CORONERS ACT, 2003

SOUTH  *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Port Augusta and Adelaide in the State of South Australia, on the 20th, 21st, 22nd, 23rd, 26th, 27th, 28th, 29th and 30th days of September 2016 and the 25th day of July 2017, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Deborah Francis McKenzie.

The said Court finds that Deborah Francis McKenzie aged 22 years, late of 8 Ookara Street, Port Augusta, South Australia died at Port Augusta, South Australia on the 13th day of March 2013 as a result of compression of the neck consistent with hanging. The said Court finds that the circumstances of her death were as follows:

1. Introduction

1.1. This is a matter of considerable complexity. Deborah Francis McKenzie took her own life. The circumstances in which she did so are complex and multi-faceted. Deborah McKenzie was an indigenous woman of 22 years of age. She died during the night of 12 and 13 March 2013. An examination of Ms McKenzie's phone records reveals that the greater likelihood is that her death occurred after midnight. Accordingly, the date of death is given as 13 March 2013.

1.2. Ms McKenzie was the biological daughter of Mr Rex McKenzie. After her birth Ms McKenzie was taken into the care of Mr Malcolm McKenzie, who is Rex McKenzie's brother, and his wife Mrs Dorothy McKenzie. From that time Mr and Mrs McKenzie raised Deborah McKenzie as their own daughter. In these findings I shall refer to Mr and Mrs McKenzie as Deborah McKenzie's parents. I shall refer to Deborah McKenzie as their daughter.

1.3. At the time with which this Inquest is concerned Ms McKenzie was living with her parents at premises at 8 Ookara Street in the Davenport Community (Davenport) at Port Augusta.

1.4. Ms McKenzie had a young boy. The boy was nearly three years of age at the time of his mother's death. The father is Shane Edwin Woods. In February 2013 Shane Woods had been released on parole having spent the previous two and a half years in prison. During that period, Ms McKenzie had supported him and had hoped that on his release from prison he would reform. On Woods' release he and Ms McKenzie resumed cohabitation. The relationship soon deteriorated. In the days preceding Ms McKenzie's death, Woods was again arrested. He was taken into and kept in custody by Port Augusta police. In fact Woods' arrest on serious alleged offences had been undertaken on information supplied to police by none other than Ms McKenzie. The arrest occurred in the early hours of the morning of Sunday 10 March 2013. On the afternoon of Tuesday 12 March Shane Woods would be released on bail by the Port Augusta Magistrates Court.

1.5. On the morning of Wednesday 13 March Malcolm McKenzie located Deborah McKenzie hanging by the neck from a rope that had been attached to a beam in the patio area of the premises at Ookara Street, Davenport. Ms McKenzie was deceased. Naturally the police became involved in the matter.

1.6. A post-mortem examination was conducted in respect of Ms McKenzie's body by Dr Neil Langlois who is a forensic pathologist at Forensic Science South Australia. Dr Langlois' post-mortem report[1] was tendered at the Inquest. Dr Langlois expresses the cause of Ms McKenzie's death as compression of the neck consistent with hanging. I find that to have been the cause of Ms McKenzie's death. The relevant anatomical findings at autopsy were a ligature mark around Ms McKenzie's neck together with fractures of the left and right superior horns of the thyroid cartilage. These findings were consistent with the act of hanging.

1.7. Other relevant post-mortem findings were that there was no notable recent trauma identified on the head, trunk (including the back), upper limbs or right lower limb or the soles of the feet. There was no evidence of any skeletal injury.

[1] Exhibit C2a

1.8. Ante-mortem blood analysis revealed the presence of the drugs temazepam and tramadol. Temazepam is a sedative. Tramadol is an analgesic. The ante-mortem samples had been taken at the Port Augusta Hospital. Ms McKenzie had been taken to that hospital on Monday 11 August in connection with what was clearly a deliberate overdose of medication. The circumstances suggested that this had happened in an attempt to take her own life.

1.9. Detected in post-mortem peripheral blood was 0.139% alcohol which is a significant concentration. A vitreous humour sample confirmed that alcohol concentration. Also detected in post-mortem blood was olanzapine which is a major tranquiliser. This drug had been administered at the Port Augusta Hospital. Temazepam was also detected in the post-mortem blood sample.

1.10. Deborah McKenzie had a previous history of self-harm. She was hospitalised on two occasions in 2008 when she was 17 years of age. On the first of those occasions she had been admitted to the Women's and Children's Hospital having ingested 98 aspirin tablets. The second admission to the Women's and Children's Hospital in 2008 had also involved an overdose of tablets.

1.11. Ms McKenzie had also previously engaged with the Child and Adolescent Mental Health Service (CAMHS).

1.12. As indicated above, on Monday 11 March 2013 Ms McKenzie had taken an overdose of medication including tramadol and temazepam. She had also taken a significant quantity of paracetamol. She was hospitalised overnight at the Port Augusta Hospital. Ms McKenzie was not detained under the Mental Health Act 2009. She was insistent on leaving the hospital and was discharged on Tuesday 12 March 2013. She would make the successful attempt on her own life within the following 24 hours.

1.13. In conjunction with the overdose of tablets that Ms McKenzie took on 11 March 2013 she penned notes which suggested that she was contemplating her own death. One note related to her funeral arrangements; she had made a list of people she did not want at her funeral.

1.14. It is clear that Ms McKenzie took her life by her own hand. There is no evidence that any other person was involved in the act of hanging. Ms McKenzie's actions in this regard were her own and I so find. In all of the circumstances it would appear that

when Ms McKenzie hanged herself she intended to end her life. The one complicating feature in this regard is the fact that she had a very significant blood alcohol concentration. There is no doubt that she had been drinking in the period leading up to her death. However, given the high lethality of the act that caused her death, and having regard to the circumstances in general, there seems little doubt that even taking into account the heavy intoxication that the alcohol would have caused, Ms McKenzie had intended to end her life. I so find.

2. Background

2.1. Much of the factual background against which Ms McKenzie took her own life in March 2013 is taken from the statements of her parents, Malcolm McKenzie and Dorothy McKenzie. Both provided statements to the Inquest[2]. The family resided at 8 Ookara Street at Davenport. Deborah McKenzie attended Flinders View and Augusta Park Primary Schools and then Augusta Park High School. Ms McKenzie had experienced some difficulties in high school and as she was growing up. I have already referred to the occasions on which she was hospitalised in the Women's and Children's Hospital. Ms McKenzie had an ambition one day to become a lawyer. Ms McKenzie met Shane Woods when she was about 20 years of age and for a short time she and Shane Woods resided in a house at Willsden. While Ms McKenzie was living at Willsden she gave birth to her son. This occurred in June 2010. The father of the boy was Shane Woods. Shane Woods, born 9 May 1989, was 23 years of age at the time of Ms McKenzie's death. Ultimately Ms McKenzie returned from Willsden to resume residence at Ookara Street with her parents. Woods did not join her because he was in prison. He was released on parole on 26 February 2013.

2.2. While Shane Woods was in prison Ms McKenzie maintained her relationship with him and she would visit him regularly. When he was ultimately released on parole they resumed cohabitation, with the young child, in a converted shed at the rear of the Ookara premises. According to Malcolm McKenzie, Deborah McKenzie, Shane Woods and the little boy were '*going really well in the beginning*'. However, after some time he noticed that Ms McKenzie and Shane Woods were having difficulties. Ms McKenzie explained to him that Shane Woods wanted to spend more time with his mates and at one stage he had told her that he '*wanted space*'. This upset

[2] Exhibit C4a

Ms McKenzie. As well, Ms McKenzie had confided to Mr McKenzie that she believed that Shane Woods may have returned to his former lifestyle that included the alleged dealing in drugs. At one point Malcolm McKenzie suggested to Woods that Mr McKenzie would attempt to secure work for Woods in the mines where Mr McKenzie himself worked. In the presence of Deborah McKenzie and his wife Dorothy, Mr McKenzie also told Shane Woods that he disliked drug dealers and that if he performed any drug dealing activities from their house he would no longer be welcome there. To this ultimatum Shane Woods allegedly responded by saying that he could not give any guarantees. I should say here that Shane Woods, and his peers, had prodigious criminal records.

2.3. According to Mr McKenzie, at one point his wife Dorothy had told him that Deborah McKenzie had told her that she had evidence that Shane Woods was dealing in drugs, that she had found drugs in his possession and was going to call the police. On this discovery Shane Woods had run from the house and left in a vehicle. Ultimately Ms McKenzie's trust in Woods significantly diminished and Woods moved out of the premises. Ms McKenzie was upset that having supported Woods throughout his term of imprisonment, as well as having supported his parole application, he had not changed for the better.

2.4. Mrs Dorothy McKenzie gave oral evidence at the Inquest. She told the Court that Ms McKenzie had expressed a belief that she was going to have a good life once Shane Woods was released from prison. However, when reality had bitten, Deborah said that Shane had come out worse than when he had gone in and that he had not changed for her and her little boy. She had said to Mrs McKenzie that she was going to inform the police about what he had been doing. She had thought that this was the right thing to do. Deborah McKenzie would in fact do this, on two occasions, as a result of which Shane Woods was arrested. Dorothy McKenzie told the Court that after Deborah spoke to the police, she said things to Mrs McKenzie to the effect that she had started to doubt whether she had done the right thing after all. In text messages she told a cousin, Maoriella Stuart, that the boy wanted his dad and was heartbroken and that as a result she was entertaining feelings of guilt and thoughts that she was a bad mother. While she was in hospital she told Maoriella Stuart that she wanted to drop the charges against Shane Woods but wanted to be talked out of it by police. The evidence before me demonstrated that Deborah became deeply conflicted about what she had done.

2.5. It is here necessary to mention something about criminal activity of which Deborah McKenzie had some knowledge and which had been committed in the Port Augusta area in June 2008 and February 2011. On 2 June 2008 a vehicle that was parked in the driveway of a member of SAPOL Port Augusta patrols, an officer Finn, was set on fire. In the early hours of the morning of 11 February 2011 the personal vehicle belonging to a police officer attached to the Port Augusta Criminal Investigation Branch (CIB), Daren Wilkinson, and which was parked on his property, was also set on fire. It appeared that petrol or some other accelerant had been poured over the vehicle before being ignited. During a subsequent search of the premises and surrounding areas a screw cap that could be identified as being that of a Coca Cola bottle was located. A smell of petrol was detected on it. It was believed that this item had been connected with the torching of the vehicle. Mr Wilkinson's vehicle was insured and was subsequently written off. Mr Wilkinson was required to pay a $1,000 insurance excess. These crimes remained unsolved until March of 2013 when Deborah McKenzie gave information about them to the Port Augusta CIB.

2.6. On the morning of Friday 8 March 2013 Port Augusta CIB received a phone call from Deborah McKenzie. She said that she could provide information in relation to Shane Woods whom she described as her ex-partner as of the previous day. She stated to a Senior Constable Kym Mayger[3] that Woods had only recently been released from prison and was already back to '*his old ways*'. She said that she did not approve of this and that she did not want their young son exposed to Woods' activities. She was therefore willing to provide police with information that would send Woods back to prison. Specifically, she mentioned information relating to Shane Woods, his brother Dylan Woods and another male by the name of Hamish Finlay who were allegedly dealing drugs in the Port Augusta area. She also indicated that Shane Woods and Finlay had been responsible for the arson of the vehicles of SAPOL members Finn and Wilkinson a number of years ago. She provided further information relating to a pending unlawful possession matter that Shane Woods was currently involved in. She asked what would happen if she provided this information. To this Senior Constable Mayger said that he would seek advice and call her back on the mobile phone number provided.

[3] Statement – Exhibit C10a

2.7. As a result of this call, and the subsequent advice that Senior Constable Mayger obtained, Senior Constable Mayger and Detective Brevet Sergeant Dawe of the Port Augusta CIB spoke to Ms McKenzie at her Ookara Street premises where it was established that she was willing to provide a signed statement regarding the arson of the two motor vehicles.

2.8. In the event Ms McKenzie attended at the Port Augusta CIB office shortly before 6:45pm on Saturday 9 March 2013. Commencing at about 6:45pm that evening Detective Brevet Sergeant Wayne Eric Roberts (now Detective Sergeant Roberts) of Port Augusta CIB took a witness statement from Ms McKenzie (the Roberts statement).

2.9. The circumstances in which Ms McKenzie gave her police statements were somewhat convoluted. The Roberts statement would not be the only witness statement that Ms McKenzie would provide to police over the course of that long weekend, Saturday 9 March to Monday 11 March 2013. She would again provide a witness statement to Port Augusta police on Sunday 10 March 2013. The subject matter of that statement was an alleged assault that she said Shane Woods had inflicted on her at about 6pm the previous evening which had been Saturday 9 March 2013. It will be observed that if the allegations regarding this assault were correct, the assault had occurred only a short time prior to her attendance that evening at the Port Augusta CIB in order to provide the Roberts statement. There is no mention of an alleged assault in the Roberts statement. But there seems to be no doubt that an incident that gave rise to the allegation of assault had occurred prior to Ms McKenzie's attendance at the Port Augusta police station that evening. I say this because shortly after 6pm that evening a SAPOL CAD was raised in which it is recorded that Ms McKenzie had complained to police by phone that Shane Woods was at her address and that she would like to speak with police about a possible assault. The report suggested that during the course of this phone communication arguing could be heard in the background. The matter appears to have been left on the basis that this would be a matter for the CIB who were noted to have already been dealing with Ms McKenzie. It was recorded that Ms McKenzie would attend at the police station to speak with the CIB. It is known of course that shortly before 6:45pm she attended to give her statement about Shane Woods' criminal activities. Why there would be nothing said about the assault during the course of that statement cannot be explained with clarity.

2.10. The Roberts statement given by Ms McKenzie at about 6:45pm on Saturday 9 March 2013 was tendered to the Inquest[4]. It was a statement formatted for the purposes of a prosecution with the usual preamble to the effect that if it contained material which the statement maker knew to be false or misleading that the statement maker would be guilty of an offence. So it is that Ms McKenzie made and signed her witness statement in the knowledge that it could be used for the purposes of prosecution and that the truth of the contents of the statement was an extremely important matter.

2.11. The Roberts statement describes Ms McKenzie's relationship with Shane Woods and in particular the fact that they had a child who was turning 3 in June. Ms McKenzie asserts in the statement that she and Shane Woods had separated on Wednesday 6 March 2013. There is no reference in this statement to Woods being present at her Ookara Street address at any stage earlier that evening. The statement contains allegations by Ms McKenzie that Woods had returned to selling drugs as he had done in the past. The statement also contains allegations of what appears to have been a joint enterprise in the selling of drugs between Shane Woods and Hamish Finlay. She provided significant detail. She even spoke of the manner in which Woods laundered the proceeds of drug trafficking. The admissions that she made in respect of her own involvement gives the statement a convincing air.

2.12. The statement goes on to describe Shane Woods' alleged involvement in the torching of the police officers' vehicles. The statement deals for the most part with the torching of Mr Wilkinson's vehicle and of the planning between Shane Woods and Finlay before it was carried out. Ms McKenzie stated that in the course of that planning Woods had made a comment which suggested that he and Finlay had been involved in the earlier torching of the vehicle of SAPOL officer Finn. Ms McKenzie said this conversation had stimulated a measure of excitement on the part of Finlay, especially when it was said that Finlay was personally to be given the job of setting fire to Wilkinson's vehicle. Ms McKenzie told police that the motive on the part of Woods for torching Wilkinson's vehicle was a disparaging remark that Wilkinson had allegedly made about Woods' children on an occasion when Wilkinson had traffic stopped Woods. Ms McKenzie gave a detailed account of other plans made by Woods and Finlay that involved burning the cars of Wilkinson and three other detectives including that of Detective Sergeant Roberts himself, but it had been decided that this aspect of the plan would not be carried

[4] Exhibit C21, pages 49-54

out. Ms McKenzie spoke of a container that was used to store petrol obtained from a particular service station. The petrol was ultimately transferred into a Coke bottle which corroborates the crime scene evidence. Finlay was tasked to burn the vehicle while Woods and Ms McKenzie conspicuously drove around Port Augusta in an attempt to set up an alibi for Woods. Ms McKenzie said that in order to reinforce the alibi they drove to a location where Woods knew there would be CCTV cameras. The following day Finlay told Woods that he had torched the vehicle. In the course of this debriefing Finlay disclosed that he had carelessly left a Coca Cola bottle lid at the scene. There was also discussion about burning another police officer's vehicle but this did not eventuate.

2.13. The final section of Ms McKenzie's witness statement deals with an attempt by Woods, while still in prison, to persuade Ms McKenzie to follow certain corrections officers to their homes so that he could establish where they lived. Ms McKenzie had refused. Woods told her that he intended to burn the vehicles of two prison officers on the Saturday night of the March long weekend, that is to say, the very night that she was making her statement.

2.14. As a result of this information, that night Shane Woods and Finlay were both arrested by police. They were refused bail. They would be kept in custody until they were released on bail by the Port Augusta Magistrates Court on the afternoon of Tuesday 12 March 2013. The release occurred despite police opposition, opposition that was not nearly as robust as it should have been.

2.15. It will be seen that the statement of Ms McKenzie contained allegations of criminal activity that had occurred years previously. Ms McKenzie's information clearly had a ring of truth to it and she was able to provide certain esoteric knowledge about the torching of Wilkinson's vehicle including the use of a Coca Cola bottle. That said, a successful prosecution of Woods and Finlay for that offence would rely heavily on the evidence of Ms McKenzie.

2.16. Detective Sergeant Roberts is now the officer in charge of the Port Augusta CIB. He gave oral evidence in the Inquest and told the Court something of the circumstances underlying Ms McKenzie's motivation in cooperating with police. He told the Court that Ms McKenzie had said that she was sick of Shane Woods' drug dealing, especially now that they had their young boy. He told the Court that he made Ms McKenzie aware

of the fact that she would have to go to court and give evidence about the matters contained in her statement. She acknowledged this. He said that she showed no reluctance at all in providing the information. Ms McKenzie did not say anything about feeling unsafe and specifically she did not say anything about any alleged assault that may have taken place prior to her attendance at the police station that evening. He was not aware of the CAD report that recorded Ms McKenzie's communication with police about a possible assault.

2.17. Detective Sergeant Roberts next spoke to Ms McKenzie by phone the following day, Sunday 10 March. By then Woods and Finlay had been arrested and were in custody. Also, by then, Roberts had been made aware of the alleged assault against Ms McKenzie and the alleged threat by Matthew Woods, but nothing was said about those matters during their phone conversation. Detective Sergeant Roberts advised Ms McKenzie of the arrests and specifically told her that he did not anticipate that the courts would release Woods on bail, a forecast that would prove to be incorrect. Detective Sergeant Roberts told the Court that Ms McKenzie never expressed anything to him to suggest that she was concerned for her own safety. She expressed no regret about having informed on these two individuals now that they were both in custody. Ms McKenzie had appeared happy with what had taken place. As seen, Ms McKenzie would not be completely consistent about those feelings.

2.18. Detective Sergeant Roberts did not speak with Ms McKenzie at any stage following his telephone call on Sunday 10 March 2013. He did not work in the days following. He told the Court that he had expected Woods in particular would remain in custody for the duration and was ultimately surprised to learn that the Port Augusta Magistrates Court had granted him bail. I will deal with the circumstances in which he was granted bail by that Court in due course.

2.19. I have mentioned the fact that Ms McKenzie made a second statement on Sunday 10 March 2013 (the second statement). That statement for the most part would concern the alleged assault by Shane Woods that she had reported by phone the previous evening. It would also mention another incident that Ms McKenzie allegedly experienced very early in the morning of Sunday 10 March. In the second statement Ms McKenzie told police that at about 5:28am on Sunday morning 10 March 2013 she received a phone call from Shane Woods' brother, Matthew Woods. She recognised his voice. She stated that Matthew Woods had said '*your fucked you dog*'. She was

scared after this phone call. She genuinely believed that Matthew Woods would come to her house and damage her family's property. She was also concerned that her little boy might be lured away from her. This telephone call occurred against the background of the fact that overnight, and only a few hours before the phone call was received, Shane Woods had been arrested and had been refused bail both by police and then by a magistrate in a telephone review.

