



FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 15th, 16th, 17th and 18th days of July 2013, the 27th, 28th and 29th days of November 2013 and the 31st day of January 2014, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Duke Zenon Hadley.

The said Court finds that Duke Zenon Hadley aged 2 years, late of 29 Johnson Street, Royal Park died at Royal Park, South Australia on the 5th day of November 2009. His cause of death was attributed to asphyxiation due to neck and/or chest compression. The said Court finds that the circumstances of his death were as follows:

1. Introduction and cause of death

- 1.1. Duke Zenon Hadley was 2 years of age when he died on 5 November 2009. An autopsy was performed by Dr Carl Winskog on 7 November 2009 and Dr Winskog prepared a post mortem report dated 15 April 2010¹ which gave the cause of death as attributed to asphyxiation due to neck and/or chest compression, and I so find.

2. Background

- 2.1. Duke had been alone with his mother, Ms Rachael Hadley, during the day of 5 November 2009. He was last seen alive by his father, Mr Jason Hura, when he left to take Duke's 9 year old sister, Chloe, to school at approximately 8:30 that morning. Mr Hura had various work related commitments during the day. On his return to the family home later that day Mr Hura found Ms Hadley locked inside the house. She was not permitting access.

¹ Exhibit C1a

- 2.2. Eventually police were called and they gained entry to the premises. They located Duke in his cot. He was dead. Dr Winskog was unable to give an exact time of death. Insect activity suggested that Duke had been deceased for some time.
- 2.3. Ms Hadley was charged with Duke's murder. She was 26 years of age at that time. In due course Ms Hadley conceded the objective elements of the offence, being that she caused the death of her son by asphyxiation due to chest and/or neck compression by placing her feet on his mouth and chest and standing on him.
- 2.4. On 5 November 2010 Duggan J found that the objective elements of the offence were established beyond reasonable doubt. However, at the time of the alleged offence Ms Hadley was in a state of acute manic psychosis. His Honour found that she was, at the time of the alleged offence, mentally incompetent to commit the offence and was therefore not guilty by virtue of mental incompetence. The outcome was that Ms Hadley was declared liable to supervision under Part 8A of the Criminal Law Consolidation Act 1935.
- 2.5. Duggan J had the benefit of the opinions of two psychiatrists, Drs Raeside and Tomasic, who both prepared reports about Ms Hadley's competence to commit the alleged offence.
- 2.6. Dr Raeside interviewed Ms Hadley at James Nash House on 29 July 2010. He noted that Ms Hadley had been admitted on two prior occasions to the psychiatric unit of The Queen Elizabeth Hospital. The first was at the age of 22 when she displayed signs of paranoia and was admitted to the hospital under a detention order for approximately three weeks. An antipsychotic drug was prescribed for her.
- 2.7. In the ensuing years the psychotic symptoms continued. Dr Raeside noted that Ms Hadley started to hear voices, a phenomenon which she first experienced at around the age of 19 years. During this time she continued to exhibit signs of paranoia. In due course she expressed delusional ideas. In the opinion of Dr Raeside, Ms Hadley was acutely psychotic at the time she killed her son. This was as the result of either a manic relapse of a bipolar disorder or a drug induced psychosis. In either event, the result was a mental impairment.
- 2.8. In Dr Raeside's view a drug induced psychosis is much less likely. He pointed to Ms Hadley's long history of deteriorating mental health, described by her friends and

partner, as well as a protracted psychosis that continued after her admission to hospital.

- 2.9. Dr Raeside said that the police description of Ms Hadley's behaviour when they arrived at the house on the occasion of her son's death demonstrated acute psychotic disturbance on her part. She was voicing bizarre delusional ideas. Her speech was rapid and pressured and marked by thought disorder. Dr Raeside said that he had seen few examples of manic psychosis as stark as Ms Hadley's reported presentation.
- 2.10. Dr Raeside concluded that Ms Hadley had a bipolar disorder and that there was an acute manic psychotic episode at the time of the killing of Duke. In Dr Raeside's view she was clearly psychotic at the time of the incident. He said she would have been unable to know the nature and quality of her actions, namely that she was killing her son. Rather, she believed that she was expelling an evil spirit from him and that she expected him to recover. Dr Raeside was of the opinion that she was unable to reason with a moderate degree of sense and composure about the wrongfulness of her actions as a result of her delusional beliefs and psychotic confusion.
- 2.11. Ms Hadley was also examined by Dr Maria Tomasic, a forensic psychiatrist. This occurred on 25 August 2010 at James Nash House. Dr Tomasic said that Ms Hadley had been transferred to James Nash House on 31 March 2010. Dr Tomasic noted Ms Hadley's disorganised and erratic behaviour after being taken into police custody and expressed the opinion that Ms Hadley was suffering a bipolar affective disorder with underlying borderline personality traits. Dr Tomasic was of the opinion that at the time of Duke's death Ms Hadley was acutely manic, elevated in mood and acting with psychotic symptoms of paranoid religious and grandiose delusions and hallucinations. She said that Ms Hadley was clearly suffering from a mental impairment at the relevant time. In Dr Tomasic's view Ms Hadley did not know the nature and quality of her actions at the time. Furthermore, she was of the opinion that Ms Hadley was not able to reason with a moderate degree of sense and composure about the wrongfulness of her actions. She did not appear to understand that her actions were harming her son but instead believed that she was saving him as she believed that he had been taken over by an evil spirit.

3. December 2008 - Ms Hadley is admitted to Cramond Clinic

- 3.1. In December 2008, some eleven months before Duke's death, Ms Hadley was admitted to Cramond Clinic at the Queen Elizabeth Hospital. Ms Hadley's admission to Cramond Clinic is best described through the evidence of Dr Mohan, consultant psychiatrist, who was a Registrar at the time he treated Ms Hadley in December 2008. He said that he was involved in her treatment as part of a multi-disciplinary team. Dr Mohan said that Ms Hadley was an inpatient between 5 December 2008 and 17 December 2008 at Cramond Clinic. She was 22 years of age and living in a rental property with her two children. Her partner was away. She had presented to the Queen Elizabeth Hospital Emergency Department after calling South Australia Police. She was afraid to stay in her house because she felt there were intruders and claimed to hear specific noises from different parts of the house which made her wonder whether people were breaking in. She also mentioned some notes on her refrigerator which she misinterpreted as being very threatening messages. She explained that the people who had lived in the house in the past may still have keys to the property and may be gaining access and stealing her things. This was the reason why she had come into the hospital. She also said that she had been using cannabis fairly recently.
- 3.2. Dr Mohan's clinical impression at the time was that she was displaying symptoms of a psychosis characterised by hearing voices which were non-existent, and having persecutory beliefs that people were targeting her. Given the proximity of the drug use, the first diagnosis that was considered was a drug induced psychosis. She was reviewed by the clinical team on a regular basis over her admission to observe how her mental state shifted over time. She was given anti-psychotic medication namely, Risperidone at 4mg. This medication alleviated her symptoms to a large extent².
- 3.3. Dr Mohan said that she was discharged on 17 December 2008 and follow up was arranged with a community team known as the Port Adelaide Community Treatment Team³. Dr Mohan said that the plan for discharge was that there would be an interim follow up as a transition of care from Cramond Clinic's care to the Port Adelaide Community Treatment Team's care. This was dealt with in what was referred to as a Transition of Care Clinic at the Port Adelaide premises. The Transition of Care

² Transcript, page 58

³ Transcript, page 59

Clinic consisted of Dr Mohan and Sue Morrison, a Social Worker with the Port Adelaide Community Treatment Team.

