk category. Therefore if the Family Safety Framework had been in place at that time, the risk assessment would have led to an implementation of the Framework in Wyatt's case. The Family Safety Framework envisages that when a high-risk case is identified by an agency, a Family Safety Meeting will be held. The meeting must be attended by representatives of all relevant agencies. The purpose of the meeting is to

[42] The Family Safety Framework is planned for implementation in the remaining parts of the State

bring together up to date information relating to the situation and sharing that information amongst the agencies. The meeting would develop strategies to maximise the safety of potential victims.

7.3. If the Family Safety Framework had been in place in this case the Family Safety Meeting would have provided an opportunity for the high risk factors at play to be shared and a management plan evolved. This would hopefully have led to a much more effective understanding of the case by all agencies as a result of a sharing of information that was not, in the event, passed on. In that way the agencies, all of which were focussing primarily on their own particular mandate, would have appreciated the need to protect vulnerable third parties – in other words, Ms Thompson, Jakob and Chloe.

7.4. It is clear that the success of the Family Safety Framework hinges on a rigorous and consistent commitment by the agencies involved. These agencies are required by a Cabinet Direction to implement and comply with the Framework. It is the responsibility of each member agency to ensure that its staff are knowledgeable of, and properly trained to, identify high or imminent risk of harm and that internal processes and procedures are in place within the agency to that end.

7.5. Information sharing between agencies and the mobilisation of resources to effect the Family Safety Meeting outcomes is paramount to minimising the risk of future harm and potentially preventing deaths in a context of ongoing and escalating domestic violence. The Family Safety Framework is a formal systemic response to addressing risk and promoting safety. Therefore it should be noted by agencies that their implementation of the framework will be examined in future Inquests where there is a context of domestic violence.

8. Reform of the release on licence system

8.1. Although it would seem that the proper implementation of the Family Safety Framework would in future have the potential to identify and prevent a repetition of what occurred in Wyatt's case, I think there is another fundamental matter to be addressed. In my opinion this case demonstrates that the release upon licence system established by the CLCA is in need of reform. It was clear from the evidence of Rayleen Harrington, and from a great deal of the material tendered in this case, that Wyatt was perfectly capable, when properly medicated, of functioning within the community. Ms Harrington agreed that he would have been capable of being incarcerated as part of a mainstream prison population when he was in that situation[43]. It will be remembered that Wyatt was by no means at all times psychotic. For much of the time he was perfectly capable of making rational decisions, although for much of the time he chose to make decisions that were poor and could not resist the temptation to indulge in illicit drugs, alcohol and gambling. These temptations in turn led to a failure to maintain his medication regime, which would then lead to episodes of psychosis, possibly involving violence.

8.2. As I have already noted, Wyatt, and presumably other licensees, are well aware that they can commit a number of breaches of their conditions of licence before any action is taken. When action is finally taken, the matter will have to be referred to the District Court and is likely to be referred by that Court to the Director of the Forensic Mental Health Service who will then provide a report for the Court whose perspective relates purely to the licensee's mental health. I am not suggesting that Wyatt had such a sophisticated understanding of the process as set out above. Nevertheless he well appreciated that, generally speaking, there were no consequences when he failed to comply with his licence conditions. The abysmal rate of compliance with urinalysis testing is ample evidence of that fact.

8.3. It seems to me that there is little point in the imposition of conditions of licence unless there is an efficient means of enforcing the conditions swiftly after non-compliance. The present system is heavily weighted in favour of a mental health approach. The focus is upon stabilising the licensee's mental health with an underlying assumption

[43] Transcript, pages 526 and 527

that this will automatically solve the problem. Furthermore, there is an underlying incentive to keep the offender out of the hospital system[44].

8.4. The present system lacks any element of imposing a sanction for a failure to comply with a licence condition. There needs to be a consequence that goes beyond a mental health response. In other words, there needs to be a punitive element to this system.