2.20. The second statement came into being the following circumstances. As a result of information received, uniformed SAPOL officers Jonker and Van Heer attended Davenport at about 7:15am on Sunday 10 March 2013. Officers Jonker and Van Heer conveyed Ms McKenzie to the Port Augusta police station where they took the second statement. Ms McKenzie firstly described the assault by Shane Woods that had allegedly occurred at 6pm the previous night. She said that at 8 Ookara Street, Davenport Ms McKenzie had located a large amount of money and a bag of 'ice' in Woods' rear jeans pocket. She was furious about the fact that Woods was in possession of drugs as she did not want her little boy to be around drugs anymore. When Ms McKenzie reached into his pocket and grabbed the contents he allegedly threw the little boy on the bed and then grabbed the money and drugs from Ms McKenzie. In the process he ripped a nail and made it bleed. He then used both of his hands and grabbed Ms McKenzie by the neck. He allegedly pinned her against the wall and lifted her off the ground for a number of seconds saying '*don't fuck with my money and my drugs*'. Ms McKenzie stated that she could not breathe. Ultimately he released her. Woods then departed in the car of a friend. It appears that Ms McKenzie was able to call police while the car was still in the vicinity. Later that night, after Ms McKenzie had provided her original statement to police concerning the activities of Shane Woods and Finlay, she received a number of missed calls from Shane Woods. A message was left saying '*Y r cops at Jackies*'. The statement then goes on to speak of the alleged threat by Matthew Woods later that morning. Matthew Woods was arrested on 10 March 2013 and was refused bail by police. He was charged with threatening to cause harm and would appear in the Port Augusta Magistrates Court on the afternoon of Tuesday 12 March 2013 following the conclusion of the long weekend. He would there be granted bail over the opposition of police and was released.

2.21. I should say something here about the arrests of Shane Woods, Finlay and Matthew Woods and the matters with which they were initially charged. Following the arrests

of Shane Woods and Finlay they were charged by police that day with damaging property, namely Wilkinson's motor vehicle, and with two counts of setting fire to a vehicle knowing that the act was likely to endanger the life of another person[5]. A written record of the reasons for refusal of Shane Woods' bail by police, known as a Form 2, was created and signed by the police officer who refused bail. The refusal was timed at 2:40am on 10 March 2013[6]. Very shortly after this refusal Shane Woods made an application to a magistrate for a telephone bail review. Documentation held by police[7] indicates that at about 2:50am a magistrate was contacted by telephone and that he refused Shane Woods bail, the time of refusal being 2:54am. There is no suggestion other than that the refusals of bail by Port Augusta police and by the magistrate were appropriate in all of the circumstances. I would add here that neither refusal of bail precluded a further application for bail once Woods was brought before the Port Augusta Magistrates Court. It would be a different magistrate, actually sitting in a Magistrates Court, who ultimately granted bail.

2.22. Finlay was also refused bail by police upon his arrest later that morning. A Form 2 was created setting out the reasons why he was refused bail. The timing of that document is 5am. I do not know of any attempt made by Finlay to seek a telephone review of that bail refusal.

2.23. Neither Shane Woods nor Finlay made any admissions or other statements in relation to the matters with which they were charged.

2.24. Also based on the contents of Ms McKenzie's second statement Matthew Woods was arrested by police on 10 March and was refused bail. There is no evidence that he made any application for a telephone review of that decision. He was charged with threatening harm. An intervention order was issued in respect of him. When questioned, he allegedly told police that he did in fact make the call to Ms McKenzie. He agreed that he had said '*your fucked you dog*', but indicated that he thought he had been speaking to his younger brother Dylan and had merely been attempting to stir him up. When he unexpectedly heard a female voice on the other end of the phone he hung up. Far from exonerating Matthew Woods, one would have thought that this statement,

[5] It is assumed that the two counts related to the two occupants of the premises that was situated in close proximity to the motor vehicle
[6] Exhibit C21, page 60
[7] Exhibit C21, pages 61-62

absurd as it is, would have heavily supported Ms McKenzie's allegation that she was the intended target of the threat.

2.25. Based on the contents of Ms McKenzie's second statement Shane Woods was charged with aggravated assault. This additional charge was laid against Shane Woods on Sunday 10 March 2013. An interim intervention order against Shane Woods was also issued. It was served on Woods. Also as a result of this charge a SAPOL parole breach notification was compiled on the basis that such an offence would have constituted a breach of the parole that Shane Woods was on at the time. This notification would be forwarded to the Parole Board on 12 March 2013. Shane Woods was granted bail on the afternoon of 12 March 2013 at a time before a parole warrant could be executed against him for breach of parole. Had timely parole intervention occurred it may have served to have kept Shane Woods in custody, but as will be seen there were other simpler means by which this could have been achieved. It will be seen that the question of Shane Woods' release on bail on the afternoon of 12 March 2013 was a significant link in the chain of events that preceded Ms McKenzie's suicide within the next 24 hours. More on that later.

2.26. At the time with which this Inquest is concerned Shane Woods, Hamish Finlay and Matthew Woods all had criminal histories. In April 2011 Shane Woods had been convicted in the District Court of South Australia of an aggravated offence of intentionally causing harm. This offence was said to have been committed in breach of a bond or bonds that had been imposed in 2008. Shane Woods had received an overall head sentence (that took into account the revocation of a previously suspended sentence) of 4 years and 4 months. A non-parole period of 22 months was fixed on that occasion. It was in respect of this period of imprisonment that Shane Woods had been released on parole in February 2013. Shane Woods had other convictions for or findings of guilt in respect of other offences in the past, both as an adult and as a juvenile. These included the imposition of a restraining order in respect of a female person, aggravated assault without a weapon against a police officer, possessing drugs for the purposes of supply, causing harm, hindering or resisting a police officer, firearms offences, other assault matters and damaging property. There is also reference in Shane Woods' criminal record to a conviction for failing to comply with a bail agreement, the offence having been committed on 19 February 2011.

2.27. Hamish Finlay, born on 21 June 1991, had a criminal record both as an adult and as a juvenile that included failures to comply with bail agreements and bonds, motor vehicle offences, carry offensive weapon, theft, unlawfully on premises and damaging a building.

2.28. Matthew Woods, born on 21 January 1991, had a criminal record both as an adult and as a juvenile for failing to comply with bail agreements and bonds, motor vehicle offences, endangering life and assault occasioning actual bodily harm.

2.29. According to Dorothy McKenzie, on Monday 11 March 2013, when it was apparent that Shane Woods had been taken into custody, Ms McKenzie was expressing doubt as to whether she had done the right thing by informing on Woods. She indicated that her little boy was asking for his father. Ms McKenzie questioned whether she had harmed the boy by causing his father to be returned to custody. She indicated that she had not been sleeping, was not feeling very well and she continued to question whether she was doing the right thing. As a result, that day Dorothy McKenzie took Deborah McKenzie to see a doctor at the Westside Medical Centre. There they saw Dr Feroza Qazi. The statement of Dr Qazi[8] indicates that during this consultation Ms McKenzie was teary. Dorothy McKenzie told Dr Qazi that Deborah had not slept, that she had been awake all night and all day and needed some sleeping tablets. Dr Qazi was told that Ms McKenzie and her partner had recently separated and that the partner was now in custody. In her statement Dr Qazi explains that it was her standard practice not to prescribe more than five tablets to patients with whom she was unfamiliar. Accordingly, Dr Qazi provided five 10mg temazepam tablets to Ms McKenzie in order to help her sleep. She expected that the tablets would be enough to cover the next two to three days.

2.30. Later that day at Davenport Dorothy McKenzie found Deborah lying on a bed with a pen and paper. She appeared to be drowsy. It is apparent that Ms McKenzie had taken all five temazepam tablets as well as a significant quantity of Panadol and tramadol tablets. Ms Therese Hunter, who is an enrolled nurse, and who is the mother of the wife of Deborah's brother Zaaheer, was asked to attend straight away. As a result of this Deborah McKenzie was taken straight to the Port Augusta Hospital. I will deal with the events at the Port Augusta Hospital in a separate part of these findings.

[8] Exhibit C43

2.31. The other concerning aspect of Ms McKenzie's behaviour apart from the ingestion of an excessive quantity of medication was the fact that she had written on a notepad a list of people whom she did not want to attend her funeral. Deborah had written that day's date on the list. There were two other sheets of paper that Deborah had written on which also smacked of an element of despair. They also bore the date of 11 March. All three of these sheets were taken to the hospital with Deborah and were placed on her hospital file. It is apparent that Ms McKenzie either had written, or would write, other notes that were not discovered until after her death. One sheet bore the date 12 March 2013. Another note spoke of a desire to be buried with her natural mother. The notes as a whole reveal a large measure of disappointment and regret aimed in the direction of Shane Woods and they express anxiety about her little boy.

2.32. In the event Ms McKenzie would be released from the Port Augusta Hospital the following day, Tuesday 12 March 2013. She would be deceased within the next 24 hours during which time Shane Woods and the other two men were released on bail. All of those events will be the subject of discussion elsewhere in these findings.

2.33. There are a number of prominent issues that require evaluation. Quite apart from the human aspect involved in all of this, Deborah McKenzie was an important police asset in respect of the ensuing prosecutions of Shane Woods, Finlay and Matthew Woods for serious alleged offences. She was an asset that required protection in the public interest as well as in her own interests. The Inquest examined whether this asset had been sufficiently protected. In this regard it is significant that police were unaware of the fact that after the three individuals had been taken into police custody on the basis of information supplied by Ms McKenzie, that Ms McKenzie was hospitalised having taken an overdose of medication in circumstances that strongly suggested that she had intended to take her own life due to the pressures that she had placed on herself by informing on those three individuals. I should also mention here that staff at the Port Augusta Hospital had only a vague and largely unexplored assertion by Ms McKenzie that she had been assisting police with enquiries relating to her partner and they had an imperfect understanding of the acuteness of the impact that her interaction with police was having on her behaviour that weekend. Secondly, it will be the Court's findings that Ms McKenzie's management whilst at the Port Augusta Hospital was suboptimal and that her release from hospital should have been postponed, even if it meant that she required detention under the Mental Health Act 2009. Thirdly, the bail process that led

to the release on bail of the three arrested individuals, a prospect that Ms McKenzie had expressed deep concern about, miscarried. What effect if any this had on the mind of Ms McKenzie and whether it had any association with her actions in taking her own life will be the subject of further discussion in these findings.

3. SAPOL response to domestic abuse and violence

3.1. The statement made by Ms McKenzie to the police concerning the alleged assault on her by Shane Woods triggered certain formal requirements on the part of SAPOL.

3.2. In existence at the time with which this Inquest is concerned was **SAPOL General Order - Domestic Abuse**. The particular General Order that was operative at the time had been issued on 3 October 2012. The General Order related to reports of domestic violence or abuse of the kind described by Ms McKenzie in her second witness statement. This fact dictated certain responses on the part of police.

3.3. I should say something about the then existing structure within SAPOL to deal with reports of domestic violence. Each metropolitan Local Service Area had a Family Violence Investigation Section that consisted of certain SAPOL personnel. In respect of a country Local Service Area the local Criminal Investigation Branch (CIB) office incorporated the roles and responsibilities of a Family Violence Investigation Section. The role of a Family Violence Investigation Section (FVIS) was to ensure consistent, coordinated, professional performance which incorporates a problem-solving approach in investigation, multi-disciplinary response and case management of child abuse and criminal neglect and family violence/domestic violence. FVIS members were to provide a '*whole of family response*' to ensure the safety of victims and children, and hold offenders accountable for their violence.

3.4. An FVIS supervisor had certain responsibilities that included the establishment and maintenance of the case management system to record among other things, domestic violence matters where the FVIS supervisor or country CIB member determines that the victim is high risk and requires ongoing management or investigation. An FVIS officer had certain responsibilities that included the reviewing of risk documentation that was brought into existence by investigating police as well as establishing and maintaining a liaison with the alleged victim. In certain circumstances that I will describe in a moment, such things as a risk management plan and/or family safety plan had to be created. There was also a duty to facilitate a family safety meeting within the

Family Safety Framework in high risk cases. Such a meeting was a local meeting where relevant agencies would gather on a regular basis to share information and implement a positive action plan in relation to high risk cases. In areas where the family safety meeting process had not been established the FVIS supervisor or officer was encouraged to establish an alternate form of meeting to respond to the needs of high risk victims.

3.5. More specifically, the procedure upon the receipt of a domestic abuse or domestic violence report was for the relevant member taking the report to complete an offence PIR (police incident report) where a substantive offence had been committed. It was also a requirement that a domestic violence risk assessment (PD438) be created in order to assess the ongoing risk to the victim. Other duties included the investigation of the allegation and the possible application for an intervention order. There was then an obligation for the documentation created to be forwarded on. The offender would be arrested as the case might require. If the compilation of the PD438 realised a score that characterised the risk as high risk, the member was obliged to forward a copy of the PIR, the PD438 and other relevant documentation to the FVIS officer in charge of a country CIB to enable victim management work to begin. Where an FVIS member was not available after hours it was a requirement that the file be initially forwarded to the supervisor to determine any further action to mitigate the high risk. In high risk cases a domestic violence risk management plan (PD440) and a domestic violence family safety plan (PD441) had to be created. In cases of standard or medium risk the FVIS officer might complete a PD441 in any event.

3.6. Thus seen the Port Augusta CIB was responsible for the implementation of the requirements contained within the SAPOL **General Order - Domestic Abuse** at the time with which this Inquest is concerned.

3.7. As seen, the second statement of Ms McKenzie was taken by a uniformed officer, Senior Constable Jonker on Sunday 10 March. It was Senior Constable Jonker and his partner Constable Van Heer who also compiled the PD438 as was required by police General Orders. The interim intervention order was also arranged by Senior Constable Jonker.

3.8. Senior Constable Jonker gave evidence at the Inquest. He told the Court that when he and Constable Van Heer attended at Ookara Street, Davenport and spoke to

Ms McKenzie she was clearly quite flustered. From that point it was their immediate concern to commence the process of reporting domestic abuse and to ensure that Ms McKenzie was safe. She was taken to the police station as already indicated. Apart from taking the statement, the officers discussed with Ms McKenzie what might be required by way of her protection. Senior Constable Jonker told the Court that it became quite apparent that she needed absolute protection and there was discussion about Ms McKenzie being relocated to different accommodation. However Ms McKenzie was adamant that she did not want to be taken out of her own home environment. Ms McKenzie indicated that she wanted to be surrounded by people she trusted. That said, Senior Constable Jonker told the Court that she was very scared and that the idea of Shane and Matthew Woods receiving bail terrified her[9]. Nevertheless she was confident in imparting further information to police.

3.9. During the course of Senior Constable Jonker's and Constable Van Heer's interaction with Ms McKenzie that day, she imparted information that she believed that Shane Woods had firearms and drugs buried around Port Augusta and that Matthew Woods knew where these firearms were buried, although she did not know exactly where they were. Ms McKenzie did indicate that her belief was that the firearms were buried between Port Augusta and Whyalla on the northern side of the road. This piece of information was recorded in the PIR investigation diary. The information did not make its way onto any ancillary report which Senior Constable Jonker said was an oversight on his part.

3.10. Senior Constable Jonker told the Court that he was communicating openly with CIB members and the FVIS on Sunday morning 10 March 2013[10]. He could not recall whether he or his partner had advised any CIB member about the possible access to firearms that either Shane Woods or Matthew Woods may have had[11], but he believed he would have made it known that firearms was a possible issue and indicated that he believed that in any event it was common knowledge that both men had access to firearms. He did not include any reference to firearms in the Form 2 reasons for refusal of Matthew Woods' bail. In the event nothing would be put before the Court at the Tuesday afternoon bail applications about possible access to firearms.

[9] Transcript, page 1028
[10] Transcript, page 1041
[11] Transcript, page 1054

3.11. Senior Constable Jonker and Constable Van Heer were responsible for the compilation of the PD438[12]. The risk score total was 33 which meant that Ms McKenzie's risk analysis fell within the medium category. However, during the course of Senior Constable Jonker's cross-examination it appeared that there were certain omissions within the compilation of this form that would have enhanced the risk perception.

3.12. Counsel assisting Ms Cacas drew a number of matters in this regard to Senior Constable Jonker's attention. Senior Constable Jonker acknowledged that a number of questions that appear on the document and which were answered negatively should have been assigned affirmative answers. These were questions relating to drug misuse and escalation in the seriousness of violence, whether there had been an assault on a child and whether the offender had access to children including knowledge of where a relevant child lived. On the basis that those answers should have been recorded affirmatively, Senior Constable Jonker accepted that the score alone should have placed Ms McKenzie in the high risk category. This in turn would have meant that the FVIS should have been notified immediately so that they could take the appropriate action in respect of Ms McKenzie's safety. Senior Constable Jonker suggested that the matter of Ms McKenzie's risk assessment should have been handled by a professional counsellor or at least someone with more training than himself. In the event a member of the FVIS would not contact Ms McKenzie until Tuesday 12 March 2013. I know of no communication between police and Ms McKenzie following Detective Sergeant Roberts' phone communication with her on the afternoon of Sunday 10 March 2013 to inform her that Shane Woods and Finlay were in custody. In the intervening period Ms McKenzie was hospitalised in relation to the medication overdose and then released all without the knowledge of police.

3.13. The FVIS officer who dealt with Ms McKenzie on Tuesday 12 March was Senior Constable Deanne Holdrich (now Brevet Sergeant). Brevet Sergeant Holdrich gave oral evidence at the Inquest. A witness statement of Brevet Sergeant Holdrich was also tendered[13]. On Tuesday 12 March 2013 Brevet Sergeant Holdrich commenced duty at about 8:30am. This was the first occasion on which Brevet Sergeant Holdrich became aware of the matter involving Ms McKenzie. She had not worked on either the Sunday or the Monday. The specific matters of which Brevet Sergeant Holdrich was made aware were the aggravated assault alleged against Shane Woods and the threatening

[12] Exhibit C21a
[13] Exhibit C28

harm allegation around Matthew Woods. In her evidence Brevet Sergeant Holdrich said that she could not remember whether she had been made aware of the other alleged offences relating to Shane Woods[14]. However, it was apparent to the Court that Brevet Sergeant Holdrich at least knew that although the PD438 had not identified anything above a medium risk, there were greater concerns raised due to information that Ms McKenzie had provided to the CIB. Asked as to what she understood the information had been she said:

> 'I don't know, I didn't ask those questions. It's not really my role to know about CIB jobs. I just knew that there were - that she'd provided information which put her at risk and that there had been an assault on her and threats made to her, so I dealt with that rather than needing to know why that had occurred.' [15]

3.14. This answer was rather troubling having regard to two matters, firstly that during that morning Brevet Sergeant Holdrich had discussed with Detective Sergeant Roberts the concerns for Ms McKenzie's safety if the arrested persons were to be granted bail and, secondly, the nature of the information that Ms McKenzie had provided, together with the seriousness of the possible consequences that the information may have visited on the informed against persons, was highly relevant to the assessment of Ms McKenzie's overall risk. It is difficult to understand why an officer in Brevet Sergeant Holdrich's position would not have made herself aware of the precise nature of information that a person in Ms McKenzie's position had provided and how it might impact on her safety.

3.15. As to the contents of the PD438, Brevet Sergeant Holdrich explained in her statement[16] that the FVIS members deal with high risk matters as a matter of priority, that moderate risk matters are dealt with at the next opportunity and standard risk matters are dealt with usually only if there is a need identified. One would have thought that a high risk matter of priority would involve an engagement with a complainant as soon as the risk is identified, that is to say immediately. In the case of Ms McKenzie's risk assessment her risk score as seen was 33, although it could have been higher had certain questions been addressed in a more precise manner. However, Brevet Sergeant Holdrich told the Court that she dealt with Ms McKenzie's matter as a matter of priority notwithstanding her score. Asked as to what difference a score exceeding that for high risk would have made, Brevet Sergeant Holdrich said that it would not have made any difference due to the fact that in her view Ms McKenzie was a high risk victim in any event. I am

[14] Transcript, page 207
[15] Transcript, page 208
[16] Exhibit C28a

prepared to accept that analysis for obvious reasons, and I am also prepared to accept that Brevet Sergeant Holdrich dealt with Ms McKenzie on that basis. However, an earlier appreciation of the high risk would in fact have made a difference in the sense that contact with Ms McKenzie by either a member of the FVIS or by a member of the CIB in relation to her needs would have occurred much earlier than the Tuesday. It will be remembered that the PD438 was created on the Sunday of that weekend. Brevet Sergeant Holdrich told the Court that when she spoke to Detective Sergeant Roberts they had a discussion concerning Ms McKenzie's safety and Detective Sergeant Roberts' own concerns in that regard. She was made aware that threats had been made to Ms McKenzie in relation to the information that she had provided to the CIB and that Shane Woods had allegedly assaulted Ms McKenzie. She and Detective Sergeant Roberts discussed the proposition that if these men were released on bail, namely Shane and Matthew Woods, that Ms McKenzie would be '*seriously at risk of further offending from both of them*'[17]. In her view '*the concerns would be that they may assault her or even worse than that*'[18]. Detective Sergeant Roberts was happy for Brevet Sergeant Holdrich to speak to Ms McKenzie and to reassure her that they were doing everything they possibly could to keep these men in custody. So, Brevet Sergeant Holdrich's main priority at that stage was to do everything that she could to make Ms McKenzie safe and to make her feel as safe as she could. To my mind this should have occurred on the Sunday.