- 3.4. The first transition of care consultation with Ms Hadley took place on 24 December 2008, only a week or so after her discharge from Cramond Clinic. Dr Mohan recorded notes of that consultation. In his evidence he recalled that Ms Hadley appeared quite reactive and was able to engage in a conversation. Her condition had not worsened since discharge and she reported that she had secured the house against intruders. She was still troubled by the noise of what she thought was a watch ticking which she could not find. She also admitted to an episode of cannabis use after discharge, which Dr Mohan thought might have explained why some of her symptoms had not dissipated. Ms Hadley reported that she had plans as to how she was spending Christmas. She reported a side effect of Risperidone, namely the secretion of breast milk, and Dr Mohan's plan was to review her in a couple of weeks to monitor that side effect and consider a different medication.
- 3.5. Dr Mohan saw Ms Hadley again on 7 January 2009, again with Ms Morrison as part of the Transition of Care Clinic. He said there was a difference in Ms Hadley's presentations. She appeared flat and was not reactive and appeared to be sad. She said that she was extremely tired and had tremors which might have been a side effect of the Risperidone, and the milk secretion was continuing. She reported that she could still hear the watch ticking but she was no longer concerned or worried about that. She was looking after the household and her two children quite well and was cooking, cleaning and doing the shopping. She said that she had stopped taking cannabis and requested that the Risperidone be tapered or reduced because of the side effects. Dr Mohan's view at the time was that the episode in December was likely to be a drug induced episode, from which she was showing improvement after abstaining from drugs. He considered that she had made a functional recovery and so he reduced the dose of Risperidone by 1mg. His plan was to gradually taper the Risperidone further over the next few months⁴.
- 3.6. Dr Mohan next saw Ms Hadley on 21 January 2009. He noted that her presentation was appropriate and that she was euthymic and reactive so that her mood had returned to base line and she was more reactive. He said that compared to her previous visit when she had appeared flat she had certainly improved although was still complaining

⁴ Transcript, page 63

of a lack of energy. She said that her partner perceived her as lazy and she attributed this to the effect of the medication. She requested a reduction in medication. She denied any psychotic phenomenon. Dr Mohan's clinical impression was still that there had been a brief psychotic episode which was drug related. However, the change in her mood from sad two weeks previously might have been a reflection of a primary psychiatric disorder such as bipolar disorder and Dr Mohan was considering that as a possibility as part of a differential diagnosis. He said that it was hard to say at that point what the true position was because there had been a recent history of drug use and that it would be necessary to review her over a longitudinal period when being followed up by the community team. He resolved to keep the differential diagnosis under review and to taper and stop her Risperidone over the next few months. He made a dose reduction at that point from 3mg of Risperidone to 2mg. He was aware that she was due to have an appointment shortly with Dr Nalaye who was a doctor at the Port Adelaide Community Treatment Team. He assumed that she would be followed up regularly by the Port Adelaide Community Treatment Team and at that point his involvement with Ms Hadley ceased⁵. Dr Mohan's expectation at that time was that Ms Hadley's needs would be met appropriately by the Port Adelaide Community Treatment Team with medication or case management⁶.

4. Ms Hadley's appointment with Dr Nalaye

- 4.1. The documentary evidence⁷ showed that she was seen by Dr Nalaye on 26 February 2009. At this time she was formally under the care of the Port Adelaide Community Treatment Team. Dr Nalaye's progress note was the only evidence of what occurred on this occasion because unfortunately Dr Nalaye developed an illness shortly after this and died in 2009. Thus, the only information for the Court to rely on is his documentation. Fortunately, the notes are quite comprehensive.
- 4.2. Dr Nalaye recorded that Ms Hadley had been referred from the Transition of Care Clinic after an admission to Cramond Clinic. He recorded that Ms Hadley said that she was stable but that she had been living with an abusive partner for the last six years. She said that she had been abused verbally and emotionally for the whole of the relationship and that she was petrified to stay with him. She was afraid that he

⁵ Transcript, page 66

⁶ Transcript, page 66

⁷ Exhibit C70

would take the children from her. She reported, according to Dr Nalaye, that she had put up with the abuse but could no longer live under the same roof as her partner.

4.3. I interpose to note that this was the first occasion on which a clinician had recorded complaints of domestic violence. Certainly Dr Mohan made no mention of domestic violence in his dealings with Ms Hadley, which were more extensive than Dr Nalaye's.

4.4. Dr Nalaye recorded that at the time that he saw her, Ms Hadley was not experiencing any psychotic phenomena and no neuro-vegetative features or delusions. He recorded her past psychiatric history and that she had reportedly ceased smoking cannabis. He recorded her developmental history quite comprehensively. He noted that her premorbid personality was that of a friendly and artistic person. He remarked that her mental state was tearful, agitated and it was hard to control her emotions. When she settled down she was friendly, cooperative and able to explain the turmoil she was in. Her speech was of normal flow and there were no delusions or formal thought disorder. Her sleep, appetite and mood were fine. In short, there were no psychotic symptoms and she had insight into her condition. Dr Nalaye made the provisional diagnosis of adjustment disorder with mild depressive symptoms. He noted that there was domestic violence. He made a differential diagnosis of mood disorder and bipolar affective disorder and then recorded the following plan:

'She was informed to contact DV Crisis Intervention and will be placed in a hotel for the time being and will eventually placed (sic) in a home with her two children. The crisis worker will send a cab for her when she goes home and pack few things. Continue with her medication Risperdal 2mg nocte.'⁸

4.5. That was the last time Ms Hadley was seen by the Port Adelaide Community Treatment Team. No follow-up appointment was made and she did not make further contact herself.

4.6. It is impossible to tell from the available material whether Dr Nalaye had planned to arrange a further appointment. It is possible that he had planned to do so and that through inadvertence that did not happen. Whatever Dr Nalaye's intentions, the fact is that no further appointment was arranged for Ms Hadley. It is quite clear that she needed to continue her treatment with the Port Adelaide Community Treatment Team. Clearly there was a need for the Risperidone to be monitored, and for the dosage to be

⁸ I have omitted certain obvious typographical errors

further adjusted and eventually ceased. Without attributing responsibility for this breakdown in care to any particular individual, it can certainly be seen as a system failure.

5. Ms Hadley's file is closed by the Port Adelaide Community Treatment Team

5.1. The next event in the chronology is when the Port Adelaide Community Treatment Team decided to close Ms Hadley's file. This occurred on 15 September 2009 and the only record of it is a handwritten note on the file as follows:

'Discussed closure of this file with team leader and TOCC worker, Sue Morrison. Close file today. No contact since Feb 09.'

5.2. That file note was written by Mr Michael Wooden who was a Social Worker with the Port Adelaide Community Treatment Team in 2009. He gave evidence at the Inquest that in 2009 the Port Adelaide Community Treatment Team did not have a formal policy for closing dormant case files. An informal process had developed. Mr Wooden said that:

'We would close files after there was six months of no contact and what we would do is we would look into whether there was – how much history there was, how much contact there was.'⁹

He said that if there was no contact and the issues seemed to be resolving, they would either write to the person or make a phone call and then close the file. They would usually send a letter saying 'if we don't hear from you within a fortnight we will assume you do not require our service and close the file'¹⁰. In this instance, no such letter was written. Mr Wooden said that 'it wasn't deemed as needing to be followed up'¹¹, by which he meant that there was some indication on the file that Ms Hadley had left the property where she was living and:

'There was no place to write to.'¹²

This conclusion was inferred from the file note that had been written by Dr Nalaye suggesting that Ms Hadley would collect her possessions and take her children to a domestic violence shelter. Mr Wooden acknowledged that there was nothing on the file to confirm that that had ever happened. The fact of the matter was that Ms

⁹ Transcript, page 333

¹⁰ Transcript, page 333

¹¹ Transcript, page 335

¹² Transcript, page 351

Hadley had continued to live at the address in Royal Park known to the Port Adelaide Community Treatment Team right up until Duke's death.