8.5. In my opinion, the system should be altered so that the responsibility for determining the existence of a breach of a licence condition is reposed in the Parole Board rather than the sentencing Court. In reaching this conclusion I mean no disrespect to the capacity of the Courts to deal with matters of this kind, however the workload of the Courts is such that it is not practical to expect a commitment by the judiciary to the very intensive case management role that is required to respond swiftly to breaches of licence conditions. The consequence of a breach must follow closely upon its occurrence. The management of a regime to properly enforce licence conditions is more akin to the management of parolees. It is therefore best reposed in the Parole Board which presently has a role in the system, but not a sufficiently effective role.

8.6. Secondly, it is my opinion that the legislation should be altered to permit the incarceration of a licensee within the prison system, notwithstanding that they were not originally convicted of any offence. This will require amendments to legislation. The purpose of this proposal is to overcome the practical difficulty which will continue to exist for the foreseeable future, that there are insufficient beds within the forensic mental health system to deal with the number of licensees[45]. They should be kept in a prison for a period fixed by the Parole Board in order to demonstrate to the licensee that a breach of a licence condition will be visited with an effective sanction.

8.7. This may not be ideal. It is arguably preferable to have sufficient beds in the forensic mental health system to accommodate the large number of people on licence to avoid the current pressure on clinicians and others working in the system to keep beds free for the sickest individuals. But Wyatt was not amongst the sickest individuals. He would typically have a relapse (more often than not induced by his own decision - freely made and not attributable to mental illness - to consume alcohol or illicit drugs) that would be resolved rapidly in custody when the effects of the illicit drugs dissipated and a proper regime of medication was reimposed. So I do not accept that

[44] Evidence of Ms Rayleen Harrington
[45] Transcript, pages 78, 80 and 81

a forensic mental health facility such as James Nash House is the only environment in which a person such as Wyatt need be held following a breach of licence condition.

8.8. I have concluded that secure accommodation in the prison system is the only solution to keep society generally, and family members particularly, safe from people like Wyatt. As I have said, he was not psychotic most of the time; he was capable of functioning in the mainstream community most of the time. He persistently breached his licence conditions while in a mental state that permitted him to realise that he was doing so, and to realise that there were unlikely to be any consequences regarding his licence as a result of his contraventions.

9. Recommendations

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

1) That the licensing system under the Criminal Law consolidation Act should be altered so that the responsibility for determining the existence of a breach of a licence condition is reposed in the Parole Board rather than the sentencing Court;

2) That the system under that Act should be altered to permit the incarceration of a licensee within the prison system, notwithstanding that they were not originally convicted of any offence;

3) That licensees detained for breach of a licence condition should be kept in a prison for a period fixed by the Parole Board in order to demonstrate to the licensee that a breach of a licence condition will be visited with an effective sanction;

4) That the relevant Ministers of Agencies party to the Family Safety Framework, note their responsibility to have operational capacity to utilise the FSF mechanisms from all parts of their Agency and across all disciplines within the agency. This is particularly relevant in large Agencies which may have a broad portfolio of multi-disciplinary services ranging from community based support services to emergency and/or tertiary services;

5) That the Agencies party to the Family Safety Framework should ensure that their staff have appropriate knowledge and training to identify and assess cases to determine risk under the Family Safety Framework. Where 'high' risk of future violence is determined each Agency should have clear referral and procedural pathways, through nominated representatives, to Family Safety Meetings as well as clear feedback mechanisms from those meetings to inform case and safety planning for interventions specific to the agency.

Key Words: Psychiatric/Mental Illness; Homicide; Suicide; Domestic Violence

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 20th day of February, 2012.

State Coroner

Annexure A

SOUTH AUSTRALIA

IN THE DISTRICT COURT

CRIMINAL JURISDICTION

No. DCCRM 05-570

BETWEEN

THE QUEEN

and

DAVID JAMES WYATT

ORDER FOR RELEASE ON LICENCE

WHEREAS on the 8th day of August 2006 in the District Court of South Australia sitting at Adelaide, DAVID JAMES WYATT ("the defendant") was, pursuant to Section 269GB(3)(a) of the Criminal Law Consolidation Act, 1935 as amended, ("The Act"), found to be not guilty by reason of mental incompetence of the offences of aggravated robbery and declared liable to supervision under Part 8A of the Act.