3.16. Brevet Sergeant Holdrich telephoned Ms McKenzie at about 2pm on the Tuesday. This was very shortly before the commencement of the afternoon session of the Port Augusta Magistrates Court in which the three arrested individuals would be granted bail. In that telephone conversation Ms McKenzie told Brevet Sergeant Holdrich that she was very frightened of Shane Woods. She was concerned also about the possibility that her son might be lured away by Shane Woods and his family. She was worried about these men getting out on bail and taking her son and she indicated that she felt that it was more than likely that one or the other or both of the Woods brothers could harm her further and could carry out the threats that had been made and to further assault her[19]. I accept all of that evidence.

[17] Transcript, page 210
[18] Transcript, page 210
[19] Transcript, page 212

3.17. Brevet Sergeant Holdrich canvassed with Ms McKenzie a number of options that Ms McKenzie might pursue in the interests of her safety. She did this because she was of a view that one could never know what a court might do in relation to bail. The options were for Ms McKenzie to leave Port Augusta, to put her in a safe house, to provide her with money and or a bus ticket to go to her destination of choice. However, just as she had indicated to officer Jonker who took her statement on the Sunday, Ms McKenzie told Holdrich that she was unwilling to leave Port Augusta. Brevet Sergeant Holdrich told the Court that Ms McKenzie was quite resolute in this. To this Brevet Sergeant Holdrich told Deborah that she could not guarantee that she would be safe in Port Augusta as bail conditions would not necessarily protect her if either Shane or Matthew Woods, or both, were determined to harm her. Notwithstanding this, Ms McKenzie said that she wanted to stay in Port Augusta, at least until she found out whether they were going to be remanded in custody or released. After this she would make her decision about what should happen.

3.18. I should add here that all of this phone discussion took place in the absence of any knowledge on Brevet Sergeant Holdrich's part that Ms McKenzie had been hospitalised in respect of the medication overdose and had only been discharged from hospital that very morning.

3.19. In the event Brevet Sergeant Holdrich managed to persuade Ms McKenzie to at least send her son away. Ms McKenzie indicated that she would make arrangements for him to go to Leigh Creek. As it happened Ms McKenzie's brother, Mr Zaaheer McKenzie, was a police officer at Leigh Creek. The little boy would be sent to that destination. Although Brevet Sergeant Holdrich knew Mr Zaaheer McKenzie as a police officer, she did not draw the connection between him and Ms McKenzie. She did not connect the fact that Zaaheer McKenzie was her brother.

3.20. At the end of this conversation Brevet Sergeant Holdrich indicated that she would contact Ms McKenzie the following day to attend to formalities once the result of the bail hearing was known. This would include making of an appointment to compile a formal safety plan (PD441), to complete an FVIS risk assessment (PD440) and to refer her to support agencies. Brevet Sergeant Holdrich asserted in effect that there would have been little point in proceeding further without knowing whether or not the three arrested individuals would remain in custody. That said, she made it plain in her evidence that she expected their bail applications to fail.

3.21. At one point while she was still on the phone to Ms McKenzie Brevet Sergeant Holdrich attended at the police prosecutions office and spoke to Senior Sergeant Relihan, the manager of the prosecutions unit. He advised Brevet Sergeant Holdrich that the matters had been attended to and that the defendants would appear in Court during the afternoon session.

3.22. At the end of the phone conversation Holdrich told Ms McKenzie that if she had any concerns at all to contact the Port Augusta police station immediately.

3.23. Following her conversation with Ms McKenzie Brevet Sergeant Holdrich again spoke to Senior Sergeant Relihan. He advised her that a prosecutor from Whyalla would have conduct of the matter. She advised him of the conversation with Ms McKenzie and of her concerns if the men in question were granted bail. She also advised him that Ms McKenzie was assisting police in relation to other CIB investigations and that the CIB considered her to be at serious risk if the defendants were to be granted bail. Brevet Sergeant Holdrich made certain arrangements in relation to ensuring that Ms McKenzie would be informed of the bail outcome.

3.24. Brevet Sergeant Holdrich completed her duties at 3pm that afternoon and received no further information about the matter until the following morning.

3.25. It is fair to say that Brevet Sergeant Holdrich, along with every other police officer involved in Ms McKenzie's matter, had a strong expectation that the three individuals who had been arrested would not be given bail by the Port Augusta Magistrates Court. Brevet Sergeant Holdrich said:

> 'I had faith in the court system that they wouldn't get bail and I strongly believed that they wouldn't get bail on that day.' [20]

She also said:

> '… my view was that I would think that no magistrate would take a risk to allow them on to bail with the circumstances that were presented to the court. Not in this day and age.' [21]

It has to be said that this expectation was not an unreasonable one, at least insofar as there was a legitimate expectation that Shane Woods and Finlay would remain in custody for such a period of time as would allow a review of any bail that was granted

[20] Transcript, page 239
[21] Transcript, page 239

in their favour. This was due to the fact that the DPP had given clear advice that a review should be flagged if anything other than home detention bail was granted. As will be seen in the next section of these findings, this would have ensured that Shane Woods and Finlay at least would be kept in custody pending a review. However, any legitimate expectation that Shane Woods and Finlay would be kept in custody until such time as proper arrangements could be made for Ms McKenzie' safety were dashed when the prosecutor failed to apply for that review. I would add also that although no advice was given by the DPP in relation to an application for a review of Matthew Woods' bail, a review could have been sought on the police prosecutor's own initiative. One would have thought that having opposed bail for Matthew Woods a police prosecutor would be inclined to seek that review, especially as the other two men involved in the matter of Ms McKenzie were going to be the subject of a review on DPP advice.

3.26. In her evidence before this Court Brevet Sergeant Holdrich was asked what her attitude may have been if she had known of Ms McKenzie's circumstances in the previous 24 hours, namely that she had been hospitalised with a medication overdose. She said:

> '… I would have gone out to see her and I would have made sure I did a face-to-face contact with her and I would have engaged with her family initially. If I couldn't get out to see her due to other work commitments then I would have had - I would have got a patrol to go out and do that and make sure that she had family with her and that there were things in place to protect her from herself. ' [22]

3.27. Similarly, if she had realised that the police officer Zaaheer McKenzie was Ms McKenzie's brother, she would have communicated with him immediately and have informed him that Ms McKenzie intended to send her son to him and that she wanted Ms McKenzie out of Port Augusta as well. As it transpired Zaaheer McKenzie, according to his oral evidence, did ask Ms McKenzie to come to his location at Leigh Creek but that she had indicated that she was afraid that Shane Woods might go to her parents' place while she was away and was afraid of what he might do[23]. It is difficult to know whether his persuasiveness in that regard might have been enhanced by pressure from members of the Port Augusta CIB or from Brevet Sergeant Holdrich herself. In the event Zaaheer McKenzie told the Court that no person from SAPOL ever communicated with him to discuss his sister's welfare on 12 March 2013[24].

[22] Transcript, page 244
[23] Transcript, page 65
[24] Transcript, page 75

Mr Zaaheer McKenzie was not aware that it had been suggested to his sister by Brevet Sergeant Holdrich that his sister leave Port Augusta[25].

3.28. In the event no contingency plans regarding Ms McKenzie were put in place pending the possible successful application for bail other than that Ms McKenzie would be advised of the outcome. However, Ms Holdrich said that she would have expected that the police would know of the outcome would be able to provide sufficient support for her[26]. That said, at no stage did she communicated any such belief to any other police officer. She left no specific instructions about what police might need to do with Ms McKenzie if she asked for assistance[27].

3.29. Ms Cacas, counsel assisting, in cross-examination established that Brevet Sergeant Holdrich did not know that Shane Woods was currently on parole in respect of a sentence for a violent offence, or that there was a suggestion that the arrested persons may have had access to firearms.

3.30. Asked as to why it was that no person from her section spoke to Ms McKenzie until she did on the Tuesday, Brevet Sergeant Holdrich suggested that the possibility was that no-one had been available until she arrived back at work on the Tuesday morning. Brevet Sergeant Holdrich herself had not been working on the Sunday or the Monday.

3.31. Brevet Sergeant Holdrich acknowledged that it was a terrible thing that police did not know that Ms McKenzie had been in hospital in relation to what may have been an attempt on her own life. It seems astonishing that police did not know this having regard to the fact that they had secured her cooperation as a prosecution witness, had taken a statement from her that she had been assaulted by one of the targets of that information and had been threatened by that person's brother. All of these matters were indicative that Ms McKenzie was indeed at high risk of retaliation and that for those reasons she should have been subjected to a measure of vigilance that would at least have established that she had been hospitalised. At all times the assumption seems to have been that she was perfectly safe while Shane Woods, Hamish Finlay and Matthew Woods were in custody. An assumption that would prove to be incorrect.

[25] Transcript, page 81
[26] Transcript, page 247
[27] Transcript, page 251

4. The bail applications

4.1. At this point it is necessary to say something about the process of applying for bail in respect of criminal charges. I have already referred to the fact that all three individuals who had been arrested over the long weekend as a consequence of the information that Ms McKenzie had provided to police had been refused bail by police following their arrests. Police have power to grant or refuse bail following an arrest. Shane Woods had sought a telephone review from a magistrate in the early hours of the morning of Sunday 10 March 2013. The application for bail was refused by the magistrate. However, this refusal did not preclude the making of a further application in Court either to the same or another magistrate.

4.2. In South Australia, bail in respect of criminal charges laid before the various courts is governed by the Bail Act 1985. It is often said that there is a '*presumption of bail*'. The effect of section 10(1) of the Bail Act is that a bail authority should release an applicant on bail unless the bail authority considers that the applicant should not be released on bail having regard to certain circumstances that include the gravity of the offence in respect of which the applicant has been taken into custody and the likelihood that the applicant would abscond, offend again, interfere with evidence, intimidate or suborn witnesses, hinder police inquiries or breach an intervention order. As well, any previous occasions on which the applicant may have contravened or failed to comply with a term of a bail agreement is also relevant. However, section 10(4) of the Bail Act states that despite the other provisions of section 10, including of course the provision that is said to give rise the presumption of bail, if there is a victim of the relevant offence the bail authority must give '*primary consideration*' to the needs that the victim may have or perceive for physical protection from the applicant. It will be noted in this case that Ms McKenzie allegedly suffered an injury to her finger as a result of the alleged assault committed on her by Shane Woods. In that sense she was a victim.

4.3. Section 10A of the Bail Act raises a presumption against bail in certain cases. It states that despite section 10 as previously discussed, bail is not to be granted to a '*prescribed applicant*' unless the applicant establishes the existence of '*special circumstances justifying the applicant's release on bail*'. A prescribed applicant includes a person taken into custody in relation to certain alleged offences which, relevantly in this case, include an offence contrary to section 250 of the Criminal Law Consolidation Act 1935, the offence with which Shane Woods and Finlay would be charged on advice from the

Director of Public Prosecutions (DPP). I will return to that matter in a moment. At this stage it is sufficient to say that in all of the circumstances the presumption against bail was enlivened in relation to both Shane Woods and Finlay but that bail was granted to both of them notwithstanding.

4.4. A decision of a bail authority to grant bail or refuse bail to a person is subject to review. Relevantly in this case, section 14 of the Bail Act would have enabled a review of the Port Augusta Magistrates Court's decision to grant bail to the three arrested individuals. The review can be made on the application of the prosecution in a case where bail has been granted or on the application of a person who has been refused bail. The review of a bail decision made by a Magistrates Court is heard by the Supreme Court. The reviewing authority may make any decision that in the opinion of that authority should have been made in the first place. Section 14(5) of the Bail Act requires that the reviewing authority hear and determine an application for review as expeditiously as possible. Section 14 of the Bail Act places no numerical time limit on this requirement. To my mind section 14 enables an expeditious review of a decision to release a person on bail notwithstanding that the person has already been released.

4.5. However, there is machinery within the Bail Act to ensure that a successful bail applicant is not released where an application for a review of the decision to grant bail is under review. Section 16 of the Bail Act provides for a stay of release of a prisoner while an application for review is made. In cases where a Magistrates Court decides to release a person on bail, if a police officer or counsel on behalf of the Crown immediately indicates that an application for review of that decision will be made, the prisoner's release must be deferred until the completion of the review or after 72 hours whichever occurs first unless the reviewing authority is satisfied there is proper reason to extend the period of 72 hours. This deferment operates as a matter of law and not at the discretion of the magistrate.

4.6. It is against that legal background that Shane Woods, Hamish Finlay and Matthew Woods applied for and were released on bail by the Port Augusta Magistrates Court on the afternoon of Tuesday 12 March 2013.

4.7. The offences with which Shane Woods and Finlay were originally charged were damaging property, namely the motor vehicle of Daren Wilkinson of SAPOL, and two counts of endangering life by setting fire to the vehicle. In respect of Shane Woods

there was the additional charge of aggravated assault. None of these charges would have activated the presumption against bail set out in section 10A of the Bail Act. In refusing the bail of Shane Woods the police bail authority compiled a Form 2 which cited the reasons for refusing bail. Those reasons included a history of prior breaches of bail and bonds, the seriousness of the alleged offences and their likelihood to attract lengthy prison sentences, the likelihood that Shane Woods would offend if released on bail having regard to an assertion that police were investigating similar offences committed by Woods against police officers, his criminal record in general, the allegation that Woods had currently been planning to burn the vehicles of prison officers in retaliation for opposing his parole and that an unnamed witness, whose identity as Deborah McKenzie could nonetheless have been no secret, believed that the witness would be assaulted by Woods or his associates if released. As well, the grave concerns held by police that Woods would intimidate and suborn witnesses and interfere with the investigation were also cited.

4.8. The reasons for refusal of bail by the police bail authority in respect of Finlay as reduced to a Form 2 were similar and included a history of prior breaches of bail and bonds as well as non-appearances in court. His extensive criminal history was also referred to as were the fears that attempts would be made to interfere with witnesses.

4.9. The reasons for the police bail authority refusing Matthew Woods bail on his charge of threatening Ms McKenzie included a prior history of breaches of bail and bonds, the fact that the allegations related to threats made to a witness in a matter involving the arson of a police officer's vehicle in Matthew Woods' brother was the alleged offender, that Matthew Woods had numerous prior offences including serious assaults, that police believed that Matthew Woods would intimidate and suborn witnesses and interfere with evidence in his brother's investigation and that the alleged victim of the threat believed that if carried out would result in significant harm. The Form 2 did not identify Matthew Woods' brother by name.

4.10. As indicated earlier Shane Woods applied for a telephone review and this had been refused by a magistrate in a phone review.

4.11. On Tuesday 12 March 2013, which was the first working day following the long weekend, police requested a DPP adjudication about the matter of Shane Woods and Finlay. Such a request was routine in relation to first appearances in major indictable

prosecutions such as this. A written adjudication was provided by Ms Robyn Richardson, a prosecutor in the employ of the DPP. Her concise written advice and direction was that the three existing charges not be proceeded with but should be substituted by two new charges. The first new charge was one of stalking Daren Wilkinson in his capacity as a public officer contrary to section 250(2) of the Criminal Law Consolidation Act 1935. The second, which was to be in the alternative, was a charge of damaging the motor vehicle of Mr Wilkinson. The DPP direction was that the charges of endangering life were not to be pursued. The fresh charge of stalking a public officer pursuant to section 250(2) of the Criminal Law Consolidation Act 1935 enlivened section 10A of the Bail Act insofar as it rendered both Shane Woods and Finlay '*prescribed applicants*' for the purposes of that provision. This meant that as a matter of law, bail should not be granted by any bail authority to either man unless there were special circumstances. The DPP adjudication stated that Shane Woods and Finlay were prescribed applicants. The DPP adjudication also stated that bail should be opposed due to the seriousness of the offending and for the protection of the complainant, that is to say Mr Wilkinson, and for the protection of other members of the police force and prison officers who were allegedly the likely targets of the two accused persons. The adjudication also stated as follows:

> 'The DPP **<u>will review a grant of simple bail</u>**. The DPP **<u>will NOT</u>** review a grant of home detention bail.' (the underlining and emboldening are present in the original text of the DPP adjudication)

The expression '*home detention bail*' requires no explanation. On the other hand, the expression '*simple bail*' is not known to the law. It does not appear in the Bail Act. But the clear implication is that in this document it was a reference to any form of bail other than home detention bail. The intent of the DPP prosecutor was that the DPP would conduct a Supreme Court review of a grant of bail to either Shane Woods or Finlay other than a grant of home detention bail. The intent of the DPP prosecutor was that a grant of bail either on the prisoner's own recognisance or with a guarantor be reviewed. Even home detention bail would not have seen the immediate release of either Shane Woods or Finlay because the obtaining of home detention bail reports would have been required before an order for HD bail could be made by the court. Although the advice does not explicitly say so, it would also have been the prosecutor's intent that section 16 of the Bail Act be activated so that an immediate flagging of a review would occur upon any order for bail other than home detention bail, thereby

staying the release of the successful bail applicant. The DPP advice did not need to spell that out because the DPP prosecutor would have been entitled to assume that the tenor of the advice was blindingly obvious to a police prosecutor of reasonable intelligence, acumen and diligence and that the advice would be followed.

4.12. When it was received a copy of the DPP adjudication was placed on the police prosecution files of both Shane Woods and Finlay. This was for the benefit of the police prosecutor who would appear in court that day when the matters of Shane Woods, Hamish Finlay and Matthew Woods were brought on.

4.13. A fresh information was laid before the Port Augusta Magistrates Court containing the two counts as advised by the DPP. I should say something here about the allegation underlying the charge of stalking a public officer in terms of its enlivening the section 10A presumption against bail. Section 250(2) renders it an offence for a person to stalk another person on account of anything said or done by a public officer in good faith in the discharge or performance or purported discharge or purported performance of his or her official duties or functions. The maximum penalty for such an offence is 10 years imprisonment. For the purposes of that offence a person '*stalks*' another if the person interferes with property in the possession of the other person in a manner that could reasonably be expected to arouse the other person's apprehension or fear. The allegations as they related to Shane Woods and Finlay were that those two individuals were parties to a joint enterprise to set fire to the motor vehicle of Daren Wilkinson on account of his having stopped and searched the vehicle of Woods in a street in Port Augusta in the course of the performance of his functions as a police officer. The basis of that allegation was underpinned by the statement that had been given by Ms McKenzie to police on the evening of 9 March. Taking into account what fell from the Chief Justice in **R v Lombardi** (2013) 115 SASR 577 and more recently from the Chief Justice in **R v Perre** [2017] SASC 102 to the effect that before section 10A of the Bail Act is enlivened there must be a reasonable basis for the allegations underlying a charge that would render the bail applicant a prescribed applicant, it would seem to me that in the case of Shane Woods and Finlay there was such a reasonable basis in respect of both of them. There is little doubt that in both men's cases section 10A was enlivened and that they should have been denied bail unless they could establish special circumstances justifying their release on bail.

4.14. The DPP advice, if followed, virtually guaranteed that Shane Woods and Finlay would remain in custody beyond 12 March. This was the case for any of three reasons; namely if bail was refused altogether, if a stay of release was effected pending a Supreme Court review of a grant of bail, or while home detention reports were being prepared.

4.15. In the event section 10A of the Bail Act rendering Shane Woods and Finlay as prescribed applicants in respect of whom there was a presumption against bail was not drawn to the attention of the magistrate. The magistrate granted bail in respect of each man despite the prosecution's opposition. When bail was granted the prosecutor failed, contrary to the direction of the DPP, to indicate that a review would be initiated. Thus Shane Woods and Mr Finlay were released that afternoon. Matthew Woods was also released on bail despite opposition. No bail review was sought in relation to him despite the existence of objectively reasonable grounds for the denial of bail. The circumstances in which this fiasco unfolded will now be discussed.