5.3. Mr Wooden did not know Ms Hadley. He had never met her and had not been involved in her care. His review involved reading the Port Adelaide Community Treatment Team file and the Community Based Information System (CBIS) record. Mr Wooden's Counsel conveniently summarised the factors that were considered by Mr Wooden in his decision to close the file as follows:

- a) Ms Hadley's admission to Cramond Clinic in December 2008 was a short one;
- b) Her principal psychiatric diagnosis was 'drug induced psychosis';
- c) Her diagnosis upon referral to the Port Adelaide Community Treatment Team was '?drug induced psychosis';
- d) There had been no contact between Ms Hadley and the service since 26 February 2009;
- e) No follow up appointment with Dr Nalaye had been made;
- f) No other service or health professional had contacted the Port Adelaide Community Treatment Team about Ms Hadley since February 2009;
- g) Ms Hadley had not had contact with any other mental health service since February 2009;
- h) Ms Hadley's referral was for medical review only and she did not have a case manager;
- i) The score recorded on Ms Hadley's file for her 'health of the national outcome' was low;
- j) Her score under the proforma 'Service Needs Scale' was low;
- k) A need for ongoing community care had not been identified;
- l) Dr Mohan's noted plan in January 2009 was 'to treat, to taper and cease Risperidone in the next two to three months';¹³
- m) Ms Hadley's Risperidone dose had been tapered;
- n) Ms Hadley was reported in January 2009 to have made 'a functional recovery' from her drug induced psychosis¹⁴.

¹³ Exhibit C72

- 5.4. Mr Wooden gave evidence that he spoke to Mr Renigers who was then the team manager at the Port Adelaide Community Treatment Team and Mr Wooden's immediate superior. Mr Renigers also gave evidence at the Inquest. Although there were some differences in their evidence, it is not necessary to reach a conclusion about those. Both Mr Renigers and Mr Wooden agreed that when Mr Wooden suggested closure of Ms Hadley's file to Mr Renigers, they sought the views of Ms Morrison about that matter before a final decision was made. They both considered that her views were important given that she had participated in the appointments between Ms Hadley and Dr Mohan as part of the transition of care process following the discharge from Cramond Clinic and pending the transfer of Ms Hadley's care to the Port Adelaide Community Treatment Team. In fact, Ms Morrison was present at each of the transition of care appointments and had some familiarity with Ms Hadley's case. The only other person in the Port Adelaide Community Treatment Team with any direct knowledge of Ms Hadley was Dr Nalaye who it will be recalled was then on sick leave from which he did not return. It was Mr Wooden's evidence that he, Mr Renigers and Ms Morrison concurred in the decision to close Ms Hadley's file. For his part, Mr Renigers' evidence was that Ms Morrison showed some reluctance about closing the file. I did not hear from Ms Morrison and I do not find it necessary to reach a conclusion about the matter. I express no criticism of Ms Morrison in this finding.
- 5.5. Mr Renigers' evidence was broadly consistent with that of Mr Wooden except in relation to the issue to which I have already referred. Mr Renigers acknowledged that the responsibility for the decision to close the file was his and his alone¹⁵. He agreed that in retrospect it would have been preferable to have made contact with Ms Hadley before making a decision¹⁶. He said that the process has now changed. A decision to discharge a client will not be made unless it has been approved by the psychiatrist as the lead clinician¹⁷.
- 5.6. Mr Renigers gave the following evidence about the nature of the service provided by the Port Adelaide Community Treatment Team:

'... we operated on a service model which is premised on flow through, so that case loads don't become too large and over-burdened. So, that we have the capacity to respond to

¹⁴ Exhibit C72

¹⁵ Transcript, page 363

¹⁶ Transcript, page 364

¹⁷ Transcript, page 365

new referrals in a timely fashion. And so the expectation is to - I suppose, facilitate recovery and then at some point refer the person on or to discharge them so that - yes, we maintain that flow through and have the capacity to respond to new clients.'¹⁸

- 5.7. I was left with the impression that the workload of the Port Adelaide Community Treatment Team was such that there was a greater emphasis on closing the file in this case than might have been the case had the workload been more manageable.
- 5.8. It was regrettable and inappropriate that the file was closed and that there was no follow-up with Ms Hadley. There should have been. In my view it was attributable not so much to any wrongful act on the part of an individual, but the systemic factors affecting the Port Adelaide Community Treatment Team, including pressure of work which is indicative of under-resourcing and poor procedures¹⁹.

6. **Mr Hura's call to the Mental Health Triage Service**

- 6.1. On the evening of 4 November 2009 Mr Hura attempted to obtain assistance for Ms Hadley whose mental condition had been deteriorating for some time. He contacted Cramond Clinic at first and then was told to contact the Mental Health Triage Service. He followed that advice and made a call to the Mental Health Triage Service and spoke to Mr Daniel Bienewitz who was on duty that evening. He is a mental health nurse and gave evidence at the Inquest. The call was recorded and a transcription was made from the recording²⁰. It speaks for itself. I have reproduced it in the appendix to this finding. Mr Bienewitz acknowledged in hindsight that he could have handled the call better²¹. He acknowledged that his approach conveyed a rather discouraging overtone to Mr Hura who was seeking assistance²².
- 6.2. While the transcript is an accurate reproduction of the audio recording of the call, it does not convey the many long pauses and the very lengthy duration of the call. The call occupied some 45 minutes in real time. An expert opinion was obtained in this matter from Professor Goldney who is a distinguished psychiatrist. He has provided many medico legal opinions in the field of psychiatry and is currently Emeritus Professor in the Discipline of Psychiatry at the University of Adelaide. Professor

¹⁸ Transcript, page 386

¹⁹ For example, no automatic process for attempting contact with a patient before a formal file closure occurs

²⁰ Exhibit C67g

²¹ Transcript, page 183

²² Transcript, pages 176-177

Goldney provided a written report²³ and also gave oral evidence at the Inquest. Professor Goldney commented that he did not think the call was handled well. He said:

'... it was somewhat excruciating listening to it because there were extraordinarily long silences.'²⁴

Professor Goldney did not think that there was any sort of empathy conveyed by Mr Bienewitz. Professor Goldney was critical of the use of leading questions and the failure to pursue things which should have been followed up²⁵. Professor Goldney said:

'And really, the whole conversation seemed to go round in circles and it was as if it was being stone-walled, that there was some - I mean it almost sounded as if the person taking the call was, you know, trying to find reasons not to help.'²⁶

Professor Goldney summed up the position as follows:

'I mean it's just not very professional and it - as I said, I mean, it was excruciating and painful to listen to.'²⁷

- 6.3. A major factor in the conversation was Mr Hura's reluctance to be nominated by the Mental Health Triage Service if they did make contact with Ms Hadley, as the person who had alerted them to her situation. Mr Hura referred to it as a need for there to be a 'referrer'. Mr Hura was reluctant and explained his reasons quite clearly. He was concerned that Ms Hadley would be angry with him and react aggressively as she had in the past in a similar situation. Professor Goldney remarked that he hoped that this is not an example of what is being done all of the time in the Mental Health Triage Service²⁸.

7. The events of 5 November 2009

- 7.1. In the result Ms Bowling, who was the shift coordinator at Western ACIS, noted the contact between Mr Hura and the Mental Health Triage Service the previous night on her arrival at work that morning²⁹. She raised the contact at a meeting at 8:30am at which the work for the day was being allocated. A decision was made to conduct a

²³ Exhibit C86

²⁴ Transcript, page 414

²⁵ Transcript, page 414

²⁶ Transcript, pages 414-415

²⁷ Transcript, page 415

²⁸ Transcript, pages 421-422

²⁹ Transcript, pages 225-226

home visit that morning and the task was assigned to two social workers, Ms Radcliffe and Ms Evans. She said the decision was made because it appeared as though Ms Hadley was probably experiencing a drug induced psychosis and they were not certain whether there were children in the house. It was decided that Ms Hadley needed to be assessed and it was to be done that morning.

