



FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 6th and 26th days of November and the 18th day of December 2019, the 13th, 14th, 15th, 16th, 17th, 20th, 21st, 23rd and 24th days of January, the 11th and 20th days of March, the 8th and 29th days of July 2020 and the 15th day of April 2021, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Gayle Elizabeth Woodford.

The said Court finds that Gayle Elizabeth Woodford aged 56 years, late of First Street, Fregon, South Australia died at Fregon, South Australia on or about the 23rd day of March 2016 as a result of multiple blunt force injuries. The said Court finds that the circumstances of her death were as follows:

1. Introduction

- 1.1. Gayle Elizabeth Woodford was 56 years of age when she was abducted, raped and murdered by Dudley Davey in the Anangu Pitjantjatjara Yankunytjatjara Lands (the APY Lands) in the north of South Australia. Davey then buried Mrs Woodford in a shallow grave near a dirt track on the outskirts of Fregon which is a community in the APY Lands. Mrs Woodford's body was found buried a few hundred metres south of the junction of Fregon Community road and the Mimili to Umuwa road.
- 1.2. Mrs Woodford's murder occurred during the night of Wednesday 23 March and Thursday 24 March 2016. It is probable that her death occurred shortly before or shortly after midnight. This conclusion is based on the satellite navigation activity report relating to the vehicle in which she was abducted prior to her murder. Mrs Woodford's remains were found in the location I have described two days later on Easter Saturday

26 March 2016. I find that the date of Mrs Woodford's death was on or about 23 March 2016.

- 1.3. A post-mortem examination of Mrs Woodford's remains was conducted by Dr Neil Langlois, a forensic pathologist at Forensic Science South Australia. Dr Langlois' report was tendered to the inquest.¹ Dr Langlois' report reveals that Mrs Woodford had sustained multiple blunt force injuries that had been deliberately inflicted by another person. It is not necessary to describe those injuries in detail except to say that they involved nearly every part of her person. The assault upon Mrs Woodford involved the application of significant and sustained force. It was a brutal assault. From the examination of Mrs Woodford's remains and from the identity and propensities of her assailant Dudley Davey, it can readily be inferred that the motivation for this crime was sexual. I so find. Mrs Woodford had been vaginally raped in the course of the assault upon her. DNA analysis would establish that Davey was the source of semen found in her vagina.
- 1.4. Mrs Woodford had worked as a registered nurse in Fregon which is one of a number of communities situated in the APY Lands. Fregon has had a fluctuating population of between 200 and 300 people. Fregon and the other communities are for the most part inhabited by Indigenous people. Dudley Davey was an Indigenous person who was aged 34 at the time of the murder.
- 1.5. Mrs Woodford lived with her husband in a house in Fregon that was provided to her by her employer, the Nganampa Health Council (NHC), which is a non-government entity that provides medical services in the APY Lands. Mrs Woodford was one of a number of NHC nurses who were living and working in Fregon and at other communities in the APY Lands.
- 1.6. On the night of Mrs Woodford's abduction and death she was the on-call member of the nursing staff in Fregon. An outside light attached to her house was on during the course of the night. As well, the NHC ambulance was parked in the street outside the house. It was common knowledge within the Fregon community that these two circumstances were intended to signify that the occupant of the premises was the on-call nurse who would be available to see patients during the course of the night.