4.16. Created for the benefit of the Port Augusta prosecutions section was a synopsis created by Detective Sergeant Peter Hore who at that time was the officer in charge of the Port Augusta CIB, the SAPOL unit that had been responsible for the investigation and arrests of Shane Woods, Hamish Finlay and Matthew Woods. There is reference in this document to the arson of two vehicles connected with police officers including Mr Wilkinson and there is a reference to an alleged intention on the part of Shane Woods and Finlay to burn the vehicles of three prison officers who had annoyed Woods while he was in prison. There is also reference to another plan to burn the car of another detective but that they had been deterred by sensor lights in his driveway. There is also reference to what I understand to be an allusion to the possibility that mobile phones and the evidence contained within them might be destroyed if bail was granted to Shane Woods and Finlay. The synopsis also makes reference to the informant having been contacted by Shane Woods' brother, Matthew Woods, and makes reference to what he allegedly said to Ms McKenzie on the telephone. The final paragraph of the synopsis stated as follows:

> 'Police have serious concerns that if released these accused will actively seek to intimidate witnesses and destroy evidence relative to the crimes. At this point Shane Woods' phone is still unaccounted for and may be lines of investigation on Finlay's phone for police to follow up once analysed. In addition Police have serious concerns for the welfare of the

> informant as all accused have extensive history for violence. Shane Woods also facing assault charge on informant from a few nights ago.' [28]

4.17. The synopsis does not make any mention of the aggravated assault charge against Shane Woods.

4.18. Detective Sergeant Hore gave evidence in the Inquest. He prepared the synopsis having regard to his knowledge of the history of Shane Woods and Finlay and the possibility that evidence might be lost if they obtained bail. The most pressing consideration as far as he was concerned was the welfare of Ms McKenzie. The synopsis was provided to and intended for the prosecutor because Detective Sergeant Hore wanted to make sure that the police prosecution section were across all of the information that police had. Detective Sergeant Hore was of the belief that Shane Woods and Finlay should not get bail and he wanted to do everything that he could to ensure that the court was furnished with all of the available information. Detective Sergeant Hore took the files relating to Shane Woods and Finlay into the prosecution unit where he had a conversation with Senior Sergeant Relihan, the officer in charge of that unit. He brought the files and the synopsis to Senior Sergeant Relihan's attention and verbally expressed his views concerning bail with him[29]. Detective Sergeant Hore told the Court that he asked as to who would be prosecuting the matter in court because he wanted to speak to that person, to which Senior Sergeant Relihan had said that he would attend personally. Detective Sergeant Hore said had that not been the case he would have spoken to the person nominated to be the prosecutor that afternoon. This exchange between Detective Sergeant Hore and Senior Sergeant Relihan took place on the Tuesday before court started around 2:15pm.

4.19. That afternoon Senior Sergeant Relihan did not appear for the prosecution in any of the matters involving Shane Woods, Hamish Finlay and Matthew Woods. This was left to another prosecutor whom I will mention in a moment. Senior Sergeant Relihan did relieve that prosecutor later in the afternoon after the Woods' and Finlay matters had been dealt with, but had no personal involvement in nor was present in court at those matters. Contrary to Detective Sergeant Hore's evidence that Senior Sergeant Relihan said he would personally handle the Woods and Finlay matters, Senior Sergeant Relihan

[28] Exhibit C21, page 142, paragraph 8
[29] Transcript, page 525

told the Court that he would have given no such undertaking because he was not in a position from a personnel perspective to have given such an assurance.

4.20. Senior Sergeant Relihan gave oral evidence in the Inquest. At the time with which this Inquest is concerned he was the manager of the Port Augusta prosecutions unit. He had only been with that unit for approximately two weeks. He had no prior knowledge of Shane Woods or Mr Finlay. Senior Sergeant Relihan gave evidence at considerable length. He told the Court of his interaction with Detective Sergeant Hore on 12 March 2013 and confirmed that it was Detective Sergeant Hore's desire that everything should be done to ensure that these individuals were kept in custody. Senior Sergeant Relihan acknowledged that the synopsis was received from Detective Sergeant Hore of the Port Augusta CIB. The prosecution files for all three accused persons were tendered to the Court. The synopsis only appears within the file of Finlay.

4.21. Once Senior Sergeant Relihan had received the briefs for Shane Woods and Finlay he worked on them. It was Senior Sergeant Relihan who organised for the DPP adjudication. When he received the DPP written advice he printed out section 10A to assist the prosecutor who was going to take the matters in court. He observed that the DPP's instruction was that a review would be sought in the event that '*simple bail'* was granted. Senior Sergeant Relihan told this Court that his interpretation of the DPP review instruction was that simple bail meant bail in the applicant's own recognisance and not bail with a guarantor. In other words, his interpretation was that if bail was granted with a guarantor, the DPP would not be seeking a review. This interpretation to my mind is incorrect and manifestly so. The advice from the DPP was as clear as it needed to be and certainly should have been clear to an experienced prosecutor. It meant and was intended to mean that a bail review should be sought for any bail other than home detention bail. Indeed, as will be seen, the correct interpretation would have been placed upon the DPP direction by the police prosecutor who attended court that afternoon had he read the DPP adjudication and advice which he told this Court he did not see.

4.22. The other matter in the evidence of Senior Sergeant Relihan that raised eyebrows was his assertion that despite the fact that the DPP advice contained specific reference to section 10A of the Bail Act and to the fact that the defendants were prescribed applicants, he did not recall picking up the significance of that in terms of it enlivening

the presumption against bail[30]. He was not aware at that time that an offence of stalking contrary to section 250(2) of the Criminal Law Consolidation Act 1935 enlivened section 10A of the Bail Act which all begs the obvious question as to why he copied section 10A and put it on the file. In any event the DPP advice was placed in the file and he said that he attached a post-it-note to it on one of those files. The file produced to the Court does in fact have a post-it-note with the word '*bail*' written on it and it is specifically attached to the DPP adjudication document[31]. The DPP adjudication is also on the other file but not highlighted with any post-it-note.

4.23. Senior Sergeant Relihan also told the Court that during that day he also received the additional arrest file in relation to Shane Woods that dealt with the assault allegation.

4.24. As to the Matthew Woods matter, Senior Sergeant Relihan said that he possibly reviewed that file but had no lasting memory of it. He did acknowledge that his writing is on the prosecution diary relevant to that file. In fact, Senior Sergeant Relihan noticed that contrary to what was stated on the Form 2 document for Matthew Woods, he was in fact not a prescribed applicant in terms of section 10A of the Bail Act. As seen, the Form 2 for Matthew Woods drew the connection between the two Woods matters in that it states that Matthew Woods' alleged threats were against a witness in the matter of his brother's arson case involving police officers' vehicles[32].

4.25. Senior Sergeant Relihan told the Court that he did not believe that he drew the connection between the Matthew Woods matter and the Shane Woods and Hamish Finlay matters[33]. This, notwithstanding that the apprehension report in respect of Matthew Woods clearly stated that the alleged victim of Matthew Woods' threatening behaviour was Ms McKenzie and that the accused person in both minor and major indictable matters was Matthew Woods' brother, Shane Woods[34]. There is also reference as seen in the Form 2 to a connection with the matter involving the torching of police vehicles. There is also the second statement of the complainant, Ms McKenzie, that referred both to Matthew Woods' threat and Shane Woods' alleged assault. Detective Sergeant Hore's synopsis also refers to the connection between the matters involving Shane Woods and Matthew Woods. In short, the connection was

[30] Transcript, page 623
[31] Exhibit C21, page 55
[32] Exhibit C21, page 284
[33] Transcript, page 645
[34] Exhibit C21, page 214

there to be drawn. Later in his evidence Senior Sergeant Relihan appeared to suggest that he may have seen a connection between the matters[35]. He also agreed that it would have '*quite possibly been important to bring the connection to the attention of the court*'[36]. Asked as to whether he had drawn the connection to the attention of the actual prosecutor who would go to court he said he did not know. He stated that it was most likely the case that he was only able to speak to the prosecutor when court was in session. I will come back to the question of his interaction with the prosecutor in a moment.

4.26. If ever there was a case in which jointly charged defendants, namely Shane Woods and Finlay, should be brought together before a bail court in relation to all matters with which they were charged, including the Shane Woods' assault matter, this was that case. And if there was ever a case where there was a need for a related matter such as that relating to Matthew Woods to be brought up in court at the same time, this was that case. In the event, for reasons that are difficult to comprehend, the matters came on before the Magistrates Court separately.

4.27. Senior Sergeant Relihan said that he also knew nothing of any information that had been gleaned by police to the effect that either Shane Woods or Matthew Woods had firearms at their disposal. he agreed it would have been a relevant matter for the court to have heard about[37].

4.28. Senior Sergeant Relihan also told the Court, and I accept this, that he had no knowledge that the complainant, Ms McKenzie, had been in hospital overnight in relation to a possible attempt on her part to take her own life. There is no evidence that any other police officer knew about this.

4.29. As to the briefing that did or did not take place between Senior Sergeant Relihan and the actual prosecutor, Senior Sergeant Relihan suggested that there was a very limited opportunity for such a briefing to have occurred and what briefing there was may only have occurred after court had started. In his witness statement, however, Senior Sergeant Relihan stated that he provided the files to the prosecutor, Senior Constable

[35] Transcript, page 669
[36] Transcript, page 670
[37] Transcript, page 689

Philip Ayling, along with a briefing in relation to the matters and with an instruction to oppose bail.

4.30. Senior Constable Ayling told the Court that he had been a prosecutor at Whyalla since the middle of 2008. Due to staff shortages within the Port Augusta prosecution section on this particular day, he had been asked to attend Port Augusta. In his evidence he stated that any briefing that he received from Senior Sergeant Relihan would not have lasted longer than a minute[38]. He received the files from Senior Sergeant Relihan just before he left to go to court at about 2pm. Naturally, he had a number of other matters that he had to deal with in court that afternoon. It is to be accepted that it must have been a busy list. Senior Constable Ayling told the Court that Senior Sergeant Relihan simply told him to oppose any form of bail in relation to the Woods and Finlay matters. Before court started he was set upon by solicitors including those representing Shane Woods and Finlay. Thus it was that Senior Constable Ayling had a limited opportunity to fully digest the file of any of these three defendants. In particular, he said that he did not at any stage read the DPP's adjudication document. He had no appreciation of the significance of the new charge of stalking in terms of it enlivening the presumption against bail, and he knew nothing about the DPPs' desire for a bail review were these men to be given bail. However, he told this Court that he would have interpreted *simple bail* as involving the release of an applicant on their own recognisance, regardless of whether or not a guarantor was ordered. Had he read the DPP's instructions he would have considered that they authorised a bail review. He agreed that anything other than home detention bail should have activated a review. Asked as to why he did not read the DPP's instructions that day he said:

> 'Basically I had the brief conversation with Senior Sergeant Relihan, I left the office, I basically got the files, put them into a tray with the rest of them; I went to court. By the time I'd set all the files up in court and then had the conversation with Ms Chumak and with Mr Coombs, pretty much then it was time to start the list so I just didn't have time to look at it.' [39]

The Ms Chumak and Mr Coombs referred to in that passage are the solicitors who that afternoon appeared for Finlay and Shane Woods respectively.

4.31. I infer from the evidence of Senior Constable Ayling that the three defendants' matters were called on separately and that they were dealt with separately by the Magistrates

[38] Transcript, page 717
[39] Transcript, page 735

Court. One matter contributing to this was the separate representation of Shane Woods and Finlay and the possibility that one of the solicitors was not ready. This was an undesirable circumstance. This is no criticism of the court. A properly briefed prosecutor would have insisted that the matters be brought on together regardless of whether solicitors or counsel were ready. The matters should not have been brought on until such time as every person involved in the three matters was ready.

4.32. Bail was opposed by the police prosecutor in all three cases of Shane Woods, Finlay and Matthew Woods. That much was in full accordance with the wishes of investigating police. However, despite the DPP's accurate advice that in the light of the new charge of stalking a public officer both Shane Woods and Finlay for the purposes of the Bail Act were prescribed applicants, and that for that reason there was a presumption against bail in their cases, none of this was drawn to the attention of the magistrate. The magistrate's reasons for granting Shane Woods bail make no mention of the fact that there was a presumption against bail in that case and I will assume the same would apply in relation to Finlay, although I have not seen any reasons in relation to that person's application. In addition there is nothing in the magistrate's reasons that would evidence any consideration having been given to the question of whether or not the presumption against bail had been overcome by the existence of special circumstances.

4.33. I have mentioned the fact that both Shane Woods and Finlay were separately represented by individual solicitors. Shane Woods was represented by a local solicitor, Mr Gavin Coombs. Finlay was represented by Ms Tanya Chumak. Mr Coombs was called to give evidence in the Inquest. Mr Coombs is an experienced solicitor who in the past had acted for Shane Woods in relation to other matters. He had acted for Shane Woods in respect of his recent successful parole application. It was evident to me that neither Senior Constable Ayling nor Mr Coombs drew the magistrate's attention to the fact that Mr Coombs' client, Shane Woods, bore the onus of rebutting the presumption against bail enlivened by the stalking charge. In Mr Coombs' case I was satisfied that the first he knew of the stalking charge as distinct from any other charge against his client was when he arrived at court and was provided by the prosecutor with, or at least was shown, the relevant paperwork. I was also satisfied that he did not appreciate that this charge enlivened section 10A of the Bail Act to the extent that his client bore the onus of establishing special circumstances in order to obtain bail.

In this regard I would observe that the charge against section 250 of the Criminal Law Consolidation Act is a charge that is rarely seen. I would be prepared to accept that it was a charge that prior to this occasion Mr Coombs probably had not seen. I accepted Mr Coombs' assurances on his oath that his not drawing the court's attention to the onus of proof that his client bore was not deliberate but was an oversight due to a lack of knowledge of the law on that occasion. I am prepared to assume the same in relation to the solicitor who appeared for Finlay.

4.34. I am prepared to find that Senior Constable Ayling had insufficient time to properly prepare for these important bail applications. I accept that he was inadequately briefed. I accept that he did not read the DPP's advice. He should have read it. He should have ensured that all three defendants came before the court at the same time and that the court was made aware of the fact that in respect of Shane Woods and Hamish Finlay there was a presumption against bail in their respective cases. Had he read the DPP advice he would have appreciated its clear intent that in the event that Shane Woods and Finlay were granted bail, a review of the magistrate's decision was to be immediately flagged so that at least those two men would remain in custody until a Supreme Court review could be heard and determined. To my mind, regardless of the DPP advice, Ayling should immediately have indicated a review in any event. Bail was opposed for good reason. The matters alleged were serious. Shane Woods and Finlay were important police targets. There was an important police human asset who required protection. Any decision not to seek a bail review would have been perverse.

4.35. Shane Woods and Finlay should not have been released on bail that day. As to Matthew Woods, although there was no presumption against bail in his case, having regard to the nature of the allegations against him it would have been prudent for a review to have been flagged in relation to his matter once it was indicated by the court that he would be released on bail. His matter was intrinsically connected to the matters of Shane Woods and Hamish Finlay. The allegations against him were serious in their own right. His admissions to police that he had made the relevant phone call and had made the alleged threatening utterance was highly relevant to the question of bail. It would have been perverse not to have flagged a review of his bail if a review of the bail of the other two had in fact been indicated.

4.36. To my mind the prosecution's role in these bail applications totally miscarried. If the DPP's advice had been followed, it would have ensured that Shane Woods and Finlay

were not immediately released. An immediate indication by the prosecutor that a review of Matthew Woods' bail would be applied for would have seen him not immediately released. Shane Woods, Finlay and Matthew Woods should all have been kept in custody at least until Supreme Court bail reviews could be heard and determined. As to the likelihood or otherwise of properly presented Supreme Court reviews being successful, it is impossible to say that they would have been unsuccessful. All things considered, the candidacy for bail of the three arrested individuals was at the very least questionable. Whether that was the case or not, if these individuals had been kept in custody at least in the short term it would have removed another factor operating on the mind of Ms McKenzie that evening.

4.37. The unsuccessful opposition to bail may have been avoided if one of the investigating officers from the Port Augusta CIB had been present at the bail hearings.

4.38. There was another means by which Shane Woods could have been kept in custody on Tuesday 12 march 2013. I have mentioned the matter of his parole. This issue is canvassed in the statement of the investigating officer in relation to Ms McKenzie's death, Detective Brevet Sergeant Spry of the Whyalla CIB. Possible intervention in Shane Woods' parole was enlivened by the alleged offence of assault against Ms McKenzie. Police sent a parole breach notification to the Parole Board over the weekend. As a result, a parole warrant was issued by the Board on Wednesday 13 March and Shane Woods was re-arrested. However, as Detective Brevet Sergeant Spry points out section 76B of the Correctional Services Act 1982 would have enabled a member of SAPOL, without warrant but on the authorisation of a Commissioned Officer, to arrest a person who has been released on parole to arrest a person who has been released on parole if the police officer suspects on reasonable grounds that the person has, while on parole, breached a condition of parole and if the officer is satisfied that the breach is not trivial and unless the person is immediately arrested, the person is likely to continue to breach conditions of parole, commit further breaches or commit an offence. This power came into operation on 31 August 2012. This power arguably would have enabled police to arrest Shane Woods on the spot on the afternoon of Tuesday 12 March and as soon as he was released on bail. To my mind it is clear that no consideration was given to this power either before or after Shane Woods was released on bail.

5. Ms McKenzie is taken to the Port Augusta Hospital

5.1. Ms McKenzie was taken to the Port Augusta Hospital arriving shortly after 3pm. She was there seen by Dr Sivasuthan. Dr Sivasuthan is a local general practitioner who was rostered to perform duties within the Port Augusta Hospital Emergency Department if and when required. He gave oral evidence in the Inquest and also gave a witness statement to police[40]. Dr Sivasuthan made notes of his initial examination of Ms McKenzie. He noted that she was drowsy and in his clinical note he attributed her presentation to:

> '?? Overdose of Medication as a process of Suicidal attempt.' [41]

He noted that it was believed that the medications that had been taken consisted of tramadol, Panadol Osteo and five temazepam tablets. Her drowsiness improved quickly. He noted that she was abusive initially but settled. In his statement he said the abuse was directed towards the relatives who had brought her in and towards herself for being in hospital. She was unwilling to be admitted at first, but after being advised that if she did not voluntarily admit herself Dr Sivasuthan would detain her and forcibly admit her, she agreed to be admitted. There is no note of this advice in the clinical record.

5.2. Dr Sivasuthan noted as his '*impression*':

> '1) Overdose
> 2) Suicidal ideation'

5.3. Dr Sivasuthan admitted Ms McKenzie to the High Dependency Unit of the hospital. A blood screen showed high levels of paracetamol which Dr Sivasuthan considered to be dangerous. As a result an NAC protocol for the paracetamol overdose was commenced. Dr Sivasuthan gave evidence that his priority that afternoon was to treat the paracetamol overdose which if left untreated would have constituted a threat to Ms McKenzie's liver function.

5.4. There is no reference in Dr Sivasuthan's clinical record to the existence of the three worrying pages of material that Ms McKenzie had written and which were brought to the hospital. However, it is clear that they were brought to the hospital as copies of the

[40] Exhibit C31
[41] Exhibit C17b, page 32

documents appear in the Port Augusta Hospital clinical record. Dr Sivasuthan acknowledged that he was aware of the existence of the notes.

5.5. In his witness statement taken on 3 June 2014 Dr Sivasuthan states that he recalled very clearly that he wrote on more than one occasion in the hospital notes that should Ms McKenzie attempt to leave the hospital, SAPOL should be contacted with a view to assisting continuation of care for her. He gave this instruction after reading the notes written by Ms McKenzie. Given that Ms McKenzie had agreed to be admitted, Dr Sivasuthan himself felt no need to detain Ms McKenzie pursuant to the Mental Health Act 2009.

5.6. It is here necessary to say something about the provisions of the Mental Health Act 2009 as they may have applied to these circumstances. Pursuant to section 21 of the Mental Health Act 2009 a medical practitioner or authorised mental health professional may make an order that a person receive treatment as an inpatient in a treatment centre if it appears to the medical practitioner or authorised mental health professional after examining the person that the person has a mental illness and, because of the mental illness, the person requires treatment for the person's own protection from harm and there is no less restrictive means than an inpatient treatment order of ensuring appropriate treatment of the person's illness. There are other requirements that do not need to be mentioned here. I speak of the enlivening requirements as they existed in March 2013. As of 4 June 2017 there is an additional requirement relating to the person's decision-making capacity, a requirement that did not apply at the time. As a medical practitioner Dr Sivasuthan had power to impose a Level 1 Inpatient Treatment Order. It will be noted that the treatment has to be administered to the person as an inpatient in a 'treatment centre' designated under the Act. At the time with which this Inquest is concerned the Port Augusta Hospital was not a treatment centre. Indeed, had Ms McKenzie been detained pursuant to this provision the appropriate treatment centre would have been a tertiary hospital in the metropolitan area in Adelaide. This would have created a difficulty, although by no means an insurmountable one, that she would have needed to be conveyed to Adelaide had such an order been imposed and confirmed. It is understood that the Whyalla Hospital is now an approved treatment centre for the purposes of the Mental Health Act 2009, a circumstance that one would expect would ameliorate such difficulty.