- 7.2. Ms Radcliffe and Ms Evans did in fact attend at the house at approximately 11am and they were unable to gain access or any response at all from Ms Hadley. After some 10 minutes or so they left the house with the intention of returning that afternoon. In the result other events overtook that plan.

8. Professor Goldney's opinion

- 8.1. Professor Goldney was asked to review this case and provided his opinion in the form of a report dated 13 July 2013³⁰. Professor Goldney said that Ms Hadley had an evolving severe psychotic illness complicated by drug abuse. Professor Goldney was not critical of Ms Hadley's treatment at Cramond Clinic, nor by her treatment at the hands of Dr Mohan. Professor Goldney was however very critical of the treatment afforded by the Port Adelaide Community Treatment Team and also of the interaction between Mr Hura and the Mental Health Triage Service, to which I have already referred.
- 8.2. Professor Goldney was of the view that it was completely unacceptable for the Port Adelaide Community Treatment Team not to have continued to afford ongoing care to Ms Hadley. It was his opinion that this was certainly necessary. At the time of her last contact with the service, through Dr Nalaye, she was still being medicated with Risperidone. The plan was to gradually titrate the dosage down at some point in the future as she responded to treatment. However, that stage had certainly not been reached at the point of her last interaction with Dr Nalaye. No further appointment had been made by Dr Nalaye or any other person at the Port Adelaide Community Treatment Team for her to be seen again.
- 8.3. As I have previously noted, Dr Nalaye was distracted by Ms Hadley's complaints of domestic violence. While I do not in any way understate the need to treat complaints of domestic violence with the utmost seriousness, the difficulty here is that Ms Hadley

³⁰ Exhibit C86

had a severe mental illness. While it might have been perfectly appropriate for an allegation of domestic violence to be explored by a domestic violence service at that point, it was no substitute for continuing psychiatric treatment. It may well have been that her complaints of domestic violence were a manifestation of her psychotic illness. Nothing would be lost by referring her to a domestic violence service, but it was certainly inappropriate not to maintain her psychiatric treatment and her contact with the Port Adelaide Community Treatment Team. That needed to happen and it did not. In fact, there was no further contact between Ms Hadley and the Port Adelaide Community Treatment Team. No further action was taken by the Port Adelaide Community Treatment Team until her file was closed in September 2009. Professor Goldney was critical of the systemic lack of continuity of care. He said that continuity of care is 'so important'. He added, however, that continuity of care is:

'...something that just doesn't seem to be valued I think in the way the mental health services are structured. There is very little continuity of care in the longer term.'³¹

- 8.4. Professor Goldney commented that Dr Nalaye's caseload of 200 people is simply 'unrealistic' and that it was not possible for Dr Nalaye to 'really do justice' to that sort of caseload³². Professor Goldney's opinion was that to leave it to Ms Hadley's own initiative to return to the service or to make an appointment, was an 'abdication of responsibility'³³. Professor Goldney was unable to discern from Dr Nalaye's note whether it was his intention that the Port Adelaide Community Treatment Team's involvement with Ms Hadley was to cease or not. He simply could not interpret Dr Nalaye's note one way or the other. As I have already said, Dr Nalaye was not heard at this Inquest because of his death following these unfortunate events. He was therefore unable to provide any explanation. But on the face of it, there has most certainly been a failure in the provision of care to Ms Hadley in this case. Whether it was Dr Nalaye's responsibility or that of someone else is really not to the point. It simply should not have happened. Professor Goldney commented that:

'... I don't think that that system is good enough and if people expect to get a specialist treatment service, they are certainly not getting a specialist treatment service at that unit.'³⁴

³¹ Transcript, page 394

³² Transcript, page 396

³³ Transcript, page 398

³⁴ Transcript, page 404

I wholeheartedly agree. Professor Goldney commented that this inadequacy was probably a result of lack of resources³⁵. Professor Goldney was very critical of the decision to close the file on the basis that Ms Hadley had not made contact with the service for some considerable time. He said that it was a result of the excessive number of patients being looked after by the Port Adelaide Community Treatment Team, which is another way of referring to the inadequacies of the Port Adelaide Community Treatment Team's resources to deal with that caseload. He remarked:

'But the dilemma is that in such a service with, you know, 500 people on the books as I understand there was, I can well understand that there is this pressure to, you know, close the file off and reduce the numbers and it's not really a very - very good service.'³⁶

8.5. Professor Goldney commented that the closure of Ms Hadley's file showed a lack of curiosity and a lack of responsibility. Alarming, he said that he thinks that those shortcomings are pervasive at the moment in the mental health system³⁷.

8.6. Professor Goldney remarked that:

'...this case amply demonstrates the paucity of people in that service who have got the qualifications to deal with psychiatric illness.'³⁸

9. Conclusions

9.1. The circumstances leading up to Duke Hadley's death are extremely disturbing. His mother was admitted to Cramond Clinic with an episode of psychosis and a differential diagnosis of possible bipolar disorder. She was prescribed antipsychotic medication that required medical supervision. She was appropriately discharged via a transition of care arrangement to the Port Adelaide Community Treatment Team, which is part of the South Australian Mental Health System. It is intended to deal with people with a psychiatric illness. It is intended to deal with people such as Rachael Hadley. The evidence shows that the Port Adelaide Community Treatment Team failed in its duties and responsibilities towards Ms Hadley. Whether that failure was causative of Duke Hadley's death is a matter on which it is not possible to reach a conclusion, given the amount of time that passed between Ms Hadley's contact with the team and Duke's death. It is not unreasonable however to speculate that had Ms Hadley been afforded proper and appropriate psychiatric care, she may not have

³⁵ Transcript, page 405

³⁶ Transcript, page 409

³⁷ Transcript, page 410

³⁸ Transcript, page 411

relapsed and deteriorated to the point of the acute psychotic condition she suffered at the time of Duke's death.

- 9.2. On any view it is extremely disturbing that the mother of a 2 year old child would be the subject of such a serious breakdown in the mental health system in February, and would be arrested for the violent murder of that child the following November, and yet that is what happened in this case.
- 9.3. The breakdown that led to the cessation of contact between the Port Adelaide Community Treatment Team and Ms Hadley was unacceptable and should not have happened. In my opinion it is a result of the unrealistically high workload that the Port Adelaide Community Treatment Team had at that time. That workload was, in Professor Goldney's words, unrealistic.
- 9.4. The decision to close Ms Hadley's file in September 2009 was an occasion on which an opportunity to rescue the system breakdown of February presented itself. The opportunity was not taken and the file was closed. I can only conclude that the pressures of work and the insufficient resources available to perform that work were such as to create an environment in which file closure occurred so readily. In such an environment the appropriate course, once again adopting Professor Goldney's formulation, of asking questions and demonstrating 'curiosity' did not exist. Instead, there was an environment in which 'flow through' to use Mr Renigers' expression, was the order of the day. Again, this is indicative of an under resourced service.
- 9.5. The explanation proffered by Mr Wooden for not writing to Ms Hadley's last known address – namely that the referral to the domestic violence service suggested that she would not be at that address by September, is facile and specious. It could only be offered in an environment in which the pressure to deflect work because of a lack of resources makes the preposterous appear to be reasonable.
- 9.6. The next opportunity to prevent Duke's death came with Mr Hura's contact with the Mental Health Triage Service. Once again, the system failed to provide an intervention that might have saved this young boy. Again, I am left with the feeling that Mr Bienewitz was working in an environment in which he felt more obliged to ration a precious resource, than to be encouraging of Mr Hura's efforts to obtain care for Ms Hadley. In saying this, I do not mean to be unduly critical of Mr Bienewitz. As I have previously said, he acknowledged that he could have done things

differently. As a witness he presented as a sincere person. In my view it was the organisational environment in which he worked that is responsible for this very poor outcome. The conversation between Mr Bienewitz and Mr Hura makes harrowing listening. If anything, Professor Goldney understates the case when he said that it almost sounded as if the person taking the call was trying to find reasons not to help. In fact, that was precisely how the call came across to me and in my opinion how it would be viewed by any reasonable listener.