¹ Exhibit C2a

- 1.7. In circumstances that I will discuss, Mrs Woodford and Davey encountered each other at her premises during the night of Wednesday 23 March 2016 and Thursday 24 March 2016. It is also clear that this encounter involved Mrs Woodford exiting her house and also leaving an enclosed area at the front of the house that was designed to maintain the security of the on-call nurse after he or she had physically exited the house proper through the front door. NHC documentation described this structure as a 'security cage'. The cage could be kept locked and acted as a barrier between the occupant of the house and a person situated outside the cage. The cage allowed direct but divided communication between the occupant and a person who presented at the premises seeking treatment from the nurse. However, the evidence suggested that it would not easily facilitate the clinical examination of a presenting patient and that it was commonplace for presenting patients to be admitted to the cage for the purpose of an examination and, if necessary, treatment for minor illnesses or injuries. It was said in evidence by an experienced nurse who had worked in Fregon for a number of years, which evidence I accept, that one '*couldn't possibly function in an on-call role without opening the cage*'.² A presentation during the night at the home occupied by the on-call nurse might also involve the nurse then seeing the patient at the Fregon clinic, about 500 metres from Mrs Woodford's house. It might also result in a house visit at premises within Fregon. Plainly, for these purposes the nurse would need to open, and leave the security of, the cage.
- 1.8. There is no direct evidence as to how Mrs Woodford came to be in the open presence of Davey not separated by the cage, but in my view certain inferences are available. At some point Mrs Woodford was abducted by Davey and was taken by him together with the ambulance that was parked at the front of her house. It is the satellite navigation activity report relating to this vehicle from which relevant times during the night in question can be taken.
- 1.9. It is noteworthy that Mrs Woodford had retired with her husband for the night and that when her buried remains were located she was still in her night attire. Her clinical bag was still in her house the following morning as was her dental plate. Whatever had caused Mrs Woodford to leave the confines of her house and the cage it had not involved the need for her to change into regular clothing as might have been the case if, say, she had decided to take Davey to the Fregon clinic or had agreed to perform a

² Evidence of Belinda Claire Schultz, Transcript page 285

house visit at his instigation. Nor had Mrs Woodford's leaving her premises necessitated taking her clinical bag. To my mind these circumstances are not consistent with Mrs Woodford having left her premises with the intention of driving the ambulance to the clinic or to a house visit. I would reject the notion that Mrs Woodford would have been prepared to travel from her house to another location by whatever means of transport or for whatever reason without changing into regular clothing. The circumstances of her departure from her house are only consistent with Mrs Woodford having left with Davey against her will. In my view her abduction was initiated at the house. I expand on this below.

- 1.10. Mrs Woodford's husband, Mr Keith Woodford, slept through whatever event had caused his wife to leave the confines of the house and cage. He did not hear or see anything connected with his wife's departure from the premises. The first he knew that his wife was not at home was when he awoke in the daylight hours of Thursday 24 March 2016. Mrs Woodford and the ambulance that had been parked at the front of the house were both absent. The last he had seen of his wife before he had fallen asleep was of her reading in bed.
- 1.11. There is no doubt that Davey was responsible for Mrs Woodford's rape and murder. In the Supreme Court of South Australia he pleaded guilty to those offences as well as to the theft of the ambulance of which he was found in possession in Coober Pedy on 24 March 2016. He was sentenced to a mandatory term of life imprisonment with a non-parole period of 32 years. There is no evidence that any other person was involved in Mrs Woodford's abduction and murder. At a later point in these findings it will be necessary to discuss briefly the factual basis upon which Davey pleaded guilty and on which he was dealt by the sentencing judge.
- 1.12. The ventilation of the principal issues in this inquest does not involve a complete reprise of the circumstances surrounding Mrs Woodford's murder. However, for reasons that will become apparent, the circumstances surrounding her abduction, particularly in relation to her home security while on-call as a nurse living and working in what was a dysfunctional and violent milieu, are of relevance to the issue as to whether Mrs Woodford's abduction and murder could have been prevented. Indeed, the broad issue in this inquest is whether Mrs Woodford's death could have been prevented and whether since these events measures have been taken, or still need to be taken, to prevent a repetition of a similar death or render it as less likely.

- 1.13. As far as Davey's past is concerned, he had a significant criminal history much of which involved assaults of a sexual nature on women. Davey's propensities in this regard were so entrenched, even before his rape and murder of Mrs Woodford, that the notion that he could have been rehabilitated or that his behaviour could have been altered by educational programs designed to correct those criminal tendencies has its manifest difficulty.
- 1.14. As will be seen in the next section, Davey had been in prison until 17 September 2015. He was not on parole or under any supervision at the time he abducted and murdered Mrs Woodford. He ultimately made his way to Fregon after his release from custody. Mrs Woodford's murder is in keeping with the general lawlessness within the Fregon community and the fact that this atmosphere of dysfunction and violence largely remained unchecked. The violence in Fregon was described by a medical practitioner of several years' standing in remote communities such as these as '*ongoing*' and '*continual*', and that if there was no violence in the Fregon community on a given day it was a '*good day*', circumstances not helped in her opinion by the lack of a police presence in the community. The practitioner described Fregon as '*completely lawless*' and the most violent place in which she had resided and worked while employed by the NHC in the APY Lands, to the point where she believed that serious consideration needed to be given to the withdrawal of services from this particular community so as to bring it to its closure.
- 1.15. At all times in the preparation of this finding I have appreciated and guarded against the risk of hindsight bias having regard to the terrible crime that was committed in respect of Mrs Woodford. In particular, I have considered the adequacy of Mrs Woodford's work system and other systems that will be discussed herein against circumstances as they existed prior to her murder and not through the prism of her terrible fate.