AND WHEREAS the Court has received the reports of Dr Cherrie Galletly dated the 7th day of December 2006, Dr Kenneth O'Brien dated the 28th day of November 2006, Dr Panayiotis Tyllis dated the 30th day of October 2006 and also the report of Ms Jennifer Fox dated the 18th day of October 2006.

AND WHEREAS the Court has had regard to and considered the matters referred to in Section 269T of the Act.

I, Jeffrey Philip Anderson, an Acting Judge of the District Court of South Australia, HEREBY ORDER the following:

1. That the defendant shall be subject to a limiting term of .....4..... years.

2. That the defendant be released on licence pursuant to Section 269O(1)(b)(ii) of the Act, subject to the following conditions:

   (a) That the defendant be under the care and direction of the Clinical Director, Forensic Mental Health Service, ("The Director") or a consultant psychiatrist nominated by him or her, and obey any directions given to him from time to time with regard to medical and psychiatric treatment and medication.

   (b) That the defendant reside where directed by the Director.

   (c) That the defendant continue to see his consultant psychiatrist for treatment at the discretion of the Director or the psychiatrist nominated by him or her and

for such period as the Director or the psychiatrist nominated by him or her, sees fit.

(d) That the defendant continue to receive his medication current at the date of this Order and further that any alteration or reduction in such medication not occur without the approval of the Director or the consultant psychiatrist nominated by him or her.

(e) That the defendant not use, possess or administer any narcotic or psychotropic drug which is not medically prescribed (excluding tobacco) by a legally qualified medical practitioner, and further that any drugs which are prescribed to the defendant by a medically qualified practitioner be possessed or administered by the defendant only at prescribed or recommended dosages.

(f) That upon release on licence, the defendant make and maintain regular contact with Drug and Alcohol Services.

(g) That upon release on licence, the defendant's case be managed by the community mental health team nearest his place of residence and that the defendant comply with all the lawful directions of his key worker from the team, particularly with respect to attendances at all appointments nominated by his key worker.

(h) That the defendant, during the period of his release on licence, be under the supervision of a Community Corrections Officer as appointed by the Parole Board and obey the lawful directions of that officer and, in particular, participate in an anger management program and submit to weekly urine analysis testing to ensure compliance with the terms of this order.

(i) In the event of any alleged breach of any direction given by the consultant psychiatrist to the defendant, that the consultant psychiatrist inform the Director of Public Prosecutions (on behalf of the Crown) and the defendant's legal advisers forthwith.

(j) That the defendant shall be returned to James Nash House at the discretion of the Director of his/her nominee if:

(i) the defendant, to the satisfaction of the Director or his/her nominee, shall have breached any condition or conditions of this order; or

(ii) the Director or his/her nominee is concerned that an action or pattern of behaviour is likely to lead to a breach of any such condition.

(iii) such return shall be for a period of not more than 14 days without further order of this court, and;

(iv) the Director or his/her nominee shall notify the Registrar of this Court, the Attorney-General and the defendant's legal advisers forthwith upon the return of the defendant to James Nash House pursuant to this paragraph.

3. That without limiting the effect of Section 269P of the Act, the defendant and the Director of Public Prosecutions (on behalf of the Crown) shall be at liberty to apply at any time and from time to time as they may be advised, at short notice to the other to vary or revoke this order or seek any other order in substitution thereof.

4. This order shall take effect on the 15th day of December 2006

GIVEN under my hand at Adelaide, this 15 day of December 2006.

J P ANDERSON
ACTING JUDGE

SOUTH AUSTRALIA * DISTRICT COURT *

I, DAVID JAMES WYATT have had the conditions of my release on licence explained to me and I fully understand these conditions. I further acknowledge a copy of the order for Release on Licence has been handed to me.

.....
DAVID JAMES WYATT

.....
Witnessed

Dated this 15th day of December 2006

STATE CORONER EXHIBIT No. C1087