- 9.7. I acknowledge that the situation was belatedly remedied the following morning when the ACIS team reviewed Mr Bienewitz's contact of the previous night and determined to send two workers out for a home visit to Ms Hadley's house. It is arguable that a different approach to the telephone contact of the previous night might have resulted in an arrangement where Mr Hura could have been encouraged to remain on the premises until the arrival of ACIS workers the following morning. Nevertheless, that is speculation and I do not suggest that the Mental Health Triage Service call, excruciating though it was, was causative of Duke's death.
- 9.8. The ACIS response on the morning of the day of Duke's death was appropriate and timely. Unfortunately it was too late to save him.

10. Recommendations

- 10.1. 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.
- 10.2. The affidavit of Lisa Courtney³⁹ refers to changes that have been made since this tragic event. It is to be hoped that they might improve the system. However, in my view there is no substitute for adequate resourcing. I recommend that the Minister for Mental Health and Substance Abuse carry out periodic reviews to ensure that all providers of mental health services are adhering to the changes referred to in Ms Courtney's affidavit⁴⁰. Secondly, that regular audits of each of the community mental health teams, such as the Port Adelaide Community Treatment Team, are regularly audited to ensure that they are adequately and appropriately staffed and have systems

³⁹ Exhibit C83

⁴⁰ Exhibit C83

to track patients and to track appointments. Thirdly, that there are regular random audits of recordings of calls made to the Mental Health Triage line to ensure, in Professor Goldney's words, that the example contained in the Appendix to this finding is not representative of calls to that service. Fourthly, that the Minister for Mental Health and Substance Abuse note Professor Goldney's comment that the mental health system as currently structured does not ensure continuity of care, and that this should be addressed as a matter of priority.

Key Words: Psychiatric/Mental Illness; Homicide

In witness whereof the said Coroner has hereunto set and subscribed his hand and

Seal the 31st day of January, 2014.

State Coroner

APPENDIX

1

HURA, Jason

KD-MHT-1

2

3

4 **PHONE CALL BETWEEN**

5

6 JASON HURA (Father of Duke HADLEY and partner of Rachael HADLEY)

7 AND

8 DANIEL BEINWITZ (MENTAL HEALTH TRIAGE)

9

10 DATE: 4TH NOVEMBER, 2009

11

12

- 13 Q Good evening Mental Health Triage can I help you.
 14 A Hi just ringing about someone that needs to go into a psych ward
 15 Q Right
 16 A I need to know what to do
 17 Q Why do you think they need to go into a psych ward.
 18 A Cause they're acting really weird
 19 Q Yeah what are they doing.
 20 A What was that
 21 Q What are they doing
 22 A Um well she's been taking Duramine tablets and smoking dope so putting her in
 23 psychosis.
 24 Q Oh ok
 25 A She's been into Crammond before, but she's probably worse than the time when she
 26 went in.
 27 Q Oh is she threatening self harm or anything.
 28 A No not that, it's just like she's ok one minute and then she's just going off her head.
 29 Q As in shouting, screaming
 30 A Yeah, yeah I mean she, she looks like an evil person yelling
 31 Q Yelling
 32 A And then she just goes back to normal
 33 Q And does she, does she know what sort of know where she is, what day it is or
 34 anything like that.
 35 A I've got no idea
 36 Q No all right and she's been doing Duramine all day today or something or.
 37 A No that's what's got her like this, I don't know when she's taken the last one or
 38 whatever.
 39 Q And you don't know when she's smoked dope last
 40 A No I don't know, she's just sort of sitting there and
 41 Q What's here name
 42 A Rachael Hadley.
 43 Q Hadley ok lets have a look. Rachael Hadley, LEY.
 44 A Yeah



- 2 Q Or DDLEY.
3 A No LEY
4 Q HADLEY is enough
5 A Yeah
6 Q Ok
7 A Yeah.
8 Q Lives at Royal Park yeah
9 A Yeah, yeah, yep.
10 Q Yep ok nobody's looking after her any longer.
11 A No she's pretty much
12 Q No
13 A Last time she went in she took herself off the tablets, I don't think she really recovered
14 from then
15 Q All right ok, um, ok, well look I mean I guess it's, it boils down to risk really, and I
16 guess the question is what risky stuff is she doing at the moment or it's just bizarre
17 behaviour.
18 A Yeah it is, yeah
19 Q Just bizarre
20 A But the problem is there's kids there and I can't just take the kids out of there.
21 Q Oh how old are the children
22 A One's 2 and one's 9.
23 Q 2 years old and a 9 year old
24 A Yeah
25 Q And are you living there as well
26 A Yeah I am yeah
27 Q Yep ok
28 A Well sometimes.
29 Q Yep, yep, and but you're staying there tonight are you
30 A Yeah I'll, yeah I'll go back there.
31 Q Yep, yep and these her kids or yours
32 A Mine and hers
33 Q Oh ok. Right and how are they coping with mum's bizarreness.
34 A The 9 year old yeah she's getting scared, she doesn't like it.
35 Q Mm, oh ok, well I guess I mean given that she's sort of, and you're definitely sure
36 she's been taking Duramine and drugs.
37 A Yeah, yeah, yeah she has yeah.
38 Q Yep, so she's a bit of a mixture of being revved up and then doped sort of trying to
39 slow it down
40 A Yeah she's taking both the uppers and a downer so she's.
41 Q So she's.
42 A Her brains going at a million miles an hour
43 Q Mm do you think if I chatted to her on the phone she would talk to me
44 A Ah I've got no idea.
45 Q Ok can I try.
46 A Yeah, yeah I don't know how you're going to do it, she'll get really angry probably if
47 people come there or talk to her.
48 Q Oh ok.
49 A Yeah like yesterday and the day before.
50 Q I closest I will get is by phone.
51 A Hey



- 2 Q The closest I will ever get is by phone. I won't be coming to the home.
3 A Yeah I'm not there at the moment though
4 Q Ok but does she have a land line there that we can ring
5 A Um she's got the mobile number but I really don't think ringing her is going to do any
6 good.
7 Q No well I guess I need to assess her for myself that's why I'm asking, if you don't want
8 that then I guess the only other suggestion I can make to you is that you take her off to
9 a hospital.
10 A Yeah it's not easy to get her out
11 Q Ok
12 A See like if I could just take the kids out of there I would but
13 Q Yeah
14 A I, I can't really do anything.
15 Q What will happen if you could, lets, lets take the scenario of you being able to
16 withdraw the children say, and you left her by herself tonight, what would she do,
17 what's, what's the worst case scenario
18 A I've got no idea would
19 Q Would she go to sleep.
20 A She could do anything no she hasn't slept for days, she sleeps for an hour and then
21 she's up again.
22 Q Ok and has she harmed herself recently or in the past.
23 A No, no she hasn't no.
24 Q So self harming is not a problem.
25 A No
26 Q No all right no then it's a case of will she harm somebody else.
27 A Well that's the thing I don't know, one minute she's ok and then like she's talking
28 about God and the devil
29 Q All right
30 A And all this stuff, like yesterday I was the devil and then today I work for the devil.
31 Q Oh ok, and what about this, what's her reference to God what's that saying.
32 A Oh God's here to help me I don't need to eat or anything. Don't need to eat or sleep.
33 Q Ok, there's no commands from God to do anything stupid like you know hurt
34 somebody or hurt.
35 A Well that's it I don't know whether.
36 Q Mm
37 A I've heard of things before where people have woken up with a frigging knife in there,
38 a knife above them and them yelling at them saying you've got the devil in you I have
39 to kill you.
40 Q So she's called you the devil today hasn't she and
41 A Yeah yesterday and the day before yeah.
42 Q Mm all right, and I mean this wouldn't be the first time that she's done this sort of
43 thing so what's
44 A No last time, last time she had, she thought she had stuff growing on her arms and she
45 picked her whole face off and her arms and
46 Q Mm so she
47 A
48 Q Really means to be seen by a Dr doesn't she
49 A Oh yeah she does yeah
50 Q Yeah so it's a matter of getting her to hospital really
51 A Yeah