5.7. In addition to the possible imposition of an inpatient treatment order, the Mental Health Act 2009 grants powers of detention to certain authorised officers and to police officers[42]. Where such an officer believes on reasonable grounds that a person has a mental illness and there is a significant risk of the person causing harm to him or herself, or the person otherwise requires medical examination, the officer may take the person into his or her care and control. No doubt this is the potential SAPOL involvement that Dr Sivasuthan is referring to in his statement. I was informed during the course of the Inquest that a local registered mental health nurse, Ms Cheryl Norton, was an authorised officer who would have had that power. Ms Norton did not see Ms McKenzie until the following day.

5.8. Although Dr Sivasuthan's notes of his direction that if Ms McKenzie attempted to leave the hospital SAPOL should be contacted are not present in the Port Augusta Hospital clinical record, I accepted his evidence that he had given a direction along those lines. I had some difficulty in understanding the precise nature of what Dr Sivasuthan had directed, and the precise circumstances in which his direction should be carried out should it come to that. For instance, I was not entirely certain whether Dr Sivasuthan's motivation for preventing Ms McKenzie from leaving the hospital was his concern that she would have put herself at physical risk posed by the possible damage to her liver should treatment for the paracetamol overdose be curtailed. By the following day that no longer remained an issue. Dr Sivasuthan explained in his evidence, if I properly understood it, that he did not have an opportunity to assess Ms McKenzie's state of mental health and that in any event she had agreed to stay at the hospital. Having seen the notes written by Ms McKenzie, he recalled writing in the clinical record that the patient should not be leaving the hospital without being properly assessed by the mental health nurse and a general practitioner. Dr Sivasuthan noted in his plan that such an assessment should take place. Dr Sivasuthan said that his view had been that Ms McKenzie should be detained if, on the following day, she tried to leave without being properly assessed[43].

5.9. It is of note that Dr Sivasuthan agreed in cross-examination by Mr Charles for Ms McKenzie's family that given the overdose and the notes that Ms McKenzie had written, he had considered that what she had done was indeed a suicide attempt[44].

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[42] Sections 56 and 57
[43] Transcript, pages 396 and 402
[44] Transcript, page 416

5.10. Dr Sivasuthan told the Court that on 11 March or 12 March 2013 he did not recall seeing information about previous overdoses.

5.11. Dr Sivasuthan again saw Ms McKenzie at approximately 9:10pm that night. Ms McKenzie was still undergoing the paracetamol protocol. She was stable and still angry. He saw her again early the following morning but she was still asleep at that point and he chose not to wake her. He did not see her again. In fact, no medical practitioner saw Ms McKenzie awake at any time after 9:10pm on the night of 11 March.

5.12. There is one matter that I should mention about Dr Sivasuthan's management and that is that he had prescribed the PRN administration of olanzapine which is an antipsychotic and major tranquiliser. PRN refers to the administration of a drug as and when required. Although only a medical practitioner may prescribe the drug, if the prescription is PRN it can be administered at the discretion of nursing staff. The prescription was for 10mg to be administered with a maximum of 20mg over a 24 hour period. In the event nursing staff at their discretion would administer 10mg of olanzapine at 10:19pm on 11 March 2013. It was the only dose that Ms McKenzie was given. There is a nursing note timed at 3:15am on 12 March 2013 to the effect that Ms McKenzie had been teary at an early point of the nursing shift, which I took to mean during the evening of the previous day, and that she was missing her son. She was recorded as having been administered '*mild*' sedation with good effect. The administration of olanzapine could not be regarded as mild sedation. During the Inquest an issue arose as to whether the administration of olanzapine on top of the overdose of medication that she had already consumed was wise in the circumstances and whether it may have adversely compromised any examination of Ms McKenzie the following day. More of that later.

5.13. Ms McKenzie would be released from the Port Augusta Hospital at 10:50am on Tuesday 12 March 2013. I have already referred to Dr Sivasuthan seeing Ms McKenzie but not waking her. According to the progress notes this occurred at about 6:50am. Dr Sivasuthan noted the plan that Ms McKenzie would be reviewed by a general practitioner that day. Dr Sivasuthan did not contemplate that he would be that general practitioner. The general practitioner who did become involved in Ms McKenzie's matter was Dr Igwe Nwachuku. Dr Sivasuthan and Dr Nwachuku did not communicate

about Ms McKenzie. Dr Sivasuthan's views about Ms McKenzie's potential detention were not conveyed to Dr Nwachuku.

5.14. Dr Nwachuku provided a statement given on 19 May 2014[45] and he gave oral evidence. Dr Nwachuku was not a member of the same medical practice as Dr Sivasuthan. He did work in the same practice as Dr Qazi who had prescribed the temazepam tablets the day before. Also in that practice was a Dr Patel who had seen Ms McKenzie in connection with events in 2008. Ms McKenzie's parents also attended this practice.

5.15. Dr Nwachuku was the local medical practitioner rostered for duties at the Port Augusta Hospital for that day. This did not necessarily mean that he would be in attendance at the hospital for the entire duration of that day. It simply meant that he would attend when called. He would also see his own patients at the hospital. For the most part he would attend to his own patients at his practice. He attended the hospital at about 8am on the morning in question and discovered that Ms McKenzie was listed as a patient admitted under his care. This was the first that he knew of this fact. Ms McKenzie was in Room 8 when Dr Nwachuku came to review her. She was still asleep. The NAC protocol for paracetamol overdose was noted. Paracetamol levels were noted as being normal at that time. Dr Nwachuku ordered that the NAC infusion be discontinued if the latest paracetamol level was normal. He also ordered some liver function tests and an INR test. He referred Ms McKenzie for review by the hospital in-house Mental Health Liaison Nurse, Ms Cheryl Norton to whom I have referred. The notes that had been written by Ms McKenzie were filed in Ms McKenzie's records. Dr Nwachuku read them. Dr Nwachuku observed Ms McKenzie to be asleep at 8:15am and also noted that she was sleeping following the administration of a tranquiliser the previous night. This is a reference to the dose of olanzapine. In respect of the reason for Ms McKenzie's presence in the hospital, Dr Nwachuku noted as follows:

> 'Suicidal attempt with drug over dose. Left a definite suicide note.' [46]

This was the only occasion on which Dr Nwachuku saw Ms McKenzie. He did not perform any further examination either physical or mental. Dr Nwachuku returned to his practice that morning. It was his expectation that there would be a review by the mental health nurse which he noted was to be undertaken '*for further evaluation*'. That

[45] Exhibit C33
[46] Exhibit C17b, page 37

review, as well as a mental state examination and mental health risk assessment, would be carried out by the nursing staff.

5.16. The precise time as to when Ms McKenzie awoke is not known, but it is clear that she was awake by 9:35am because that is the time at which her nursing assessments began. The mental state examination of Ms McKenzie[47] and her mental health risk assessment[48] were conducted by a registered nurse Bianca Reid (nee Leith as she then was). These assessments appear to have been conducted between approximately 9:35am and 9:50am. Ms Reid provided a statement[49] through the Crown Solicitors Office. The statement is dated 15 September 2016. Before dealing with the contents of that statement it is necessary to refer to documentation that she created based on her assessments. The salient features of this documentation are as follows:

- The identification of Ms McKenzie as being at moderate risk of self-harm and suicidality;
- Her family support was minimal, although there is specific reference to issues with her partner in this regard;
- That the precipitating factor was her partner being back in prison as a result of Ms McKenzie reporting her partner for offences;
- That she had good support from her uncle and brother and that she had a small child;
- That she had nil current thoughts of suicide and wanted to go home;
- That she made nil eye contact with slow speech and one word answers;
- That her mood was sad, that her effect was upset++ and that she was teary++; I can only infer that the plus signs were intended to signify that Ms McKenzie was emotional to an obvious and significant degree;
- That her judgment was impaired and that she had a history of impulsiveness;
- That she was not sleeping well, that her energy was down, but that her appetite was '*okay*'.

According to the risk domain scoring matrix attached to the documentation, the assigning of a moderate risk of suicidality implied that there were in existence multiple

[47] Exhibit C17b, pages 91-92
[48] Exhibit C17b, pages 85-86
[49] Exhibit C22

risk factors with few protective factors and that Ms McKenzie had suicidal ideation with a plan but with no intent or behaviour. It also implied that the relevant possible intervention might consist of admission depending on risk factors, but with the development of a crisis plan involving the provision of emergency and crisis phone numbers. I note that according to this matrix, by definition a high risk of suicidality would involve psychiatric diagnoses with severe symptoms or an acute precipitating event. In Ms McKenzie's case one would have thought that there had been such an event. According to the matrix, in such a risk assessment admission to hospital would generally be indicated and that suicide precautions would be implemented.

5.17. Ms Reid's statement taken in September 2016 indicates that Ms McKenzie's lack of judgment was a concern, but that she had answered *'yes'* when Ms Reid asked her if she felt safe. She had denied suicidal ideation. Ms Reid said in her statement that she did not have any concerns for Ms McKenzie's mental state. If she had concerns she would have contacted the medical officer or have asked for an urgent review by the mental health nurse. In fact, as it transpired, there was such a review conducted by Ms Norton immediately following Ms Reid's assessment. Ms Reid adds that her documentation in relation to Ms McKenzie's lack of family support was an error and that she should have instead noted that she had a supportive family. I am not certain that this was an error because the observation about lack of family support, I think, was directed more towards Ms McKenzie's relationship with her partner. The documentation did record that she had good support from her uncle and brother. The fact of the matter was that she did have good support from her parents and her brother. Ms Reid stated that she did not recall any conversation with Ms McKenzie or any member of Ms McKenzie's family about contacting the police if Ms McKenzie wanted to leave the hospital. Nor was anything said about possible detention if Ms McKenzie elected to leave the hospital. That said, it is noted more than once by Ms Reid that Ms McKenzie wanted to go home.

5.18. Regardless of the accuracy of Ms Reid's assessment as described in her witness statement that Ms McKenzie had denied suicidal ideation and that Ms Reid did not have any concerns for Ms McKenzie's mental state, the fact remains that Ms Reid recorded that Ms McKenzie was at moderate risk of self-harm and suicidality, although perhaps on the low side of moderate.

5.19. The review by a mental health nurse was conducted by registered mental health nurse Ms Cheryl Norton. Ms Norton gave oral evidence at the Inquest. She also provided a statement[50]. It was Ms Norton's assessment on which the decision that Ms McKenzie could be released from hospital was based.

5.20. Ms Norton made handwritten notes of her review and assessment within the progress notes. I am not certain how long this assessment took. Ms Norton's note is timed at 11am, apparently written in retrospect. The next note is timed at 11:45am. This is a note made by a nurse Crawford, again made in retrospect. In this note it is recorded that the mental health nurse spoke to Dr Nwachuku wherein it was agreed to allow Ms McKenzie to be discharged which took place at 10:50am. In the note Ms McKenzie is said to have been discharged '*with family member*'. That family member has never been identified.

5.21. The salient points of Ms Norton's handwritten notes of her review were that the overdose of the previous day had taken place after Ms McKenzie had reported her ex-partner to SAPOL. It is noted that he had been released from prison and that he was supposed to be looking after their 2-year-old son but that he was selling drugs instead. Ms Norton recorded that Ms McKenzie said that after reporting the partner to police she had felt that she was taking away her son's father and depriving the son of fatherly input. Other important features as noted include that Ms McKenzie now felt foolish for the previous day's actions and that she now just wanted to sleep for a while and not die. Ms Norton specifically recorded that Ms McKenzie said that she did not remember writing the notes that were brought in with her, including of course the note that spoke of her funeral and those she did not want attending it. There is also a note recording Ms McKenzie's realisation that she would put the custody of her child at risk if she continued to self-harm. There is a note also that Ms McKenzie was relieved that she did not die and that she denied any current suicidal ideation. As to the physical observations of Ms McKenzie, relevantly it is noted that her affect was flattened and that this appeared to be in the context of a '*situational crisis*'. She was alert and oriented. There is no note as to how or whether the situational crisis had resolved. As will be discussed the current crisis in her life was far from resolved. The plan or at least desire on Ms McKenzie's part is noted as being one where she would go home in the

[50] Exhibit C30

company of her family for the next few days until she was more settled. It is recorded that Ms McKenzie did not want referrals to any other agencies or services.

5.22. There is a notation made by Ms Norton that the matter was discussed with Dr Nwachuku and that he was 'happy' for Ms McKenzie to be discharged. There is nothing recorded as to the details of Ms Norton's conversation with Dr Nwachuku. This conversation took place over the telephone.

5.23. In Ms Norton's note there is notably no reference to the current situation regarding the police matter, how acute that situation was and what it was or might be developing into. Whether a situational crisis had resolved or was likely to resolve in any way favourably for Ms McKenzie is not discussed. As well, there is no reference to the Panadol overdose which would not appear to be consistent with an intention on Ms McKenzie's part simply to secure better sleep. Ms McKenzie's previous history of self-harm, including her overdoses in 2008, is also conspicuously absent from the note.

5.24. It should be observed at the outset that this assessment occurred against a background of Ms McKenzie's strong desire to leave the hospital and that her responses may well have been tailored towards that outcome, especially answers in relation to her intent when taking the overdose and her claimed amnesia in relation to the notes that she undoubtedly wrote in conjunction with that overdose.

5.25. At the time with which this Inquest is concerned registered nurse Cheryl Norton was a nurse of some 13 or 14 years standing. She had completed her general nursing training in 1990 through the hospital training system. She subsequently obtained qualifications in mental health nursing in 1993. She has been involved in work in both hospital based and community based nursing. She has worked at Glenside Hospital, the Repatriation General Hospital, Whyalla Hospital and in the community. At the time with which this Inquest is concerned she was working in the community mental health team in Port Augusta. She was also the clinical practice consultant mental health nurse at the Port Augusta Hospital. She held that position for two years commencing in 2011. Indeed her duties were predominantly conducted within the hospital. Her duties included the review of patients who had been referred to her via the nursing staff by the medical practitioners practising within the hospital. Her job was to assess the patients and to make recommendations to the nursing staff and to the medical practitioners. Her role was to provide education for the other members of the nursing staff as well as to provide

a better standard of mental health management within the hospital. There were no other dedicated mental health nurses working at the hospital in March 2013, although other mental health nurses from the community team, if they were available, would attend the hospital on Ms Norton's days off. Importantly, no psychiatrist worked at the Port Augusta Hospital nor privately within the region. However, from time to time a number of psychiatrists would visit the region. Ms Norton described, as Dr Sivasuthan had also described in his evidence, the access to the Rural and Remote Triage Service conducted from the Glenside Campus in Adelaide that enabled clinicians in Port Augusta to speak to mental health clinicians over the telephone in respect of their Port Augusta patients. This service was not utilised in the case of Ms McKenzie.

5.26. In her oral evidence Ms Norton elaborated upon what was contained in her one page progress note. In her evidence-in-chief she told her counsel, Ms Maloney, that at the time of her review she had not been aware of Ms McKenzie's prior mental health history[51]. This is in spite of the fact that, as is evident from facsimile headers, the Women's and Children's Hospital separation summaries in relation to the admissions in 2008 which involved previous overdoses had been obtained by the Port Augusta hospital not long after her admission and had been placed on Ms McKenzie's file. Ms Norton also told the Court that she did not ask Ms McKenzie any further details about her contact with SAPOL other than what was recorded about that issue in the notes. One would have thought that there were many relevant questions that could have been asked. For example, Ms McKenzie could have been asked when it was that she had provided the police with the information that had implicated her partner in relation to the time at which she had taken her overdose. She could have been asked about the current status of any custody that her partner was then undergoing, whether it was likely that his custodial state would remain as it was and what her attitude to the prospect of his possible release was. Had enquiries such as this been made, and if Ms McKenzie had answered truthfully, there would have been a very good case for alerting the local SAPOL authorities to Ms McKenzie's current predicament. It is not looking at the matter with the wisdom of hindsight to suggest that these were all pertinent enquiries to have been made of a person who had acutely entered hospital with an overdose that had been taken ostensibly in an attempt to take her own life.

[51] Transcript, page 312

5.27. Ms Norton also confirmed in her evidence-in-chief that Ms McKenzie stated that she could not remember writing the suicide notes that she had written. Ms Norton told the Court that when she showed Ms McKenzie the notes it elicited what appeared to be a significant look of surprise on Ms McKenzie's face. Ms McKenzie said that it had not been her intention to die. Ms Norton seems to have accepted this assertion as the truth. A moment's reflection ought to have established grave doubts in Ms Norton's mind as to the veracity of any claimed lack of memory. In reality this was a case where the facts spoke for themselves. Ms McKenzie had taken an overdose of various forms of medication. She appeared to have consumed everything she could lay her hands on. And regardless of whether or not Ms McKenzie had any active recollection of writing the notes, the notes confirmed that she was contemplating her own death when she wrote them.

5.28. As to the question of there having been a '*situational crisis*', it is difficult to see how Ms Norton could have regarded the situational crisis as one that had been resolved and was no longer likely to impact upon Ms McKenzie's behaviour. Certainly, there was a situational crisis that had probably precipitated Ms McKenzie's actions in respect of the overdose, but that situation had by no means resolved itself. Indeed Ms Norton told the Court that Ms McKenzie said that she now regretted having made the report against her partner. There was nothing to suggest that this regret was not going to be an ongoing and dominant frame of mind of Ms McKenzie.

5.29. Ms Norton told the Court that she did not believe that Ms McKenzie was detainable under the Mental Health Act 2009. She had a recollection that the nursing staff had told her that a doctor had said that Ms McKenzie should be detained if she tried to leave the hospital[52], but that Ms Norton's view was that Ms McKenzie was not detainable and that this had been based upon what she had seen during her own assessment. When she eventually spoke to Dr Nwachuku on the phone, he had concurred that she was not detainable and that she could go home.

5.30. Ms Norton's evidence was that her preference had been that Ms McKenzie should stay another day, meaning overnight on 12 March 2013. I accepted this evidence. It was corroborated in an email that she later sent to Ms Therese Hunter to whom I have

[52] Transcript, page 330

already referred. I also accept that she would have indicated that preference to Ms McKenzie but that Ms McKenzie had been determined to leave the hospital.

5.31. Ms Norton told the Court that the person whom she described as a cousin of Ms McKenzie, being a female person, had been with her during the course of the assessment. This person has not been identified and it seems clear from the evidence of Mr Zaaheer McKenzie that when he saw Ms McKenzie in the hospital carpark almost immediately after she had been discharged, she was then not in the company of another person.

5.32. Ms Norton eschewed the suggestion that it would have been appropriate for her to have collected collateral information regarding Ms McKenzie's frame of mind from her parents, Mr and Mrs Malcolm McKenzie. She attributed this reluctance to privacy and confidentiality considerations which to my mind are specious, particularly having regard to the fact that it was Mrs Dorothy McKenzie who had brought Ms McKenzie to the hospital in the first place. Similarly, Ms Norton's suggestion that it would not have been appropriate to speak to the police about Ms McKenzie's predicament is equally questionable. There was one thing that Ms Norton said that particularly did not make sense and it was that she would only seek such collateral information if the patient was perceived to be at significant risk of harm which she assessed Ms McKenzie not to be. This is a non-sequitur in that it may very well be the collateral information that gives rise to the perception of the significant risk. There is a case for saying that to avoid obtaining such information would constitute wilful blindness to potentially important information.

5.33. There was one matter from Ms Norton's evidence that particularly troubled the Court. In cross-examination by Ms Cacas, Counsel Assisting, it was pointed out to Ms Norton that one of the documents created at the time of Ms McKenzie's admission had stated that her relevant past medical history included two overdoses and two previous attempted suicides by overdose. This was no doubt a reference to the episodes in 2008 in which Ms McKenzie was hospitalised at the Women's and Children's Hospital. I am not certain what the original source of that information was on 11 March 2013, and in particular whether it may have come from those persons accompanying Ms McKenzie on her arrival at the Port Augusta Hospital. Be that as it may, it was a document to which Ms Norton could have had regard to. In her cross-examination by Ms Cacas, Ms Norton said that she had read the page on which this entry was written and had read that particular entry. Following that acknowledgment Ms Cacas asked

Ms Norton whether she had asked Ms McKenzie about the contents of that entry. She told the Court that Ms McKenzie denied that she had made previous suicidal attempts[53]. This passage of her cross-examination occurred after Ms Norton had been provided with the opportunity to read the separation summaries from the two 2008 overdose episodes. Ms Norton said that she had not read them at the time. One can only infer that in the face of everything Ms Norton accepted Ms McKenzie's denials that there had been previous suicide attempts by Ms McKenzie. Not only were the previous attempts highly relevant to Ms McKenzie's assessment of risk of further self-harm, her denials in the face of clear evidence to the contrary in the form of the separation summaries that were available, but not read, would have cast significant doubt on Ms McKenzie's credibility. This doubt should have filtered into an evaluation of Ms McKenzie's denials that she remembered writing the notes from the day before, of her denials of suicidal ideation and of her denials that the overdose had been taken without an intention to end her own life.