2. Dudley Davey's criminal history

- 2.1. Davey's date of birth is recorded as 1 January 1982. His sexual offending commenced as a juvenile.
- 2.2. Davey's first sexual offence was committed at the age of 14 years on 13 November 1996. On that occasion he went to the house of a nurse in Fregon, knocked on her door and when she opened it he indecently assaulted her. She persuaded him to attend the

clinic but there he pulled down his jeans, exposing his erect penis. He tried to grab the victim on multiple occasions. As he was a juvenile he was reported for that offence.

- 2.3. On 2 May 1997 Davey was charged with attempted rape and indecent assault. The charges were amended and ultimately he was convicted of assault with intent to commit an offence. On that occasion the victim was a 16-year-old girl walking in metropolitan Adelaide. Davey walked past her, grabbed her from behind, covered her mouth and dragged her into the bushes. He told her not to scream and attempted to take down her underwear. As he tried to undo his own trousers she broke free and ran away. As she escaped she observed that Davey was masturbating.
- 2.4. Between December 1997 and October 1998 Davey was charged with a series of offences perpetrated against women. He was convicted and detained. The first offence in that series occurred in 1997 when Davey ran towards a female and punched her to the head and knocked her to the ground. He then proceeded to kick her numerous times to the head and body. The second victim was a nurse working in Fregon. In September 1998 she was at home alone when Davey knocked on the door. When she went outside to see who it was she was forcefully grabbed by Davey and pushed into the house. He then proceeded to sexually assault her. As she continued to push him away and yell for help he grabbed her around the throat and squeezed with considerable force. Davey then suddenly stopped and left. The circumstances of this event are strikingly similar to what I have found happened to Mrs Woodford at Davey's hands, except of course that the victim of this earlier offence at Fregon survived the experience.
- 2.5. In October 1998 a woman at Bonython Park believed that she was being followed. She was tackled from behind by Davey. As he pinned her down he sexually assaulted her. The woman managed to escape and Davey was arrested. He admitted that he assaulted her because he wanted to rape her, but decided not to because she was screaming.
- 2.6. In November 2000 in the Northern Territory Davey committed an offence for which he would be convicted of aggravated assault. He approached a female victim from behind and placed both hands around her torso and a struggle ensued. He attempted to stop her from screaming before she was able to break free and alert a member of the public.
- 2.7. In February 2001 Davey, as an adult, was charged with the offence of assault with intent to commit an offence. He was imprisoned. On that occasion the victim and a witness were walking around the Fregon air strip and were followed by Davey. Davey was

naked and masturbating as he approached them. He grabbed the victim and took her to the ground and tried to pull her pants down. The witness threw rocks at Davey and kicked him off the victim.

- 2.8. Between April and September 2007 Davey was charged and convicted in respect of a number of offences including an indecent assault. The victim was paying for a parking ticket in Adelaide when Davey approached her from behind and grabbed her buttock. He said '*Fuck you, you Chinese bitch*'. He then grabbed his penis through his pants and laughed.
- 2.9. In April 2007 Davey was reported for aggravated assault in respect of his female partner.
- 2.10. In November 2009 Davey was charged and convicted of the offence of trespass and assault causing harm. The victim on that occasion was walking in Kilburn when she was struck by Davey to her face causing her to fall to the ground. The following day the victim was at her friend's house when Davey entered the house without permission and assaulted her again.
- 2.11. In April 2011 Davey was charged and convicted of aggravated assault and carrying an offensive weapon. Davey assaulted a female by hitting her on the side of the head with a rock. He was carrying a broken screwdriver.
- 2.12. In respect of the offence that he committed prior to the murder of Mrs Woodford, on 27 September 2012 Davey was seen by witnesses on North Terrace lying on top of a female person with his pants down around his ankles. He was thrusting his groin. Davey was interrupted by witnesses and ran off. The victim's only memory was waking in hospital with injuries to her face. Davey was initially charged with assault with intent to rape. However, a plea of guilty was taken in respect of offences of indecent assault and assault. On 18 August 2013 he was sentenced to 3 years imprisonment with a non-parole period of 20 months. The sentence was backdated to commence on 27 September 2012, the day he was taken into custody. This meant that between 27 September 2012 and 18 August 2013 Davey was not actually serving a sentence but was on remand in custody. This circumstance carried implications in terms of Davey's ability to participate in rehabilitative schemes conducted by the Department for Correctional Services (DCS) in respect of prisoners actually serving a sentence.