- 2 Q Yeah
3 A Last time she thought she had stuff growing on her so I convinced her to
4 Q Mm
5 A Go see the, go to the hospital emergency and
6 Q Mm well that seems to be the same path what we're going to have to go today.
7 A Yeah.
8 Q Back to hospital
9 A It's just getting her there and
10 Q Yeah.
11 A Cause I don't know what she'll do
12 Q Well I guess I mean at the end of the day lets take it, lets take it that she might become
13 aggressive you know like you're strong enough to defend yourself are you not or
14 A Yeah I am yeah
15 Q Yeah
-
- 16 A But the thing is she won't stop.
17 Q So it's at that point in time that you call the police
18 A Yeah but
-
- 19 Q Are you able to do that.
20 A Well yeah that's the thing though you have to knock her out to stop her. That's the
21 thing it's like she's on speed
22 Q Yeah so what I'm saying is can we then ask the police to be involved. I mean I'm
23 A Well possibly I don't know can you get the police to come there and take her in or
24 what.
25 Q Well you would, you would have to be the caller and
26 A Yeah that's the thing if she knows that I've called them then she's going to get a bit
27 more pissed off with me again.
28 Q Oh well only today when she comes out of this, she'd say, she'd probably even forget
29 out it, she wouldn't even know what happened maybe. There's a high likelihood that
30 she may not even be aware of things to be able to remember
31 A Yeah well that's the thing that's, like today she's, she's not like yesterday when I come
32 home every time I walked around the room or walked past her she'd come and tell me
33 stuff
34 Q And say you're the devil or what else would she say.
35 A Yeah and that and then today she's just sitting there and she's not yes
36 Q And what other things has she said.
37 A Oh she just says stuff and then laughs.
38 Q All right so giggles to herself
39 A Yeah
40 Q What else does she say though.
41 A She says that God lives there in the house and he's there to protect her and
42 Q Mm
43 A Everyone's evil, all her friends are evil now.
44 Q Yeah anything else.
45 A Um it would have been easier if I had recorded her
46 Q Yeah all right what I'll do
47 A She like she's getting calm, it's like she's going to go into a coma the way she's
48 getting now
49 Q Yeah
50 A She's just getting slower and slower.
51 Q Ok so given that we don't really know how much she's had of anything really it's



- 2 important to get her off to hospital, I guess I'm happy to put you through to the
3 ambulance department and then you tell them that you know she's got a bit of a violent
4 streak about her she may lash out so police will be required and, and then go from
5 there. If you don't think you can do it yourself to take her to hospital.
- 6 A Yeah I don't know how she'll react.
- 7 Q Well what other option do you want.
- 8 A I've got no idea. Can you have people come around and like sit down and talk to her
9 so they can see what she's like and then
- 10 Q Well I don't know
- 11 A Get the police to come down and take her.
- 12 Q Mm oh I suppose we can ask the ASIS team to, to, to see her, I can't guarantee that
13 they'll be able to tonight I can only ask.
- 14 A It wouldn't, it wouldn't matter if it's tomorrow.
- 15 Q Um, you'd have to be there to let them in.
-
- 16 A Yeah I can probably do that.
- 17 Q Well I mean if they will want, the team will want to have a referral person's name,
18 who is the referrer and then they will want somebody to facilitate the process,
19 otherwise they won't do it. So in other words somebody who will open the door, let
20 them in the door and introduce them to Hayley.
- 21 A Yep.
- 22 Q Um it looks as though she's had input earlier this year
- 23 A Yeah she was in, in December I think or
- 24 Q Have a look here, mm ok is she getting any support or help or dealing with her drug
25 abuse.
- 26 A No see the last time she just went off the tablets and then that was it no one contacted
27 her or nothing.
- 28 Q Oh ok well they did a brief thing with her but that didn't go very long, um ok, I'll start
29 a fresh episode. Ok, lets try I'm miskeying tonight sorry. All right so you don't care if
30 she's not seen until tomorrow
- 31 A No
- 32 Q No
- 33 A She'll be all right yes
- 34 Q She'll be all right for the night
- 35 A Yep
- 36 Q So then if she'll be all right for the night well what's the chance of getting her to see a
37 Dr tomorrow.
- 38 A Oh I've got no idea. The problem is I'd have to take her to emergency wouldn't i.
- 39 Q No a GP.
- 40 A Yeah, yeah last time she went to see a GP and they did nothing.
- 41 Q Oh
- 42 A They just said oh you need to go to hospital and see a psych patient or see a psych Dr
43 and that's all they did
- 44 Q Oh. Ok, I guess you've got to realise that if by tomorrow the drugs have left her
45 system and she presents quite normal then basically the team will say what am I doing
46 here.
- 47 A No well the thing is she's just sitting there now smoking that's all she's doing. Sitting
48 in a little room smoking.
- 49 Q Mm that's why in a way I would prefer to talk to her if I could. Then I won't.
- 50 A Do you want me to give you her number then
- 51 Q I won't, I won't, I won't force the issue but I would, I would like to talk to her. So um



- 2 let me just quickly tidy this up. Ok now your name was
3 A Jason
4 Q Jason and you are a friend or what
5 A Yeah, yeah
6 Q Or you're her defacto or
7 A Yeah
8 Q You're defacto
9 A Yep
10 Q Ok, so same address, and your contact number
11 A Um it's 0412
12 Q 0412
13 A 58
14 Q Mm
15 A 25
-
- 16 Q Yep
17 A 28.
18 Q No worries, ok, at this point in time she's not aware of anything so all right so Jason
19 rang concerned that Rachael is not well he feels sorry she isdisorganised and
20 fluctuates between quiet and normal conversation to being aggressive verbally and
21 screaming and telling him he is the devil and she giggles to herself and she keeps to
22 herself but so far has not threatened self harm, he would like her seen and reviewed,
23 now I guess Jason one of the problems with this whole scenario is I guess is that she's
24 not threatening you with harm and she's not harming herself, she's behaving as
25 somebody who is under the influence of some drugs, um which she's chosen to take, I
26 guess it's a case of if there's no imminent risk it's a case of then letting those drugs
27 wear off and wear out.
28 A Yeah they're not going to wear out.
29 Q Then, and then for her then to sort of settle down, um and then I mean this one is really
30 a situation of unless she's at risk the team can't force her to do anything, um and so
31 then it's a case of when she's, you know when the drugs have left her system and she's
32 normal again to then try and get her to involve herself with drug and alcohol services
33 and seek some therapy that way, will she do that.
34 A Probably not no.
35 Q Mm so we've got a revolving situation here where somebody who will continue to take
36 drugs, continue to then behave in a bizarre manner being on the drugs
37 A She'll be like this until she goes to hospital.
38 Q Oh
39 A She's not just going to just come out of it.
40 Q So she'll continue to take these drugs.
41 A Yeah
42 Q Where does she get them from
43 A I've got no idea.
44 Q Ok.
45 A Yeah cause last time she went in she was, she probably wasn't even this bad.
46 Q How much, how much marijuana is she doing do you know
47 A No I've got no idea.
48 Q Just so
49 A Constantly doing it
50 Q How do you know that she's taking all this stuff if you don't know how much
51 A Cause she's always sitting there smoking.