5.34. For all of the above reasons to my mind the assessment by Ms Norton was superficial and inadequate. As seen earlier the assessment would form the basis of her conversation with Dr Nwachuku and in turn form the basis upon the doctor's agreement that Ms McKenzie could be discharged from the hospital.

5.35. Dr Nwachuku's statement taken in May 2014 asserts that Ms Norton called him at about midday. In his evidence he adjusted that time to a time between 10:30am and 11am having regard to certain records. This would be more in keeping with the time as described by Ms Norton. Accordingly, I find that this call took place sometime before 11am. According to the doctor's statement Ms Norton told him that Ms McKenzie was remorseful for her actions of the previous day and that she no longer had any suicidal ideation. Ms Norton told him that Ms McKenzie had no recollection of the suicide note. She had indicated to Dr Nwachuku that Ms McKenzie wanted to be alive for her son and that she wished to be discharged to get on with her life now that her son's father was going back to prison. She described the asserted strong family support that was in place and said that Ms McKenzie planned to meet with Ms McKenzie's uncle and his wife with whom she lived. He stated:

> 'In her opinion based on Deborah's presentation that morning, there was minimal risk involved in letting her go home and it was safe for us to discharge her.'

[53] Transcript, page 462

5.36. As a result of that conversation Dr Nwachuku agreed that Ms McKenzie could be discharged and suggested that a follow-up appointment be made to see him the following week.

5.37. There were some differences between the evidence of Ms Norton and that of Dr Nwachuku in respect of this conversation. Ms Norton denied that she planned to meet with Ms McKenzie's uncle and wife, that is to say Mr and Mrs Malcolm McKenzie. Ms Norton said that she would not have made any such arrangement and that no such arrangement was made. That much is clear, no such arrangement was made, certainly on that day at any rate and certainly not before Ms McKenzie was discharged. Neither Mr nor Mrs McKenzie were present when Ms McKenzie was discharged. However, whether she was discharged in the presence of any other person is a matter that is completely unclear. The other area where their evidence differs is that Ms Norton denied that she said to Dr Nwachuku that there was '*minimal risk*' involved with Ms McKenzie's discharge. It is not possible to determine where the truth lies in respect of that issue. No detailed note was made by either person of this important phone conversation. In any event, it is clear that Dr Nwachuku should have determined the issue of risk for himself, that is to say by seeing and evaluating the patient himself.

5.38. Dr Nwachuku gave evidence at considerable length, both in Port Augusta and in Adelaide. He obtained his medical degree in Nigeria in 1990. He also has a degree in pharmacology. He worked at the Augusta Westside Medical Centre in 2013 having obtained his Fellowship of the Royal Australian College of General Practitioners in 2009. Dr Nwachuku is also a member of the Royal College of Physicians of the United Kingdom. In his oral evidence Dr Nwachuku stated that on the morning of 12 March 2013 his understanding was that Ms McKenzie had taken a drug overdose as an attempted suicide[54]. He did not wake Ms McKenzie that morning because he did not believe that a drowsy patient would be an ideal patient to be the subject of a mental health assessment. He was conscious of the fact that she had been sedated with a tranquiliser since the previous evening. He told the Court that the main factor in his mind as far as discharge from the hospital was concerned was whether Ms McKenzie was no longer at risk of self-harm or suicide. He said that this was the major

[54] Transcript, page 494

consideration[55]. Dr Nwachuku read the notes that Ms McKenzie had written and he had regarded to it as a definite '*suicide note, fairly detailed, including a list of persons she didn't want at her funeral*'[56]. He said that he was under no misapprehension about this having been a serious suicide attempt because the presence of the note suggested that.

5.39. Dr Nwachuku confirmed the account of his conversation with Ms Norton as set out in his statement. He confirmed that Ms Norton told him that Ms McKenzie wanted to be discharged and that she was adamant that she did not want to stay in hospital and wanted to go home.

5.40. Dr Nwachuku raised with Ms Norton the obvious issue about how the suicide note, which he described as '*elaborate*'[57], could be explained if the risk of suicide was minimal. As indicated Ms Norton denied that she said that, but I accept Dr Nwachuku that he queried with Ms Norton the significance of the note.

5.41. Asked the obvious question as to why he did not examine Ms McKenzie himself, he stated that the report that Ms Norton gave him was quite unequivocal. She had made it clear that Ms McKenzie had insight and was very remorseful, saying that she did not want to kill herself. As well, the suicide notes that he had been concerned about had also been denied in the sense that Ms McKenzie had no recollection of having written them. Therefore he believed that she was no longer suicidal and did not believe that he had any reason to reassess her. He said '*I trusted what was reported to me by Ms Cheryl Norton*'. He agreed that Ms McKenzie could be discharged. He accepted that this had been his decision. I would add here that, like Ms Norton, Dr Nwachuku also appears to have accepted without question Ms McKenzie's assertions, as reported by Ms Norton, that she had no recollection of writing the notes.

5.42. Dr Nwachuku said that he had a very limited recollection of Ms McKenzie's previous mental health history. He knew that she had been to his surgery. He had in fact seen her himself in relation to mental health issues. She had been brought in to see him because of suspicions that she was using recreational drugs. He was also aware that Dr Patel had seen her in relation to depression. He said:

> 'So outside that, the rest I knew was what I saw in the notes on that day which showed that there had been previous suicide attempts in 2008 from a drug overdose.' [58]

[55] Transcript, page 498
[56] Transcript, page 498
[57] Transcript, page 504
[58] Transcript, page 508

Dr Nwachuku was there referring to the triage notes. However, he said that he did not see the faxed material from the Women's and Children's Hospital relating to those 2008 incidents[59]. Later in his evidence he asserted that on 12 March 2013 he did not recall any of the history that had been reported by Dr Patel from 2008.

5.43. I accepted Dr Nwachuku's evidence that he was not told anything about the observations that had been made by nurse Reid prior to Ms Norton's assessment. Asked as to what he would have done if Ms Norton had told him that Ms Reid had recorded that Ms McKenzie's judgment was impaired, that she was upset and teary and had a history of impulsiveness, this would have raised significant doubt in Dr Nwachuku's mind as this information would have contrasted with that provided by Ms Norton. He said that this information on its own would have been a compelling reason for him to seek a reassessment, either to be performed by himself or one involving a consultant psychiatrist[60]. He also regarded other aspects of Ms Reid's assessment as not being consistent with Ms Norton's.

5.44. In cross-examination Dr Nwachuku made a number of important acknowledgements. Dr Nwachuku acknowledged that he had overall responsibility for the management of Ms McKenzie[61], that he did not have regard to the 2008 history of previous overdoses[62], that when he was at the hospital he had believed that the notes that Ms McKenzie's notes were serious enough to indicate that it would be necessary for him to personally assess the patient[63] and that his not having done so was one of his greatest regrets in the whole matter. He also acknowledged that he knew nothing of the assessment of Ms Reid that Ms McKenzie had been at moderate risk of suicidality. He acknowledged that had he known this it would have influenced his decision to discharge. He said:

> 'I wouldn't be discharging a patient with a moderate risk of committing suicide.' [64]

He also acknowledged that a lack of memory of having written the notes did not necessarily mean that Ms McKenzie had not known what she was doing when she wrote them[65]. He also acknowledged that an asserted lack of memory did not necessarily mean that Ms McKenzie had no intent to end her life when she wrote them[66]. He also

[59] Transcript, page 508
[60] Transcript, page 768
[61] Transcript, page 785
[62] Transcript, page 782
[63] Transcript, page 785
[64] Transcript, page 803
[65] Transcript, page 808
[66] Transcript, page 808

acknowledged the possibility that her lack of memory may have been a ploy to secure her discharge from hospital. He said that a deception in this regard was a possibility, but that generally clinicians were trained to believe their patients unless there was a compelling reason not to[67]. He also acknowledged that when he spoke to Ms Norton he was in no real position to assess the truth or otherwise of Ms McKenzie's assertions that she could not remember writing the notes and that therefore he had probably not been in a position to make any proper determination as to whether the girl had intended to take her own life when she wrote the notes[68].

5.45. Dr Nwachuku said that he had not been aware of the court proceedings that involved Ms McKenzie and in particular that she had been instrumental in her partner being arrested for serious criminal offences, that the partner had been arrested in relation to a domestic assault upon her and that the partner's brother had been arrested for threatening her over the phone. He agreed that these issues might have been factors in her mind at the time of the overdose[69].

5.46. There is no escaping the fact that Dr Nwachuku should have examined Ms McKenzie and assessed her for himself. If he done that, and had taken into account what nurse Reid had documented as well as such matters as the previous overdoses, it is likely that further attempts would have been made to persuade Ms McKenzie to remain in the hospital. It is also possible that a psychiatric opinion would have been remotely sought.

6. The evidence of Professor Robert Goldney

6.1. Professor Goldney is a recently retired consultant psychiatrist. He is an Emeritus Professor in Psychiatry at the University of Adelaide. He practised in the field of psychiatry as a clinician for over 40 years. He is an experienced clinician who has given expert evidence on numerous occasions. Professor Goldney provided an independent expert overview of Ms McKenzie's management during her hospitalisation at the Port Augusta Hospital. I regarded Professor Goldney as an expert in the field of psychiatry and in the management of suicide risk.

[67] Transcript, page 818
[68] Transcript, page 811
[69] Transcript, page 818

6.2. Professor Goldney provided a written report to the Inquest[70] and gave oral evidence at considerable length.

6.3. Professor Goldney commented on several matters connected with Ms McKenzie's presentation and management. Professor Goldney believed in essence that Ms McKenzie's mental health assessment on the morning of 12 March 2013 had been inadequate and superficial and that she was in reality detainable pursuant to the Mental Health Act 2009. Professor Goldney was of the view that Ms McKenzie would have benefited from a period of further admission at the Port Augusta Hospital and that her discharge was premature. He said that the threat of detention and transfer to Adelaide could have been used as a lever to get Ms McKenzie to remain in hospital.

6.4. In his oral evidence Professor Goldney indicated that in his opinion Dr Sivasuthan's approach on 11 March 2013 to the question of hospitalisation and possible detention was reasonable. It will be remembered that Dr Sivasuthan's approach was, if I understood it correctly, that Ms McKenzie should be detained by SAPOL should she leave the hospital. Dr Sivasuthan's principal clinical objective was to treat the paracetamol overdose by way of the NAC protocol. In the event Ms McKenzie did remain willingly while this treatment was carried out. I agree with Professor Goldney that this medical practitioner's management strategy in all of the circumstances was appropriate.

6.5. Professor Goldney adversely commented on Dr Sivasuthan's prescription of olanzapine which he described as a major tranquiliser. Professor Goldney believed that there were other more suitable means by which Ms McKenzie could have been sedated. Professor Goldney was of the view that the residual effects of the olanzapine may have compromised Ms McKenzie's mental health assessment the following morning. As well, it had to be remembered that the reason for Ms McKenzie's original presentation was an overdose of medication including temazepam which is also a sedative. However, in his evidence Dr Sivasuthan suggested that psychiatric opinion in the possession of the hospital was to the effect that olanzapine was a suitable tranquiliser to be prescribed to a patient in Ms McKenzie's circumstances and that this was a routine measure at the Port Augusta Hospital. The nursing staff also seemed to suggest that this was the case. I do not know whether that is a completely accurate assessment of

[70] Exhibit C32

the situation, but accepting as I do that this may have been regarded as standard practice at this particular hospital I am not critical of Dr Sivasuthan in prescribing olanzapine. That said, I accept Professor Goldney's evidence that the practice is generally undesirable. I would also accept that there is an element of undesirability in a major tranquiliser such as this being routinely administered on a PRN basis at the discretion of nursing staff without a medical practitioner being consulted first.

6.6. Professor Goldney commented upon the significance of Ms McKenzie's overdose on 11 March 2013 and the manner in which the overdose, coupled with the notes that she had written, should have been viewed. Professor Goldney told the Court that when assessing a person's suicidal intent there is significance in the fact that the person has taken the entirety of a supply of medication that they have in their possession, in this case the temazepam. He said in general terms the more tablets a person takes the greater the lethality and intent associated with the attempt. As to the question of Ms McKenzie's statement that she really just wanted to sleep and not die, Professor Goldney suggested that this was a very common response by patients and was frequently associated with a dangerous mindset whereby the person did not care whether they woke up or not[71]. I would observe here that the layman would probably equate such a state of mind with an intent to end one's life. As to the compilation of the notes by Ms McKenzie, Professor Goldney noted that on her presentation to the Port Augusta Hospital she had a Glasgow Coma Scale that moved from 14 to the maximum of 15 which suggested that she may have been intact and lucid. This in turn tended to suggest that any claims of amnesia in relation to the notes could possibly be discounted. Professor Goldney suggested that the type and amount of medication that Ms McKenzie had taken would not be expected to result in amnesia of that kind. Professor Goldney agreed that the note as to Ms McKenzie's preferred funeral arrangements indicated that she contemplated her own death[72], and that when one married up those denials with the patient's strong desire to leave the hospital, one may have come to the conclusion that the assertion that she did not remember writing the notes was disingenuous[73]. He suggested that in a sense this was the most logical and simplest explanation. It will be remembered that Dr Nwachuku in his evidence had suggested doctors were trained to believe the patient. Professor Goldney agreed that

[71] Transcript, page 943
[72] Transcript, page 1000
[73] Transcript, page 942

this approach needed to be modified in the context of a person who is desperately wanting to leave a hospital and desperately trying to avoid detention under the Mental Health Act 2009[74]. Professor Goldney said:

> 'Because I mean it's all very well saying you believe the patient, does that mean he's not believing what the patient wrote.' [75]

Professor Goldney was unimpressed by the fact that Ms McKenzie's assertion that she had no recollection of writing the notes went unchallenged[76].

6.7. I accepted Professor Goldney's evidence on that issue and preferred it to any evidence to the contrary. The fact of the matter was that the overdose was regarded as an attempt on the part of Ms McKenzie to take her own life. The fact that she said that she did not remember writing the notes was neither here nor there. There is no doubt that she wrote the notes. There is no doubt that when she wrote them she contemplated her own death which, when examined in conjunction with the potential lethality of the overdose, indicated that she was suicidal.

6.8. Professor Goldney was naturally asked to comment upon the relevance if any of Ms McKenzie's previous overdoses. He said:

> 'It's the best indication of somebody who ultimately may take their life.' [77]

He commented upon the separation summaries from the Women's and Children's Hospital relating to the two episodes in 2008. He suggested that it was significant that these previous episodes had required detention. The episodes had indicated that when Ms McKenzie became distressed she became very distressed, although the gap of a number of years since these events tended to suggest that she had been coping in the meantime. He agreed with Mr Charles of counsel for Ms McKenzie's family that there was an element of consistency between what had been noted in 2008 about Ms McKenzie's behaviour and her then reaction to the mental health system on the one hand and on the other with what then occurred in 2013. Professor Goldney agreed that it was very analogous[78]. All that said, Professor Goldney suggested that although it would have helped Dr Nwachuku to have entered into discussions with Ms Norton about the 2008 material, it would not have been necessary information for him to have

[74] Transcript, page 942
[75] Transcript, page 942
[76] Transcript, page 987
[77] Transcript, page 934
[78] Transcript, page 965

had in order for him to have acted differently. I took this observation to mean that there was enough to suggest that Ms McKenzie was acutely in serious difficulty even ignoring her previous history.

6.9. Professor Goldney was also asked to comment upon the relevance if any of the concurrent involvement that Ms McKenzie had with the police. This topic was enmeshed in some ways with the description of Ms McKenzie's plight as a '*situational crisis*'. It will be remembered that this is how Ms Norton characterised Ms McKenzie's situation. Professor Goldney viewed the police matter as an ongoing stressor that Ms McKenzie had no control over[79]. Professor Goldney suggested that the knowledge that the three men had been granted bail was a matter that would have terrified her. He suggested that this probably would have influenced her decision to take her own life even if she was not able to articulate all that in her own mind[80]. He also suggested that it appeared that there had not been many questions asked within the hospital about the nature of Ms McKenzie's predicament[81] and that this may have engendered in Ms McKenzie's mind the thought that they did not care about her and that the only solution for her was the solution that she had resorted to when she originally took the overdose[82]. This may have engendered in her mind a feeling of abandonment and have re-awakened her other abandonment. Cross-examined about the fact that there was no threat to her personal safety while the three men remained in custody, Professor Goldney suggested that there may have been an anticipatory stressor in that in her mind perhaps they were going to be released after all[83]. Professor Goldney was of a very firm view that it was not adequate to have characterised Ms McKenzie's predicament as a situational crisis or that her behaviour had been a situation reaction[84]. It was necessary for there to have been an exploration of whether the situational crisis had passed or not, or whether it might still act upon Ms McKenzie. On this Professor Goldney said:

> 'Yes, because if you are going back into the same environment with the same stressor, you are almost likely to end up the same way, unless you have carefully discussed what alternatives do you have to this behaviour, and if you discuss that and you have got safeguards in place you might - I mean there are some situations you can't do anything

[79] Transcript, page 961
[80] Transcript, page 961
[81] Transcript, page 962
[82] Transcript, page 962
[83] Transcript, page 979
[84] Transcript, page 946

about, but at the very least you've got to explore them to see whether or not they can be influenced.' [85]

6.10. I accepted Professor Goldney's evidence on this topic without any hesitation. Even if Ms McKenzie's predicament could be termed a situational crisis, it was clear that the crisis had not passed. There was also potential for the crisis to escalate in that things for Ms McKenzie could have become worse were Shane Woods to have been released on bail. To my mind one would not have to be a mental health nurse or a psychiatrist to draw such a conclusion.

6.11. Professor Goldney also stressed the importance of the obtaining of collateral information about a patient, a matter that has been stressed in the literature and in many coronial Inquests in the past. Firstly, Professor Goldney suggested that there is no ethical or other basis to prevent a mental health nurse from collecting information about a patient. He acknowledged that there may be certain circumstances where there would be a difficulty if permission was withheld by the patient. However, he said that it would be almost mandatory to seek information from a parent, a sibling or a husband and he would not view this as breaching confidentiality. He cited as an example the situation at hand with Ms McKenzie, namely her living with an aunt or uncle, in which case he would suggest that it would be mandatory to seek information from such a source[86]. I would observe that in this case an inquiry of Dorothy McKenzie would have revealed the extent of Ms McKenzie's anxiety and guilt in respect of her having informed on her partner Shane Woods, both of which were at significant levels. It would also have elicited Ms McKenzie's prior history.

6.12. Professor Goldney commented upon the assessment conducted by Ms Reid. He regarded it as a well-documented assessment. To him it seemed to constitute a reasonably comprehensive mental state examination. As to the question of moderate risk as identified by Ms Reid, Professor Goldney suggested that this was a contentious area as clinicians are not very good at predicting risk. However, moderate meant that it was more than low and that in a clinical situation it was grounds for concern[87]. In this context he suggested that every patient who takes an overdose should be taken seriously. Professor Goldney found it difficult to reconcile Ms Reid's assessment with that of Ms Norton, other than by the fact that people's mental states can fluctuate. But

[85] Transcript, page 947
[86] Transcript, page 945
[87] Transcript, page 934

this in itself would constitute a significant finding in that one would question why a person's mental state should fluctuate in such a short period of time. Ms Norton's assessment did not seem congruent with the report of Ms Reid. Professor Goldney went on to suggest that the fact that Ms Norton's assessment differed from Ms Reid's meant that it warranted some explanation, particularly having regard to the fact that Dr Nwachuku relied on Ms Norton's assessment. Ideally it would have been desirable for Dr Nwachuku to have known of Ms Reid's assessment as well[88]. I accept Dr Nwachuku's evidence that he knew nothing of Ms Reid's assessment.

6.13. As to Ms Norton's assessment, Professor Goldney was quite critical of it. He suggested that it was superficial and inadequate. He suggested that this was exemplified by Ms Norton not asking questions about the patient's possible use of alcohol, not asking questions about whether there were biological features of depression, not adequately enquiring about past psychiatric history and her insistence that it was her practice not to interview friends or relatives[89]. I have already mentioned Professor Goldney's views about the way in which Ms McKenzie's plight was regarded as a mere situational crisis. Professor Goldney also thought there was inconsistency between Ms Norton's description of Ms McKenzie as cooperative and Ms McKenzie's claims that she could not remember writing the suicide notes. The inadequacy of the assessment was also illustrated by the fact that Ms McKenzie's denials of previous suicide attempts were not but should have been regarded as 'red flags'[90]. I have already commented on the fact that these demonstrably false denials would have made one significantly sceptical of anything that Ms McKenzie said, thereby adding to the impression that Ms McKenzie would be prepared to say almost anything to secure her discharge from the hospital.