- 2.13. On 16 February 2015 Davey was released on parole for the first time. Ultimately his parole was breached by his failing to abide by certain conditions. This resulted in him being reincarcerated in respect of the original sentence. On 17 September 2015 Davey was again released on parole. The original head sentence expired on 26 September 2015. This meant that Davey was on parole for a period of approximately nine days prior to the expiration of the head sentence. Davey failed to report to Coober Pedy Corrections as required under the conditions of his parole.
- 2.14. From 26 September 2015 onwards Davey was free of any sentences of imprisonment and parole. It meant that he was free to travel to and reside at any location of his choice.
- 2.15. On 29 November 2015 in Coober Pedy Davey was arrested and charged with being unlawfully on premises and of providing false information regarding himself. He was released. On 10 February 2016 Davey failed to attend court at Mimili in the APY Lands in respect of these alleged offences. A warrant was issued for his arrest. It was not executed. Davey remained at large until 24 March 2016 when he was found at Coober Pedy in possession of the Fregon ambulance having murdered Mrs Woodford. A conviction for these offences would not have had any impact on the parole in respect of which Davey had been released in September of that year. This is due to the fact that, as previously indicated, the head sentence had expired. There is no certainty that he would otherwise have been imprisoned for these offences such that he would have been in custody as of the date of Mrs Woodford's murder.
- 2.16. The last confirmed sighting of Davey before Mrs Woodford's disappearance occurred at Fregon on the evening before her disappearance. He was seen playing basketball in the company of three other men at a community barbecue that was held at the Fregon school grounds on the evening of Wednesday 23 March 2016.
- 2.17. In another section of these findings I will discuss the failure of the authorities to have Davey included in the Australian National Child Offender Register (ANCOR) pursuant to the Child Sex Offenders Registration Act 2006. Davey could have been so included on the basis that the victim of his most recent sexual offence on North Terrace, Adelaide was a minor at the time of that offence. I will also deal with the question as to whether before Davey's ultimate release, and prior to the expiration of his head sentence, an application could have been made for Davey to be kept in custody for an indeterminate period of time pursuant to section 23 of the Criminal Law (Sentencing) Act 1988.

3. The circumstances of Mrs Woodford's abduction

- 3.1. The circumstances in which Mrs Woodford was taken against her will are relevant to the suggestion made in the inquest, particularly on behalf of Mrs Woodford's family, that certain practices connected with the presentation of patients to on-call nurses presented dangers to those nurses and that these practices were encouraged, condoned or had a blind eye turned to them by the management of the NHC. It will be acknowledged in this regard that the Fregon nursing staff while on-call were expected to see patients during the course of a night and that this might involve a patient presenting at a nurse's home in the first instance. The suggestion that these dangers were inadequately mitigated by the nurses' employer, the NHC, has meant that this Court should explore the circumstances in which Mrs Woodford relinquished the protection of the caged enclosure, and in particular whether she did so for medical purposes, in other words did so in the course of her employment. The alternate suggestion has been made that Mrs Woodford may have relinquished the protection of the cage for a reason other than medical, thereby facilitating her abduction by Davey.
- 3.2. There is no direct evidence of the circumstances of how it was that Mrs Woodford left the confines of her house and then the confines of the cage. What transpired in this regard is essentially a matter of inference. Evidence was given by Mr Woodford that to my mind renders it unlikely that Mrs Woodford would have left the protection of her house and the cage ill-advisedly or for a reason that was unconnected with her work as a nurse. Mrs Woodford was a woman who had lived and worked in Fregon for several years. Having regard to her own experience and to that of others in positions similar to hers, it is inconceivable that she would have been naïve to the inherent dangers that leaving the protection of the cage could present. It is likely that she would have had a healthy regard for her own safety and would not have compromised it lightly. Mr Woodford confirmed that his wife was safety conscious. So did the NHC former Health Services Manager.
- 3.3. For reasons that follow I have found on the balance of probabilities that Mrs Woodford did forsake the protection of the cage for reasons that were medical and which were connected with a presentation by Dudley Davey at her house. I have borne in mind that the required standard of proof for such a finding is the balance of probabilities. I do not need to make such a finding beyond reasonable doubt. As the standard of proof is on the balance of probabilities, I do not need to conclude that all other reasonable