- 2 Q So you'd have some idea then wouldn't you.
3 A Well I don't know how much she use when you're smoking it. So
4 Q So she continuously smoking a joint here a joint there so you know when you count
5 the joints that she smokes or the pipe or whatever do you know what, observe how
6 much she puts in there.
7 A No I'm not, I'm not always there though.
8 Q So how do you know she's doing Duramine do you see her pop the pills or what
9 A Oh she just tells me.
10 Q Ok. So what's she doing is she sleeping at night time or what's she doing
11 A No
12 Q Night time
13 A She sits up all night with music on, just talking to herself and laughing.
14 Q Music on talking to herself all right day or night. So she's sleeping I've written here
15 sleeping an hour here and there day or night.
-
- 16 A Yep
17 Q And eating.
18 A No not really
19 Q Snacking
-
- 20 A All that I know of or I've seen her eat in the last 5 days was ½ of a fillet of fish meal.
21 Q Does she drink alcohol what does she do to you know keep herself going. Any, any
22 A Ah she drank the other day but that it.
23 Q Water um coffee, tea
24 A Just coke
25 Q Oh
26 A Coke and iced coffee.
27 Q All right what's her presentation like does she look dishevelled, filthy, unclean
28 A Yeah I
29 Q Hair been combed or what
30 A Probably hasn't had a bath for a week.
31 Q Not showered
32 A That's the thing I'm not always there so I don't really know
33 Q Oh well does she smell
34 A Yeah.
35 Q Do her clothes look dirty
36 A Yeah a bit.
37 Q So who looks after the 2 year old when you're not there.
38 A Oh she does.
39 Q So how does a 2 year old like you know that's, that's not responsible if she's
40 A Yeah well that's what I mean, she needs to be in hospital. Cause I can't take the kids
41 out of there or I can drop Chloe off at school
42 Q But why can't you take the children what will happen
43 A Well she won't let me.
44 Q If you just take them what can she do.
45 A Well she'll yell a lot
46 Q Yeah and
47 A And I've got no idea probably try and grab him and rip him back.
48 Q You're not willing to try that.
49 A Not really no
50 Q Why not
51 A Because I don't know what she'll do.



- 2 Q So last time you didn't take the children away either.
 3 A No last time I convinced her to go to hospital
 4 Q Oh ok
 5 A And just dropped her off there and went
 6 Q All right, so all right, so not showered or bathed for some time, smells, clothes a bit
 7 dirty, hair dishevelled
 8 A Yeah
 9 Q Hair mattered and dishevelled, all right what's the house look like then
 10 A Um have you ever been to a rubbish dump
 11 Q Yeah
 12 A Well
 13 Q That's what it looks like inside
 14 A Yep
 15 Q So the child's living in a rubbish dump
-
- 16 A Yep
 17 Q Ok, a rubbish dump, so I need to report this to Family and Youth Services you realise
 18 that don't you
-
- 19 A Yeah they, well I think they come down last time.
 20 Q I'm going to have to report it again. House looks like a rubbish dump, um 2 year old
 21 child looked after by mother when mother is taking substances. Um is she, I guess
 22 she's irritable all the time I suppose
 23 A Hey
 24 Q She's irritable all the time I guess
 25 A Yeah she is yeah
 26 Q Irritable often, suicidal no you're telling me.
 27 A Well not that I know of
 28 Q Not verbalised. And no history of all right and so from what you've observed she just
 29 what sits around, walks around and that's it, that's her day
 30 A Yep pretty much
 31 Q Tends to either sit around and listen, listen to music and smoke, or walk around, or
 32 walk around and this is her daily routine, so the 2 year old um 1 is assuming she's
 33 neglected or he's neglected so the question is, is he looking in bad shape the 2 year old
 34 A No he looks all right
 35 Q Well dressed or cleanly dressed
 36 A Yeah clean yeah.
 37 Q Mm all right so Jason's says that the 2 year old is looking fed and cleaned and clean
 38 clothes that's what you're telling me
 39 A Yep
 40 Q Yep all right so how long has she been, how long has Rachael been doing this now,
 41 what you've describe to us.
 42 A Um probably the last few weeks.
 43 Q Last few weeks, ok, and what about medically, is she medically ok, asthma, diabetes or
 44 anything like that.
 45 A Ah no.
 46 Q Don't know
 47 A Don't know she was a bit asthma, got asthma I think a bit I don't know.
 48 Q Not known.
 49 A No she has a puffer sometimes.
 50 Q Mm all right, alcohol is one of her problems, cannabis is the other and Duramine. Ok
 51 come on computer do as you're told, not listening, all right so medication she's not on



- 2 any anti, anti psychotic medication is she.
 3 A No she took herself off them.
 4 Q Oh not taking prescribed medication. Lets see if this thing will co operate now, no it
 5 won't, ok, is gambling an issue for her.
 6 A Oh just scratchy tickets.
 7 Q Ok, who's her Dr.
 8 A Um I've got no idea, I've never been there, I think it's the little Dr surgery on
 9 Frederick Road she normally goes there.
 10 Q Does she have a psychiatrist or anything.
 11 A No
 12 Q Any other services involved with her
 13 A No there's not no.
 14 Q Ok so and basically living alone by the sounds of what you're telling me.
 15 A Yep
-
- 16 Q Living alone with 2 year old what's the 2 year old's name
 17 A Duke.
 18 Q Duke.
 19 A Yep.
-
- 20 Q DUKE
 21 A Yep
 22 Q Yep, and the 9 year old
 23 A Chloe.
 24 Q So living alone with 2 year old Duke and 9 year old Chloe, in Housing Trust I
 25 presume.
 26 A No it's not no
 27 Q Private rental
 28 A Yeah
 29 Q She manages to make food for the children.
 30 A Yeah.
 31 Q Or do they do that themselves does the 9 year do it
 32 A Oh sometimes she does yeah.
 33 Q So would you say that for the last week or so the 9 year has been making the food for
 34 the 2 year old and doing, looking after the 2 year old and
 35 A Oh whenever I'm there I do it.
 36 Q Right ok, do you ask the 9 year old do you know when I'm not here does mummy do
 37 anything.
 38 A Yeah I do yeah.
 39 Q
 40 A Sometimes she doesn't yeah.
 41 Q Oh ok mm she manages to make food for the children sometimes. How often.
 42 A Hey
 43 Q Query how often
 44 A I don't know normally she'd just walk to the shop and buy food.
 45 Q And then querying whether it's healthy food anyway
 46 A Yeah
 47 Q Or whether it's just take away food
 48 A Yeah normally yeah just take away.
 49 Q All right and as far as how does Chloe get to school
 50 A I drop her off
 51 Q Right so Jason daily takes Chloe to school



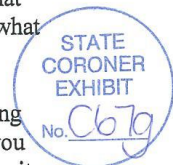
- 2 A Yeah, yeah.
- 3 Q Hadley takes Chloe, Chloe to school and then what happens to the 2 year old, what do
- 4 you do with the 2 year each day
- 5 A He, he just stays home
- 6 Q The 2 year old stays with Rachael.
- 7 A Yep
- 8 Q All right mm, so cultural or religious issues I presume are none.
- 9 A What was that
- 10 Q Cultural or religious issues
- 11 A No
- 12 Q Nothing environmental risks at the home there.
- 13 A What does that mean
- 14 Q In other words are there any dangers at the home there like weapons or
- 15 A No, no
-
- 16 Q Aggressive dogs or
- 17 A No they're not aggressive.
- 18 Q So no weapons, and no aggressive dogs, any dogs
-
- 19 A Yeah
- 20 Q Small dogs, big dogs
- 21 A Um medium
- 22 Q What sort of, maybe I better ask what sort of dog
- 23 A Um golden retriever, blue heeler and a great ridge back crossed with a Labrador.
- 24 Q Ok golden retriever, um I've forgotten the other 2. Golden retriever what was the next
- 25 one
- 26 A Ridge back cross.
- 27 Q Ridge back cross
- 28 A And then a blue heeler
- 29 Q And a blue heeler. And they can be put out the back
- 30 A Yeah that's where they live out the back yeah.
- 31 Q And these dogs are generally not aggressive that's what you're saying, they wouldn't
- 32 A Yeah, no they wouldn't bite no.
- 33 Q And as far as any obstructions to the home, gates or
- 34 A No
- 35 Q Things that are lose or whatever, now you said it was like a rubbish dump so any
- 36 dangers that way.
- 37 A Oh no it's just there's clothes everywhere
- 38 Q Right needles.
- 39 A No
- 40 Q No needles.
- 41 A No
- 42 Q Or sharp objects lying around according to Jason. Is she in trouble with the law.
- 43 A No
- 44 Q Ok, a apprehension violence order on her at all
- 45 A What is that
- 46 Q A restraint order.
- 47 A No
- 48 Q No, ok, so we have now a picture of somebody who you're saying is not wanting to
- 49 harm themselves, is not really wanting to harm others but yelling and screaming at
- 50 Jason, do anybody do people come to the home or anything like that, does she get
- 51 aggressive with them or