6.14. Professor Goldney suggested that Ms Norton's telephone communication with Dr Nwachuku was also inadequate because Ms Norton did not have sufficient information to provide to the doctor. He exemplified this by reference to the fact that nothing had been explored about the biological features of depression, about the possible influence of the olanzapine, about the importance of the suicide note and about

[88] Transcript, page 970
[89] Transcript, page 997
[90] Transcript, page 998

the issue of the patient not acknowledging having written the notes, which appeared to have been taken at face value without considering other possibilities.

6.15. As to Dr Nwachuku's involvement, or lack of it, Professor Goldney raised a number of concerns. Ideally there should have been a verbal handover between the two medical practitioners, Dr Sivasuthan and Dr Nwachuku[91]. He believed that Dr Nwachuku should have woken Ms McKenzie in the morning. Not to have done so meant in essence that he had not assessed Ms McKenzie for himself but instead had placed total reliance on what a mental health nurse had said. If he had woken her he could have asked pertinent questions of Ms McKenzie. Professor Goldney suggested that there was no substitute for actually seeing the patient. That said, Professor Goldney suggested that in a country region where there are no fulltime medical staff, as a matter of expediency one might have to accept the scenario that unfolded between Ms Norton and Dr Nwachuku. He suggested he would not automatically be critical of such a scenario[92]. Professor Goldney also suggested that the administration of the olanzapine should have alerted Dr Nwachuku to ask more questions of Ms Norton and have been more concerned about the detail of information that he was obtaining from her[93]. He suggested, for example, that he should have enquired as to whether or not Ms McKenzie exhibited biological features of depression and assessed whether, depending on the answer, antidepressants should have been prescribed. He would need to see the patient for himself in those circumstances[94]. Professor Goldney agreed with the proposition that a decision to discharge a patient cannot be deferred to the mental health nurse and that the medical practitioner has to make that decision. This imposed an obligation on the doctor to be confident that what he or she is being told is complete and reliable[95]. This scenario had to be seen in the context of a place like Port Augusta where there is no resident or in-house psychiatrist or psychiatric registrar and where one has to rely on the services of general practitioners who may have various levels of skill in mental health assessment. However, Professor Goldney reminded the Court that there are such things as tele-psychiatry and that Country Health enjoys a good reputation for the use of tele-psychiatry. There was really no explanation in this case as to why that service

[91] Transcript, page 924
[92] Transcript, page 926
[93] Transcript, pages 985-986
[94] Transcript, page 986
[95] Transcript, page 1016

was not considered or used. It seems to the Court that this would have been the obvious action to take.

6.16. Professor Goldney was of the firm view that Ms McKenzie had not been kept in hospital long enough[96]. He suggested that she was still sedated by the olanzapine. The people who assessed her did not know her. There had been no enquiry about alcohol and binge drinking. There was no detailed inquiry about the overdose and clinical staff did not know what was really going on with Ms McKenzie. Having regard to her strong desire to leave the hospital, Professor Goldney said that one way of overcoming that was simply to have said to her that it would be better for her to stay in hospital for some days rather than having to be transported to Adelaide under detention. He believed that such a ploy would have had a very powerful impact upon her. Professor Goldney believed that in any event Ms McKenzie was detainable pursuant to the Mental Health Act 2009[97]. I accepted Professor Goldney's evidence that one could have brought Ms McKenzie's situation within the requirements of the Mental Health Act 2009. As to the suggestion that detention must be reviewed as a '*last resort*', Professor Goldney had this to say:

> 'Not really because I mean it is a last resort, I mean, it's more work to detain somebody than not. I mean it really is the easy way out to let people go so it involves extra work so it is a last resort and no-one really likes doing it. And very often, with examples like this person, if one really asserted that 'Look, you know, you have to stay', I strongly suspect that she would have stayed. ' [98]

6.17. Professor Goldney suggested that the prospect of detention and inevitable transfer to Adelaide should not deter clinicians. Regardless of whether patients are in Port Augusta or the city they should receive the same treatment. He believes that detention should not be seen as a punitive measure[99].

6.18. I accepted Professor Goldney's evidence in its entirety. On the basis of that evidence I concluded that Ms McKenzie had been discharged from the Port Augusta Hospital prematurely and that every effort should have been made to keep her in hospital even if that had amounted to detention under the Mental Health Act 2009.

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[96] Transcript, page 950
[97] Transcript, page 951
[98] Transcript, page 1008
[99] Transcript, pages 1009-1010

7. Events following Ms McKenzie's discharge from hospital

7.1. The Port Augusta Hospital progress notes record that Ms McKenzie was discharged with a family member at 10:50am on 12 March 2013. The family member is not identified either by gender, name or description. Mr Zaaheer McKenzie told the Court that by pure chance he saw Ms McKenzie in the hospital carpark and that she was on her own at that stage. She had just been discharged.

7.2. The events of that afternoon do not require detailed discussion except to the extent that efforts were made to notify Ms McKenzie that her ex-partner Shane Woods had been released on bail. Ultimately a police officer left a message on Ms McKenzie's phone to that effect. No other attempt was made by a member of the FVIS or the Port Augusta CIB to contact Ms McKenzie. A chain of emails that involved a number of police officers occurred during the course of that afternoon and early evening about the question of bail and Ms McKenzie being notified about the same. I accept Brevet Sergeant Holdrich's evidence that she did not see any email to the effect that bail had been granted until the following morning, by which time Ms McKenzie was deceased. At a time which I took to be after 6:16pm on 12 March 2013, which was the time at which an email was sent to Brevet Sergeant Holdrich about the matter, Ms Robyn McPherson who is an administrative services officer employed by SAPOL received a call from Ms McKenzie. Ms McPherson gave a statement to police on 16 September 2016. She also gave oral evidence in the Inquest. In her statement Ms McPherson said that she could not recall the time of the call nor its content. Other evidence suggested that Ms McPherson verbally informed Ms McKenzie that Shane Woods had made bail. I was curious to know from Ms McPherson what Ms McKenzie's demeanour was during this telephone conversation, and whether the content of the call concerned the fact that Shane Woods and others had received bail that afternoon. In her oral evidence Ms McPherson said that this may have been the topic of the conversation but she could not recall. I was curious to understand what Ms McKenzie's reaction may have been to information that Shane Woods in particular had been granted bail, but I accepted Ms McPherson's evidence on oath that she was unable to assist in this regard.

7.3. At some point during that day Ms McKenzie's son was conveyed to Leigh Creek to stay with Zaaheer McKenzie and his family. Ms McKenzie did not go with him.

7.4. Mrs Dorothy McKenzie's statement reveals that after Ms McKenzie had been released from hospital she and others met Ms McKenzie at Hungry Jacks. Ms McKenzie then went home. She had agreed that Zaaheer would take her son to Leigh Creek with him. That afternoon Ms McKenzie asked Dorothy McKenzie for money to buy Jack Daniels to calm her nerves. Dorothy McKenzie was reluctant at first but decided that if it relaxed Ms McKenzie she saw no particular harm in it. The Jack Daniels was purchased. Taliah Karena was with Ms McKenzie at that stage. Ms Karena also lives at Davenport. At 8 Ookara Street Ms McKenzie and Ms Karena consumed the Jack Daniels.

7.5. At one point Ms McKenzie phoned a Maoriella Stuart[100]. The time was about 7:40pm. Ms McKenzie brought some cans of Jack Daniels with her to Ms Stuart's premises. They went to Ms Stuart's room. It appeared to Ms Stuart that Ms McKenzie was in a good mood. However, Ms McKenzie told Ms Stuart that she was worried because Shane Woods had been released on bail and she did not know how this had happened. According to Ms Stuart Ms McKenzie could not get her head around it, especially since he had broken his probation. Ms McKenzie expressed concern that she hoped Shane Woods would not look for her son. She expected him to try and telephone for the boy. Ms McKenzie also expressed concern that Matthew Woods might come out to Davenport but she seemed to derive some comfort from the fact that she had been told that the bail conditions precluded their presence at that location. Ms Stuart reassured Ms McKenzie that they probably would not come out to Davenport and suggested that Ms McKenzie had done the right thing by her son. To this Ms McKenzie had said that she knew that she had done the right thing by her son because she did not want him living that type of lifestyle. She said that she was going to be strong for the boy. Ultimately Ms McKenzie left and as she did she said that she was becoming paranoid about the '*Woods Mob*' possibly waiting over the road in the sand hills. Later she and Ms McKenzie exchanged text messages and Facebook posts. In one message Ms McKenzie said that she was '*wasted*'. In one Facebook post Ms McKenzie made reference to Mike Tyson merchandise that she had in her possession and whether anybody wanted any. This was a reference to property belonging to Shane Woods. Ms McKenzie was threatening to dispose of it. Ms Stuart also detected another Facebook post from Ms McKenzie timed at 10:44pm which she believed was a

[100] Exhibit C7a

reference to Ms McKenzie announcing to Shane Woods, and also presumably the world at large, that he no longer had her family's support.

7.6. Later at 8 Ookara Street Ms McKenzie told Ms Karena that someone was calling her phone and was swearing and threatening her. She said that the caller was a male person and that his name was Jake or something similar. Ms Karena states that while Ms Karena was with Ms McKenzie she became aware that Ms McKenzie received a number of these calls to which Ms McKenzie responded by hanging up. According to Ms Karena, Ms McKenzie rang the Port Augusta police station and told police that she was receiving threatening phone calls.

7.7. Constable Adam Meyer was the officer who received that call. Constable Meyer made a statement[101] and gave oral evidence at the Inquest. That evening Constable Meyer was performing uniform station duties at the Port Augusta police station. His duties involved answering the telephone, manning the radio and attending to front counter enquiries. He had become aware of the court outcomes for the Woods brothers and Finlay. He had rung the mobile phone of Ms McKenzie and left a message identifying himself and advising that Shane Woods had been released on bail. According to Constable Meyer, at some point Ms McPherson, the ASO, had advised him that Ms McKenzie had called and had been informed of Shane Woods' release. It appears that after Ms McKenzie had received the message from Meyer, she phoned the police station and received verbal confirmation from Ms McPherson. Hence my desire to ascertain what Ms McKenzie's immediate reaction had been. As seen, Ms McPherson could not recollect. There is no question but that the preferable course would have been for a CIB member or Ms Holdrich to have broken that news to Ms McKenzie and to have discussed with her what she wanted to do, or indeed what she should do, in the light of that development. Contact with the CIB or Ms Holdrich may also have served to ensure that Ms McKenzie at least remained in a reasonable state of sobriety. It may also have served to have informed Ms McKenzie's parents of developments so as to have enabled them to maintain appropriate vigilance in relation to their daughter. There are other possibilities that may have altered the course of events. That said, there would have been no guarantee that when left alone Ms McKenzie was completely safe from her own possible actions.

[101] Exhibit C27

7.8. As things transpired any police communication with Ms McKenzie would have to be handled by Constable Meyer who knew very little about the underlying circumstances. This was a most unsatisfactory state of affairs. Later in Meyer's shift Ms McKenzie rang the police station and Meyer answered the call. Ms McKenzie advised Meyer that she had received a call from a private number and that an unknown voice had asked about the whereabouts of Shane Woods' child. She did not recognise the voice. Constable Meyer checked the current bail conditions for Shane Woods on PIMS and established that a condition of bail was that Shane Woods could not contact her. He asked Ms McKenzie whether she wanted him to contact Shane Woods to ensure that none of his associates were trying to cause problems for her. Ms McKenzie agreed. Constable Meyer then made contact with the person listed as Shane Woods' guarantor. This person was a Ms Footner. Constable Meyer informed Ms Footner of the phone calls that Ms McKenzie had received and explained that he was calling to ensure that Shane Woods was complying with his bail conditions and to confirm that none of his associates would try to cause any problems. Ms Footner advised that she would call Woods and remind him of his bail conditions.

7.9. Later that evening Ms Footner and Shane Woods attended at the front counter of the Port Augusta Police Station. Constable Meyer attended to them. They assured Meyer that Woods intended to honour his bail conditions, adding that there was an incentive for him to stay out of trouble as he had an imminent child access hearing. Shane Woods asserted that he had not phoned Ms McKenzie and that he had also told his associates not to. Ms Footner who was in possession of a tablet computer drew Constable Meyer's attention to Ms McKenzie's Facebook posting that suggested that she was intending to sell Shane Woods' Mike Tyson memorabilia. Another post that she showed Constable Meyer indicated that she had run out of alcoholic beverages. Footner and Woods then left the station.

7.10. Later Ms McKenzie again phoned the police station and spoke to Constable Meyer. Ms McKenzie stated that she had received further phone calls but they had not been threatening. Constable Meyer advised Ms McKenzie that he had spoken with Shane Woods and his guarantor and had reinforced in Woods' mind the bail conditions. He further explained that Woods had told him that he had instructed his close associates not to make contact with Ms McKenzie. Constable Meyer also discussed the Mike Tyson Facebook posting and suggested that it was not appropriate to offer to sell

someone else's property and that to do so would only antagonise and provoke Woods. There was further discussion about a car in respect of which Ms McKenzie threatened to cancel the registration in order to get Woods into trouble. She also threatened to put all of his stuff outside which Constable Meyer said to her was a bad idea. There was other discussion that included an acknowledgement by Ms McKenzie that she had been drinking that night. Ms McKenzie also asserted that Woods would attempt to buy her silence. She said that she had more information regarding Woods. She indicated at one point that she wanted to do the best for her son. She also suggested that if Woods came around to her house that night she would kill him and claim self-defence. Constable Meyer naturally discouraged this line of thinking. There was further discussion about a police patrol driving by her address. In his statement Constable Meyer described Ms McKenzie's conversation as rambling and repetitive. Constable Meyer told Ms McKenzie that she should call the police station in the morning to arrange for property to be exchanged. He ended the call.

7.11. Constable Meyer spoke to his Sergeant and it was decided that the discussions would be recorded in a journal. The CIB were not informed of these developments.

7.12. In his oral evidence Constable Meyer told the Court that Ms McKenzie did not sound distressed or emotional and did not raise any concerns about her own safety or the safety of her family. In addition, he said that it appeared that Ms Footner was doing her best to keep Woods out of further trouble.

7.13. In cross-examination Constable Meyer acknowledged that if he had further information about the McKenzie/Woods matters he may have elected to call Brevet Sergeant Holdrich. He added that there did not appear to him to be any urgency to take any specific action. He did not see the need for a patrol to actually attend at her address as distinct from merely driving by. It must be said that to Constable Meyer there would not have been any reason for him to think that Ms McKenzie was at risk of self-harm. Woods' and Footner's visit to the police station gave him a degree of comfort that Woods was taking the matter seriously. They had attended the police station of their own volition. Meyer believed that this had been done in an effort to reassure police that Woods had a full appreciation of the seriousness of his bail conditions. Importantly Meyer did not know that Ms McKenzie had been in hospital the night before. He did not know about any suicide notes that had been written or that Ms McKenzie had been the subject of an overdose. Asked whether he would have done things differently that

night if he had known of those matters, he said that he would have placed a tasking on the system to ensure that a patrol attended at her address and would even have considered police detention for an assessment by a medical practitioner. He told the Court that if he had had gained any indication that Ms McKenzie was contemplating self-harm he would have acted upon those indications.

7.14. Constable Meyer said that he had not understood that the phone calls received by McKenzie had actually been threatening phone calls, but believed that they had involved an inquiry as to the whereabouts of Shane Woods' child. If he had been told that the phone calls were of a threatening nature he would have sent a patrol to McKenzie's address.

7.15. I accepted Constable Meyer's evidence. I am aware of the contents of the statement of Ms Karena that suggested that Ms McKenzie told police that she was receiving threatening phone calls. But I am also mindful of the fact that Ms Karena and Ms McKenzie had been drinking alcohol, in Ms McKenzie's case clearly to excess. I prefer Constable Meyer's account of the telephone conversation. I note that within the journal entry that Constable Meyer compiled in respect of his longer telephone conversation with Ms McKenzie that there is no mention of Ms McKenzie receiving threatening calls. The entry states that Ms McKenzie had advised that she was receiving phone calls asking for '*Shane's kid*'. This is consistent with Meyer's version of the phone conversation.

7.16. Having regard to the state of Constable Meyer's information about the McKenzie/Woods situation I do not believe there is any criticism to be levelled at him in respect of the manner in which he handled the matter. It would have been better if Constable Meyer had been fully briefed about the whole matter of Ms McKenzie and Shane Woods rather than to have allowed him to be stranded by a chain of uninformative emails.

7.17. Ms Karena's statement indicates that she left Ms McKenzie's residence at about 11:30pm. At that point Ms McKenzie was in a good mood but looked tired. She said she was going to bed. At no time did Ms McKenzie indicate to Ms Karena that she wanted to hurt herself. After Ms Karena herself arrived home she called Ms McKenzie on a number of occasions but she did not receive any answer.

7.18. It is evident that after Ms Karena left Ms McKenzie's premises Ms McKenzie serially attempted to communicate with Shane Woods by phone either by calling him or texting him. The statement of Detective Brevet Sergeant Jeffrey Spry of the Whyalla CIB who investigated this matter sets out the efforts that Ms McKenzie made to communicate with Shane Woods. What is known is that at 8:19pm a message had been sent from Ms McKenzie's phone service to a number recorded in her contact list as Shane. This number was used by Woods at the time. The message was not responded to. There were further attempts by Ms McKenzie to contact Shane Woods by phone late in the evening. These attempts were also not responded to by Woods. There were further attempts after midnight. A final SMS was sent to Woods some time before 1am on 13 March 2013. This was the last outgoing communication from Ms McKenzie's service. It was not responded to. She later hanged herself.

7.19. The time at which Ms McKenzie took her own life is not known with complete certainty.

8. Was Deborah McKenzie's death preventable?

8.1. This is a very difficult matter to determine.

8.2. It is obvious that Ms McKenzie was deeply conflicted about her having informed on Shane Woods. She had expressed regret about that, at least partially based on the effect that Woods' latest custody would have on her young boy. She also must have realised that even if Shane Woods were to be granted bail in all of the circumstances it would be difficult for Woods to conduct any meaningful relationship with the boy. It is significant that in that frame of mind Ms McKenzie took the overdose and wrote notes which strongly suggested that the overdose was an attempt to take her own life. Many if not all of those same pressures existed at the time that she made the successful attempt on her own life in the early hours of the morning of Wednesday 13 March 2013.

8.3. Also requiring consideration is the fact that in the past Ms McKenzie had taken overdoses, albeit several years previously.

8.4. I have found that meaningful intervention by the FVIS should have occurred much earlier than Tuesday 12 March 2013 when Brevet Sergeant Holdrich telephoned Ms McKenzie and spoke to her for the first and only time. That said, it was not Brevet Sergeant Holdrich's fault that she was not working on the Sunday or the Monday.

Ms McKenzie's first statement as given to Detective Sergeant Roberts was not given until the Saturday evening by which time Brevet Sergeant Holdrich had concluded her duties. However, intervention by the FVIS after Saturday 9 March 2013 may not have made any appreciable difference to Ms McKenzie's circumstances, particularly having regard to the fact that when spoken to by officers Jonker and Van Heer on Sunday 10 March 2013 she had shown the same determination not to leave Port Augusta. She would maintain that same resolve even on Tuesday 12 March 2013 when spoken to by Brevet Sergeant Holdrich. Ms McKenzie appears to have consistently demonstrated strong resistance to police assistance.

8.5. There is no question but that police should have been aware of Ms McKenzie's circumstances on 11 and 12 March 2013 and in particular have been aware of the fact that she had taken an overdose of medication in circumstances that suggested she was intent on taking her own life. It will be remembered that Brevet Sergeant Holdrich suggested that her approach would have been different had she herself known about that. What action that she may have taken to have prevented any further attempt by Ms McKenzie on her own life is not completely clear.