hypotheses consistent with Mrs Woodford having left the premises for reasons other than medical have been excluded as would have been the case if the standard of proof required was beyond a reasonable doubt. I have directed myself that when considering the weight of circumstantial evidence where the required standard of proof is the balance of probabilities, it is enough if the circumstances appearing in the evidence give rise to a reasonable and definite inference but that they must do more than give rise to conflicting inferences of equal degrees of probability so that the choice between them is a mere matter of conjecture.³ If the circumstances are proved in which it is reasonable to find a balance of probabilities in favour of a certain conclusion, then although the conclusion may fall short of certainty, it is not to be regarded as a mere conjecture or surmise.⁴ I have directed myself that if reasonable hypotheses exist other than that Mrs Woodford left the confines of her house and cage for purposes other than medical, the existence of those hypotheses is a matter to be taken into account in determining whether a conclusion that she left the house and cage for medical reasons should be inferred from the facts proved.⁵

- 3.4. During the course of the police investigation Dudley Davey did not make any admission as to Mrs Woodford's abduction and murder. However, his identity as the abductor and murderer cannot be disputed. It is also clear that when Mrs Woodford left the environs of her house she did so in the NHC ambulance and in the company of Davey. Ultimately she was taken to a location where she was buried by Davey in a shallow grave. Davey thereafter made his way to Coober Pedy where that day he was found in possession of the ambulance.
- 3.5. There are a number of circumstances relevant to the issue under discussion. They are:
- Davey had a demonstrated propensity to attack women. His motivation was sexual.
 - I have found that recently in Fregon Davey had made assertions to the effect that having been released from prison he desired to have sexual intercourse with, if not rape, a female person. I find that he had said this either to or in the hearing of Arshaan Ahmad Khan. I find that Khan told the truth about these assertions in his

³ **Bradshaw v McEwans Pty Ltd** (Unreported, High Court of Australia 27 April 1951)
– as reproduced in **Holloway v McFeeters** (1956) 94 CLR 470 at 480-481

⁴ See **Bradshaw v McEwans** *supra*

⁵ **R v Doney** (1990) 171 CLR 207 at 211

police witness statements⁶ and I make this finding despite Khan's prevarication in the witness box.

- There is no evidence that Mrs Woodford had encountered Davey in the past. There is no evidence that even if Mrs Woodford had encountered Davey in the past, she knew of his propensities regarding sexual and other abuse of women.
- It was common knowledge in Fregon that the external light and the presence of the ambulance at the front of a house signified that the house was that of the on-call nurse. This circumstance would not have been lost on the predator that was Dudley Davey.
- Given the scarcity of house phones and the lack of mobile phone coverage in Fregon at that time, a medical need that arose during the night was usually met by a presentation at the house of the on-call nurse.
- When Mrs Woodford's body was located she was clad in the night attire that she had been wearing during the course of the night.
- Her clinical bag which she would take with her either to the clinic or to a house visit while on call was still inside her house.
- Mrs Woodford did not refit her dental plate before leaving the premises. This was still at her bedside table. Mr Woodford's evidence, which I accept, was that his wife would not leave the premises to go to the clinic or to a house call without her dental plate.
- A mirror situated on the outside of the bathroom door in the house had been dislodged from its hanging point and had smashed. This was not the first occasion on which the mirror had fallen from its hanging position. However, it had not smashed in the past. There was no other sign of disturbance inside the house. On a kitchen table there was a white plastic cup that was used to dispense tablets to patients. There were also blister packs of tablets, one of which was believed to contain Panadol.
- I accept Mr Woodford's evidence⁷ that the door to the house was found by him to be closed the following morning.