- 2 A Um I think most of her friends don't come around any more
3 Q Ok have no visitors.
4 A Like she, she did her last visitor came today I think
5 Q Ok
6 A So I don't think she'll be back for a while
7 Q Oh rightyo limited visitors, all right, now having a problem with functioning, we're
8 assuming it's, sounds as though she doesn't have much support.
9 A Yeah that's the problem.
10 Q Where's the mother and brothers.
11 A A lot, she had a lot of problems when she was a child that's probably the main cause of
12 everything.
13 Q Right
14 A Cause she's bought that up the last few weeks.
15 Q Ok
-
- 16 A All the things that happened to, to her
17 Q Right. So that could be an important thing. West Lakes, a lot on her childhood and
18 what specifically about her childhood didn't she, that you know
-
- 19 A Well she never coun, counselled on anything like she was raped when she 12 by her
20 mum's boyfriend at the time
21 Q Ok raped when 12 by mother's boyfriend, any other issues or is that it that, that one
22 there.
23 A She was teased at school cause her mother spread rumours about her and like things
24 like that.
25 Q Her mother spread rumours about her all right so now Jason I do want to try and talk to
26 her if I could please.
27 A Yeah I'll give you the number, what are you going to, who are you going to tell you are
28 though
29 Q Mental Health.
30 A Oh ok yeah so I don't know that might make her go off her head again.
31 Q Ok
32 A That's the only trouble can you talk to her like you're someone else or
33 Q Well I can except for the fact that ultimately it will come out in the wash and then that
34 will be well why did you tell me a lie. And then you know she'll piece it altogether
35 eventually and then it will come out you know then she'll say well you were dishonest
36 with me then why should I trust you, how can I trust your service and so on and so on
37 it goes.
38 A Just say you're following up her last years being in there you had to talk to her or
39 something.
40 Q Mm
41 A If you could do something like that it would be easier.
42 Q All right.
43 A If
44 Q I will have to probably be a little bit straight with her and say you know there has been
45 some concerns made by the people that have seen you today, so that means more than
46 one person obviously.
47 A Yeah or you say within the last week.
48 Q mm
49 A Just to make it more of a
50 Q Mm I mean she's going to have to address this at some point isn't she.
51 A Yeah but what, that's the thing if you can tell if something's wrong then going, how



- 2 you going to go about doing it.
- 3 Q Well mm, I guess I can only try and engage her if she refuses and hangs up on me well
- 4 then, then that's what she does, I can't
- 5 A Yeah then that's the trouble then I've got to be there when she's pissed off
- 6 Q Yeah
- 7 A And like there's knives in the house
- 8 Q Right
- 9 A And she's threatened me with a knife before so
- 10 Q Now you're telling me.
- 11 A Yeah that was last time
- 12 Q So she does have a history with threatening with knives
- 13 A Well she did it once. She come in the room and slammed it down on the table and said
- 14 I'll use it if I have to. That's the thing I don't know what will, that's the thing when
- 15 they're like this anything can trigger them off.
-
- 16 Q It sounds to me as though you're in the house there with her at the moment.
- 17 A No I'm not no.
- 18 Q No
-
- 19 A I wouldn't ring you from there.
- 20 Q Ok, um that's very awkward Jason cause I guess I mean at, at some point in time lets,
- 21 lets work this one through, at some point in time you want this team to come to the
- 22 home.
- 23 A Yep
- 24 Q They come to the home you let them in the door and they're going to be quite frank,
- 25 you know we've been asked to come here, oh why, who told you, oh we've been asked
- 26 by Jason to come and see you
- 27 A Yeah see that's the problem I don't believe in doing that.
- 28 Q But they won't do it unless there's a referee.
- 29 A Yeah see that's what happened last time, I told the Dr everything and he just went and
- 30 told her and then
- 31 Q Yep well the ASIS teams will not go unless they're given a referee.
- 32 A Yeah so i
- 33 Q So that's where it's sitting right
- 34 A They go around thing, they do things the wrong way.
- 35 Q Mm well she has to confront these issues at some point doesn't she
- 36 A Yeah I know that.
- 37 Q Whether she does it, whether she does it in the house or whether she does it in the
- 38 hospital either way she'll remember that you were the one involved, um so all she'll
- 39 A Yeah but if no one told her she wouldn't know that's the thing.
- 40 Q Mm well she'd ask though wouldn't she. She'd ask you or she'd try and find out
- 41 somehow where not, lets put it this way I mean I can try and not mention your name
- 42 but I can't guarantee that it won't come out, she might just say the right things in
- 43 which I'm then forced to sort of mention your name.
- 44 A Yeah.
- 45 Q Clearly because you know if we're going to be seen as a um you know a service that
- 46 she can trust she needs to know that we, we can be honest with her. If you know what
- 47 I mean
- 48 A Yeah
- 49 Q Do you want to, I mean I haven't done anything yet, I've taken the details it's sitting
- 50 here on the computer do you want to think about it, do you want to ring us back, you
- 51 can ring us back any time you want. Think about it, ring us back and we'll activate it



- 2 then. It's up to you
3 A Seetake her to hospital.
4 Q All right
5 A It might be easier
6 Q Well I'll leave it up to you to make that decision, I've put it all on the computer now so
7 it's all sitting there basically
8 A Yeah have you got a direct number or not.
9 Q Only no.
10 A In the system
11 Q Just 1340. Oh her's.
12 A yeah all the details in the system then.
13 Q Yeah, yeah I've put it under Rachael Hadley and it's all in the system now
14 A Yep
15 Q And I've put in her's I don't have, I don't have a number for you but I have her
16 number I think, 0421, is it. I think you gave me your number that's right.
17 A no I gave, I gave you my number
18 Q Yes you did yeah
19 A Yeah
20 Q Yeah I've typed it in
21 A Yeah
22 Q 0421 is her's, 210 does that sound right
23 A Yep 979
24 Q Yep that's what I've got
25 A Yeah, yeah.
26 Q Yeah so I've got her's as well
27 A Yep
28 Q So I won't do anything until you, until you ring us back
29 A Yep all right
30 Q How's that sound
31 A Yeah
32 Q does that give you a bit of space to think about it
33 A Yep I'll see how she is in the morning.
34 Q In the meantime I will have to talk to Family & Youth Services, in the meantime
35 A Yeah
36 Q Now I won't be here should you ring back tonight at all
37 A Yep
38 Q Um it will have to, it will have to be done by somebody else, but it's all on the
39 computer any way.
40 A Yep
41 Q All right, you just tell them to look at my write ups and basically they can use mine if
42 they want to
43 A Yep
44 Q Is that all right with you
45 A Yeah that's all right yep
46 Q Ok well.