8.6. All that said, to my mind what is reasonably clear is that if Shane Woods had been kept in custody at least overnight on 12 and 13 March 2013 pending a Supreme Court bail review, her attempted telephone and Facebook interaction with Shane Woods that she embarked upon during the night of her death probably would not have occurred. She attempted to contact him by way of phone and text message. She also posted material on the internet about Shane Woods and in particular posted an item about his property and made threats that she would dispose of it. I infer that Ms McKenzie's intent and expectation was that Shane Woods would see and read that post. It was in fact drawn to his attention. Her motivation in doing this may well have been stimulated by the effects of alcohol. If Shane Woods had been kept in custody as he should have been that night, it is unlikely that Ms McKenzie would have made the rebuffed attempts to contact him. In his written submission Mr Charles for the McKenzie family points out that Professor Goldney expressed the view that Ms McKenzie's conduct in attempting to contact Shane Woods that night was consistent with her distressed mental state upon her release from hospital. She was affected by alcohol and had no doubt become disinhibited and reverted and regressed into the burden of her unresolved emotions. The point is well made.

8.7. Ms McKenzie's death may have been prevented if the following had occurred:

- If Shane Woods had been kept in custody as he should have been, thereby removing another significant stressor on Ms McKenzie;
- If police had known of Ms McKenzie's overdose and hospitalisation overnight on 11 and 12 March which would have provided them with added impetus to scrutinise Ms McKenzie's subsequent behaviour more closely;
- Greater pressure, and earlier pressure, had been placed upon Ms McKenzie to accompany her son to Leigh Creek to stay with her brother Zaaheer. It was unfortunate that her connection with Zaaheer McKenzie, a responsible member of the police force, was not appreciated in terms of the assistance that this could have provided. Zaaheer McKenzie may well have had greater success in persuading Ms McKenzie to accompany him to Leigh Creek. If Mr and Mrs McKenzie had known that it was the desire of police that Ms McKenzie go to Leigh Creek, they also may have been a persuasive influence. That said, Ms McKenzie may still have resisted all meaningful assistance;
- If uniform staff at the Port Augusta police station, in particular Constable Meyer, had been fully briefed about the McKenzie/Shane Woods situation, including the fact that Ms McKenzie had been hospitalised with a drug overdose, in which case Constable Meyer, on the night of Ms McKenzie's death, probably would have sent a patrol to visit Ms McKenzie at Ookara Street, Davenport as distinct from sending a patrol simply to drive by. In addition, it is possible that Constable Meyer would have contacted the members of the CIB with the same purpose in mind.

8.8. In his report Professor Goldney acknowledged that even if a full and proper assessment of Ms McKenzie had occurred at the Port Augusta Hospital it may not have led to management which necessarily would have prevented her death. In his oral evidence he expanded upon that opinion. He said:

> 'I suppose the simplest way of putting it is that we just don't succeed in every patient and that we can't, even with the best will of the world and the best cooperation, there are some patients who will take their own lives. So even if one had, you know, assessed her fully, one can't say that in the longer term she wouldn't have taken her life. What one can say is that if she had been detained it's more likely than not that she wouldn't have taken her life

> in the next couple of days, but even then, you know, she may have taken her own life within a hospital setting if she had been forced to stay.' [102]

It will be remembered that in his evidence Professor Goldney expressed the firm view that Ms McKenzie should have been kept in the Port Augusta Hospital longer than she was, even to the point of detention under the Mental Health Act 2009. It is also worth noting that had she been detained under the Mental Health Act 2009 it is highly likely that she would have been transferred to a tertiary hospital in Adelaide for that purpose. The chain of events that led to her death would clearly have been significantly altered had that occurred. In my view Ms McKenzie's death on 13 March would have been prevented if she had been stopped, by whatever means, from leaving the Port Augusta Hospital. Whether this would have prevented her death in the long run cannot be known with complete certainty.

9. Conclusions

9.1. The Court reached the following conclusions:

a) Deborah McKenzie hanged herself in the early hours of the morning of Wednesday 13 March 2013. No other person was involved in that act. I find that in spite of her significant level of intoxication Ms McKenzie intended to take her own life;

b) In the days preceding her death Ms McKenzie had furnished information to Port Augusta police about alleged criminal activity committed by her partner, Shane Woods, and his associates. In addition, she made statements to police that included reference to an alleged assault upon her by Shane Woods that had occurred in the presence of her son, and of alleged threats made by Shane Woods' brother, Matthew Woods. The alleged threats by Matthew Woods could be connected to the fact that Shane Woods had been arrested by Port Augusta police for alleged offences based on the information given to police by Ms McKenzie;

c) Following the provision of information to police, Ms McKenzie began to entertain serious reservations about what she had done. She was concerned about the effect that Shane Woods' re-incarceration might have on their young son;

[102] Transcript, page 1017

d) I find that Port Augusta police advised Ms McKenzie that she should consider leaving Port Augusta. This suggestion was made to her on Sunday 10 March 2013 and again on Tuesday 12 March 2013. Ms McKenzie flatly refused. Her reason for refusing this was the concern that she entertained for her parents who resided in the Davenport Community at Port Augusta. Ultimately Ms McKenzie agreed to send her son to Leigh Creek to stay with her brother, Zaaheer McKenzie, a police officer;

e) On Monday 11 March 2013 Ms McKenzie took an overdose of medication. It is apparent that Ms McKenzie consumed everything that she had available to her. Ms McKenzie also wrote notes that strongly suggested that when she took the overdose she contemplated her own death. I find that when Ms McKenzie took this overdose she intended to take her own life. Ms McKenzie was subsequently taken by members of her family to the Port Augusta Hospital where she was admitted;

f) On 11 March 2013 Ms McKenzie was treated in the Port Augusta Hospital for toxicity of paracetamol that she had taken in conjunction with the overdose of other medication including temazepam and tramadol. The focus of Ms McKenzie's treatment at that time was to treat the paracetamol overdose. In my view Ms McKenzie could have been detained pursuant to the Mental Health Act 2009 on this day having regard to the lethality of the action that she had taken and to her clear intent in respect of that action. She was not detained. I find that Dr Sivasuthan had given instructions to the effect that Ms McKenzie should be detained should she attempt to leave that day. In the event Ms McKenzie agreed to be admitted to the hospital and to stay overnight;

g) Ms McKenzie was successfully treated for the overdose of medication, in particular for the paracetamol overdose;

h) On Tuesday 12 March 2013 Ms McKenzie was reviewed by a mental health nurse. I find that the review was superficial and inadequate. Ms McKenzie exhibited a determination to be discharged from the hospital that morning. I find that naïve credence was given to assertions by Ms McKenzie that she had not intended to end her life by way of the overdose, that she had no recollection of writing the notes that she had written in conjunction with that overdose and that she had not attempted to take her own life in the past. All of these matters were demonstrably incorrect

and should have been regarded as such. Her plight was regarded as a situational crisis. This was incorrect. In any event whatever situational crisis there was had not passed. No proper and complete exploration was made of Ms McKenzie's current circumstances and of the matters operating on her mind. Ms McKenzie should not have been released from the hospital on Tuesday 12 March 2013. If necessary, Ms McKenzie should have been detained pursuant to section 21 of the Mental Health Act 2009;

i) On Tuesday 12 March 2013 Ms McKenzie was not seen awake by a medical practitioner. The only clinical staff who saw Ms McKenzie while she was awake were the nursing staff. This was a wholly inadequate management strategy. Dr Igwe Nwachuku in particular should have examined Ms McKenzie for himself. He was given an inadequate briefing over the telephone by nursing staff in relation to Ms McKenzie's status. As a result of that he agreed that Ms McKenzie should be discharged. This was an error;

j) Port Augusta police had contact with Ms McKenzie in connection with the information that she had provided to them on Saturday 9 March and Sunday 10 March 2013. I know of no further communication between police and Ms McKenzie until Tuesday 12 March 2013 when she was spoken to by Brevet Sergeant Holdrich of the Family Violence Investigation Section. This contact should have occurred earlier when the high risk that was posed to Ms McKenzie was identified. Whether earlier intervention by the FVIS would have made any difference cannot be known with complete certainty;

k) I find that Ms McKenzie was deeply concerned by the prospect that Shane Woods, Hamish Finlay and Matthew Woods would obtain bail and be released from custody. On Tuesday afternoon 12 March 2013 all three individuals were released on bail pursuant to orders made by the Port Augusta Magistrates Court. The bail procedures that afternoon miscarried in that important matters of fact and law were not drawn to the court's attention. In addition, advice and directions given by the DPP that a Supreme Court bail review should be instigated in relation to Shane Woods and Hamish Finlay were ignored. As a result bail reviews were not immediately indicated in relation to Shane Woods and Hamish Finlay and they were released. No review was indicated in relation to the matter of Matthew Woods and he also was released. If bail reviews had immediately been indicated, none of the

three individuals would have been released on 12 March 2013. The reason the bail procedures miscarried was that the prosecutor did not read the relevant paperwork. The amount of time that the prosecutor had to prepare for the bail applications was inadequate. The briefing by his superior was also inadequate;

l) I find that Ms McKenzie became deeply concerned when she learned that the three individuals, in particular Shane Woods, had been released on bail. That night Ms McKenzie consumed a significant amount of alcohol and was intoxicated. She posted Facebook entries in relation to Shane Woods that were probably calculated to aggravate the situation between them. She attempted to contact Shane Woods by telephone, both by way of calls and text messages. These were not responded to by Shane Woods. It is highly unlikely that Ms McKenzie would have attempted to contact Shane Woods if Woods had been kept in custody as he should have been;

m) When Ms McKenzie took her own life there were many negative factors operating on her mind. They included a measure of guilt as a result of her having informed on her partner Shane Woods, the effect that Shane Woods' ensuing prosecution and her role in it, and Woods' possible re-incarceration, would have on their son, concern on her part that her son might be lured away by Shane Woods, concern on her part that her parents' premises might be approached by Shane Woods and/or his associates, her intoxication on the night in question and her unsuccessful attempts to contact Shane Woods during the course of that night;

n) As to whether Ms McKenzie's death could have been prevented, paragraphs 8.7. and 8.8. herein are repeated.

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.

10.2. In his oral evidence before the Court Dr Nwachuku suggested that there are a number of matters connected with the issue of suicidality in patients presenting in a country hospital that are ripe for change. Dr Nwachuku also wrote a letter to the Court dated 10 October 2016 that identified other possible areas for change. Mr Charles, on behalf

of Mr Malcolm McKenzie, responded to that letter by way of his letter dated 16 November 2016.

10.3. I have given careful consideration to the suggestions that have been made. In his oral evidence Dr Nwachuku told the Court that in his view the situation in regional and country hospitals is not ideal. Firstly, there is no fully functional psychiatry department or unit that has consultant psychiatrists, registrars and mental health nurses attached to it. At the Port Augusta Hospital the void was filled by general practitioners and mental health liaison nurses. So the robust assessment one would normally expect in an ideal world was somewhat defeated by '*the practicalities on the ground in a regional hospital in South Australia*'[103]. Counsel for Country Health SA, Local Health Network and the Commissioner of Police, Ms Moloney, indicated to the Court that since these events the Whyalla Hospital has been designated as a treatment centre for the purposes of the Mental Health Act 2009. I understand it is now an approved treatment centre. The mental health inpatient unit at that hospital opened with six beds and is said to constitute an option for Port Augusta Hospital to treat mental health patients closer to home. I know nothing of the clinical staffing arrangements at that unit.

10.4. In his oral evidence Dr Nwachuku identified a number of areas for improvement. They include the need for face-to-face or at least phone handovers between general practitioners in respect of patients admitted in the hospital with a mental health issue. He also identified the importance of collateral information being obtained in relation to patients admitted with mental health issues. I would add that this issue has been the subject of much literature and coronial commentary in the past. Dr Nwachuku suggested that his experience at Port Augusta was that collateral information about a patient was collected as far as was possible and that there was usually an effort to reach out to family members. However, to his knowledge there was no dedicated person within the hospital who could undertake that responsibility as part of their actual duties. The third matter that Dr Nwachuku identified was a need for a patient admitted with a mental health diagnosis to be reviewed by a doctor or even a psychiatrist prior to a patient's discharge from hospital. He said that he believed that a doctor should see all patients who present with mental health issues, but that not all of them necessarily need to be reviewed by a consultant psychiatrist. He suggested that one way of bridging the deficiencies in Port Augusta would be insistence that for any patient who is admitted

[103] Transcript, pages 770-771

following an attempted suicide prior to discharge, there should be input by a consultant psychiatrist regardless of however stable the patient may be at the time. That would have the benefit of providing expert opinion on the patient's presentation and would also remove the onerous responsibility from a general practitioner.

10.5. Dr Nwachuku's letter dated 10 October 2016 is entitled '***Suggestions for improvement in mental health services in Port Augusta***'. Dr Nwachuku has a two-pronged suggestion for improvement, firstly at the community level and secondly at the Port Augusta Hospital.

10.6. At the community level Dr Nwachuku suggests that the biggest challenge facing the community mental health team is their inability to retain staff for a substantial period of time. This is particularly relevant because the nature of mental health care is such that outcomes are often influenced by the ability of personnel to build rapport with patients over time. He referred to this state of affairs as a '*revolving door*'. He said that the same considerations also apply to Drug and Alcohol Services South Australia (DASSA). He believes that SA Health should look at ways of incentivising mental health workers to spend more time in regional areas. Dr Nwachuku makes other suggestions in relation to the improvement of community mental health services in the region. While acknowledging that Dr Nwachuku's ideas are helpful, community mental health care was not really the issue in this Inquest. I say no more about that issue.

10.7. At the hospital level Dr Nwachuku expresses the strong belief that the status of Port Augusta as a regional hub for many remote areas is such that it deserves a fully-fledged mental health team domiciled at the Port Augusta Hospital. This should be complete with consultant psychiatrists, registrars, mental health nurses and workers. This is essentially a repeat of what Dr Nwachuku submitted during the course of his oral evidence. He points out rightly that this would make for a more robust assessment of patients presenting with mental health issues and would also simplify the application of mandatory treatment orders when needed. It would obviate the difficulty that exists in respect of detained patients needing to be transferred to Adelaide for further assessment. As seen, there is a case for saying that Whyalla Hospital being designated as an approved treatment centre might mitigate that difficulty. Certainly, there is a great need for an improvement of mental health service delivery in that region.

10.8. Finally Dr Nwachuku suggests that it would be advisable to develop a new protocol for patients presenting with attempted suicide at the Port Augusta Hospital to guide general practitioners in management. One of the key facets of such a protocol would be that all such cases should be reviewed by a consultant psychiatrist prior to discharge, irrespective of how innocuous the attempt may be. This again is a repeat of what he said in his evidence. In his letter he added that such a review could be achieved by way of tele-psychiatry through the Rural and Remote Mental Health Service.

10.9. I refer to Mr Charles' letter for and on behalf of the McKenzie family. Much of what Mr Charles writes is to be viewed from the perspective of the indigenous community in that region. The letter points out that Aboriginal people tend to want to use Aboriginal services for very good reasons. Mr Charles states in his letter that his client Mr Malcolm McKenzie agrees that there is a need for the community mental health team in the region to be improved particularly in relation to its ability to retain staff. Mr McKenzie believes that active processes of consultation with the Aboriginal community and with Aboriginal community organisations is absolutely essential for the improvement of services. As far as hospital based services are concerned Mr Charles writes that Dr Nwachuku's views about this issue reinforce the contention that a properly resourced psychiatric unit is justified for Port Augusta Hospital and that the retention of good psychiatric staff is paramount. Mr McKenzie's observation is that competent staff are more likely to be retained if they feel a strong sense of connection to the community. Mr Charles advises that Mr McKenzie supports Dr Nwachuku in his specific proposal that a protocol for patients presenting with attempted suicide be promulgated such that they must be assessed and reviewed by a consultant psychiatrist prior to discharge, however innocuous the attempt may be.

10.10. I deal with the question of the interaction between South Australia Police and other entities such as SA Health in cases involving high risk of domestic abuse and violence. It will be remembered in this case that the Port Augusta police had no awareness of the fact that Ms McKenzie had been hospitalised in respect of a drug overdose or at all. Staff at the Port Augusta Hospital had a very limited understanding of the extent of Ms McKenzie's involvement with police over the March long weekend in 2013. It would be hoped, however, that the Multi-Agency Protection Service initiative would alleviate much of the difficulty that was experienced in this case having regard to the interagency communications that would be engendered in a case involving high risk.

However, I intend making a general recommendation that in cases of identified high risk of domestic violence or abuse, SAPOL should routinely ensure as far as is possible that they are kept informed of medical issues that may be experienced by the victim of domestic abuse or violence.

10.11. I intend making recommendations concerning the administration of olanzapine in situations such as those experienced in this case.

10.12. I also intend making certain recommendations in relation to police procedures involving arrest and bail of arrested persons.

10.13. The Court makes the following recommendations directed to the Commissioner of Police, the Chief Executive of SA Health, the Chief Executive of Country Health SA LHN, the Chief Psychiatrist and the Chief Executive Officer of the Australian College of Rural and Remote Medicine:

1) That a dedicated and properly staffed psychiatric unit be maintained in the Port Augusta region that has the capacity and lawful authority to accommodate, treat and if necessary detain patients who are at risk of suicide. The unit should be designated as an approved treatment centre pursuant to the Mental Health Act 2009. The unit should be staffed by at least one full-time and permanent consultant psychiatrist who is resident in the region and by at least one psychiatric registrar also resident in the region.

2) That all clinicians at regional hospitals, including general medical practitioners and nursing staff, be instructed to use tele-psychiatry services operated by the Rural and Remote Triage Service in relation to all patients who are suspected of being at risk of suicide or who have already made a suspected or actual suicide attempt.

3) That no patient who is suspected of being at risk of suicide or has made a suspected or actual suicide attempt should ever be discharged from a regional hospital without being reviewed and assessed by a medical practitioner. A psychiatrist's input should be sought, either in person or remotely, in relation to any proposed discharge.

4) That continuity of care for patients who are perceived to be at risk of suicide should at all times be maintained. Proper in-person handovers should take place as between one medical practitioner and another. Ideally the same practitioner should maintain care in relation to the patient.

5) The need to gather collateral and corroborative information relating to a patient who is at perceived risk of suicide should be reinforced in the minds of clinicians. The discharge of a patient should not occur until all necessary collateral information has been sought and provided.

6) That clinicians practising in regional hospitals, including medical practitioners and nursing staff, should assess with a critical mind a patient's denials of current suicidal intent and should consider the possibility that denials of important and critical circumstances may be engendered by a desire to be discharged from the hospital so as to enable the patient to act upon undisclosed or denied suicidal intent. In particular, denials of previous suicide attempts should be evaluated against the patient's documented medical history.

7) That the Port Augusta Hospital review its practices in relation to the prescription of the drug olanzapine as a means of sedation in cases where (a) there is no evidence of psychosis, (b) where there has been an actual or suspected overdose of other medication or substances, (c) where it may be necessary to carry out a mental health assessment and where the effects of olanzapine may still exist at the time of such assessment and (d) where there are other more suitable sedating medications available.

8) That the Commissioner of Police develop and establish a domestic violence protocol to cater for instances in which the complainant is also an informant in relation to other alleged criminal acts committed by the complainant's domestic partner. The protocol should deal with matters such as witness protection, the welfare of the complainant and bail. In cases of identified high risk to the complainant, SAPOL should, as far as is possible, routinely ensure that they are kept informed of medical issues that may be experienced by the complainant.

9) That the Commissioner of Police ensure that police prosecutors are made fully aware of their duties and responsibilities in connection with the issue of bail, particularly in cases involving alleged domestic violence. Education should be

delivered to prosecutors regarding section 10A of the Bail Act 1985 and in respect of the offences that enliven that provision. Prosecutors should be reminded that DPP advice should be read, properly understood, evaluated and strictly adhered to. In circumstances in which strong opposition is raised in relation to the granting of bail in a Magistrates Court, the immediate indication of a Supreme Court bail review should be considered as the default position to be taken.

10) That the Commissioner of Police ensure that in cases involving the prosecution of serious crime, the arresting or investigating officer, or that officer's properly briefed nominee, should attend court on any bail application that is opposed.

11) That the Commissioner of Police ensure that prosecution units in the Port Augusta/Whyalla region are properly staffed and that prosecutors withfsin those units are at all times properly briefed.

12) That the Commissioner of Police take steps to ensure that investigating officers are made aware of the need to protect important and vulnerable witnesses and that as far as is possible to ensure that they are made aware of the hospitalisation of such witnesses, especially in circumstances involving the mental health of such witnesses.

10.14. Finally, Mr Charles in his original written submission has informed the Court that Ms McKenzie's family have asked for a recommendation that a halfway house/psychiatric institution be built for young Aboriginal people who find themselves in situations similar to that of their late daughter and that it be named in her honour. I direct this request to the Minister for Health and the Minister for Aboriginal Affairs.

Key Words: Domestic Violence; Suicide; Bail Act 1985

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 25th day of July, 2017.

Deputy State Coroner