⁶ Exhibit C73

⁷ Transcript, page 129

- I accept Mr Woodford's evidence⁸ that the door to the cage was found by him to be closed the following morning. In that state, the door would be locked and a key would be needed to re-enter. I find it was locked.
- I accept Mr Woodford's evidence that if his wife went out to the ambulance she would not close the cage door.⁹
- If Mrs Woodford had intended to return to the interior of her house but contrary to her usual practice she had closed the cage door, she would have needed to unlock the cage door to get back in.
- The ambulance was parked in the street at the front of the house. The light signifying that this was the house of the on-call nurse illuminated the ambulance.
- Mr Woodford at no time woke up during the event that led to Mrs Woodford leaving the house and the cage. Whatever sound was created when his wife left the house and the cage, Mr Woodford did not hear it. He remained asleep. Such sounds might have included the doorbell being activated to gain the attention of the occupant of the house, the sound of any conversation between Mrs Woodford and another person, the sound if any caused by the opening and closing of the front door and the cage door, the sound of the fence gate being closed, Mrs Woodford calling out to her husband for assistance, the sound of any struggle between herself and her abductor, the impact between the mirror and the floor and the smashing of glass and the starting of the ambulance engine and its being driven away. Mr Woodford slept with a CPAP machine for sleep apnoea.
- The community of Fregon was relatively small geographically rendering it unlikely that Mrs Woodford would have agreed to drive Davey in the ambulance to a location in Fregon unless it was connected with medical necessity. It is even less likely that she would have agreed to drive Davey to a location outside Fregon.
- There was a practice on the part of on-call Fregon nursing staff upon the presentation of a person at the house at night to open the cage door and leave the protection of the cage for the purpose of driving the ambulance to the Fregon Clinic if necessary.
- There was a practice on the part of on-call Fregon nursing staff upon the presentation of a person at the house at night to open the cage door and leave the

⁸ Transcript, page 129

⁹ Transcript, page 129

protection of the cage for the purpose of driving the ambulance to another premises in Fregon in connection with a house visit for medical purposes.

- There was a practice on the part of on-call Fregon nursing staff to open the cage door and to admit a patient presenting at night for the purpose of assessment and treatment for minor injuries or complaints if necessary. I accept Mr Woodford's assertions that his wife in particular engaged in the practice of admitting a patient to the caged area for these purposes.
- Earlier in the night Mrs Woodford had travelled in the ambulance from her house to the Fregon Clinic to attend to a male patient. That person was not Davey. The patient was in the company of two other men. The identity of one is known and the identity of the other is not known.¹⁰ Mrs Woodford had significant previous clinical contact with the patient. Although it is believed that Dudley Davey had a known association with one of these men, there is no evidence one way or the other as to whether Davey was the unknown male person of the three or was otherwise involved in this event. The two men whose identities are known were not those men in the company of Davey earlier that evening at the community barbecue at the Fregon school. The available evidence suggests that the three men in the company of Mrs Woodford at the Fregon Clinic were not chaperoned by any female person. The ambulance activity report records that Mrs Woodford would have been back at her house by 8:39pm at which time the ignition of the vehicle is recorded as having been switched off.¹¹
- At approximately 11:30pm the Woodford's neighbour who occupied a dwelling that was semi-detached from that of the Woodford's, heard the fence gate at the front of the Woodford premises close. She did not hear the ambulance start, but the neighbour suggests that it is possible that it was started without her hearing it.¹²
- The next activity of the ambulance after 8:39pm is at 11:25pm when the ignition of the vehicle is recorded as having been switched on. The ignition was switched off at 11:30pm after a recorded journey of 1.9 kilometres. The recorded coordinates of the locations of the vehicle are consistent with the vehicle then being at a different location from where it had been when the ignition was switched on.

¹⁰ See the statement of Dr Martin Kelly, Exhibit C5a

¹¹ The times and distances recorded on the ambulance activity report have not been independently verified. The precise accuracy of the records is of limited importance in any event.

¹² See statement of Margaret Lee, Exhibit C7a

- The next recorded activity of the ambulance is at 11:36pm when the ignition of the vehicle was switched on. The ignition was switched off at 11:38pm after a recorded journey of 0.7 kilometres. The recorded coordinates of the locations of the vehicle are consistent with the vehicle then being in a different location from where it had been when the ignition was switched on.
- The next activity of the ambulance is recorded as having occurred at 11:58pm when the ignition of the vehicle was switched on. It was switched off at 11:59pm.
- The next activity of the ambulance is recorded as having occurred at 12:04am when the ignition was switched on. The activity record states that the ambulance had been at unspecified locations at Fregon up to and including this point in time. Mrs Woodford's body would be located on the outskirts of Fregon. The ignition was switched off at 12:50am after a recorded journey of 53.3 kilometres. Its recorded location was then Mimili in the APY Lands.
- Thereafter there were recorded journeys in and around Mimili, Indulkana and Marla. At 9:33am the ignition is recorded as having been switched off, its recorded location then being Coober Pedy. The vehicle would later that day be located there by police, as would Davey himself.

3.6. It is evident from the sentencing remarks of Justice Vanstone that when Dudley Davey pleaded guilty in the Supreme Court his counsel submitted to the Court that initially Davey had not intended to kill Mrs Woodford. However, he had not been willing to give evidence about what had happened. Later, however, Davey through his counsel did acknowledge that he formed an intention to kill Mrs Woodford. A further submission was made by Davey's counsel that Davey had attended at the Woodford home and had told Mrs Woodford that his grandmother needed Panadol for pain. According to Davey, as outlined by his counsel, Mrs Woodford had then agreed to deliver the Panadol herself. She then opened the gate of the cage and walked to the ambulance. Davey overpowered her and drove away in the ambulance with Mrs Woodford held in it. Justice Vanstone was told that Davey had not planned to rape Mrs Woodford but had only intended to steal the ambulance to drive to Adelaide. Justice Vanstone found beyond a reasonable doubt that Davey had gone to Mrs Woodford's home intending to entice her outside and to rape her which was contrary to what Davey's counsel had put to the Court. Her Honour was further satisfied beyond reasonable doubt that Davey decided to kill Mrs Woodford in the hope

of covering up the rape and theft. Justice Vanstone inferred that Davey had tricked Mrs Woodford into opening the security cage, perhaps on the false claim about the need for medical assistance related to his grandmother. Her Honour was satisfied beyond reasonable doubt that Davey immediately overpowered Mrs Woodford when she opened the cage door.

- 3.7. On Justice Vanstone's analysis it is clear that Her Honour was satisfied beyond reasonable doubt that Davey had enticed Mrs Woodford from the security of her cage on some false pretext.
- 3.8. It is not surprising that Justice Vanstone would have viewed with scepticism the suggestion that Mrs Woodford had agreed to deliver the Panadol herself to Davey's grandmother. I too would reject that as an explanation because it is inconceivable that Mrs Woodford would have agreed to do that. She simply could have given the Panadol to Davey to deliver himself. Davey has shown himself to be a poor historian.
- 3.9. The findings of this Court are independent of those of Justice Vanstone. I have considered the circumstances of Mrs Woodford's abduction afresh but, as earlier indicated, in the light of a different standard of proof from that of the criminal standard.
- 3.10. To my mind the possibility that Dudley Davey and Mrs Woodford encountered each other outside the cage by chance can be discounted as unlikely. A coincidence that Davey just happened to be loitering aimlessly in the vicinity of Mrs Woodford's home when Mrs Woodford just happened to emerge from the cage for whatever reason is unlikely. Due to Davey's propensity to attack women it is probable that he attended the vicinity of Mrs Woodford's home with that intent. However, it is improbable that Mrs Woodford fortuitously emerged from the cage when Davey was in the vicinity waiting for that contingency to occur. It seems to me that the likelihood of that scenario is very low. After all, would Davey have needed to wait for Mrs Woodford to fortuitously emerge from the house? The answer is no. Having regard to his propensities, Davey would not have hesitated to try to attract her attention either by yelling out or, what is more likely, simply by ringing the doorbell. He would have known that she would respond. She was the on-call nurse with the light on and the ambulance parked at the front. The fortuitous emergence explanation would also require a reason for Mrs Woodford to have left the confines of her house and the cage in her night attire and in possession of her car keys. It is highly unlikely that if

Mrs Woodford left the confines of her house and the cage with the intention of driving to some unknown location she would have done this in her night attire. That would be all the more so if, say, she had been required to attend the clinic or to perform a house visit as the result of having received a phone call. In that case she would also have taken her clinical bag with her and she would have refitted her dental plate.

- 3.11. The suggestion that Mrs Woodford may have left the confines of the house and the cage with a view to retrieving something from or to lock the ambulance, and that she was abducted in the course of doing so, can also be discounted as unlikely. It is to be acknowledged that this scenario would explain how she came to be in possession of the ambulance keys which she must have been at some point for the ambulance to have been started and driven away. It would also explain why she emerged from the house just in her night attire, without her bag and without the dental plate. However, that scenario is not consistent with Mrs Woodford having closed the door of the house as well as the door to the cage behind her. It is more likely that if she had intended to return to the house having checked the ambulance she would have left one or both open, and certainly the cage door open because in order to re-open it she would have had to unlock it with a key from the outside. This scenario seems to me to be unlikely because in exploring whatever she needed to explore with regard to the ambulance she probably would have left both doors open. Both doors were found closed the following morning.
- 3.12. I also think it unlikely that Mrs Woodford emerged from the cage, say, to investigate a possible intruder on the property or someone whom she thought may have been interfering with the ambulance or her personal vehicle. Firstly, the ambulance would have been illuminated by the light and Mrs Woodford would have been able to see if anyone was in or around the ambulance without needing to leave the cage. Secondly, Mrs Woodford would only have left the cage to conduct such an investigation if she had an intention to return to the house, in which case it is likely that she would have left at least the door of the cage open thereby obviating the necessity for her to unlock it in order to get back to the house. Thirdly, it might be thought that if Mrs Woodford was investigating an intruder to the point where she would leave the protection of the cage in order to do so, she may have sought the assistance of her husband. It is to be acknowledged she may not necessarily have done that, but her not having done so is consistent with Mrs Woodford believing that she could, on her own, handle whatever it was she left the house for, such as the routine presentation of a purported patient.

- 3.13. In my view it is much more likely that Mrs Woodford got out of bed and emerged from her house as a result of a successful attempt by Davey to attract her attention. This is supported by Davey's propensities towards vulnerable women and the ease by which he would have been able to attract her attention in her capacity as the on-call nurse. I find that this scenario is more probable than not. I so find on the balance of probabilities.
- 3.14. Why then once out of her house did Mrs Woodford open and leave the cage? Evidence was given by other nurses who had worked at Fregon in circumstances almost identical to those of Mrs Woodford, that from time to time Fregon residents would attend at the on-call nurses' homes and seek the use of a telephone or even ask to be driven to another location. Clearly, neither of these two scenarios would involve a medical situation. However, in my view both of these scenarios are unlikely as explanations as to why Mrs Woodford would have left the confines of her house and the cage. There would be no need for her to agree to either of these requests. As I understood the evidence, the use of the phone would not require the person attending to actually enter the cage as the phone could be passed through the cage to the individual concerned. As to the possibility that she left the cage having agreed to drive Davey to a place in Fregon for a reason unconnected with medical need, it seems to me that Mrs Woodford's regard for her own safety would have stopped her from doing this at that time of the night when in any event the distances in Fregon are relatively small and can be comfortably walked. As well, it does not seem at all likely that Mrs Woodford would agree to do this in her night attire.
- 3.15. It will be remembered that Mr Woodford did not wake up at any stage. Mr Woodford asserts that if Mrs Woodford left the house that night for any non-medical reason she would have woken him beforehand. She would let him continue sleeping if there was a medical callout.¹³ I accept that evidence. Clearly Mrs Woodford did not wake her husband in this particular instance. This is another indication that Mrs Woodford did not willingly leave the environs of her house for reasons unconnected with medical need.
- 3.16. To my mind the most likely scenario is that Davey presented at the Woodford home and drew Mrs Woodford's presence to the enclosed cage by using the doorbell or by

¹³ Statement of Mr Woodford, Exhibit C44 page 10

yelling out. I find this scenario as being more probable than not. It is not merely one scenario out of a number of equally compelling scenarios. I also find to the same degree of probability that Mrs Woodford was persuaded to open the door to the cage on a pretext held out by Davey in relation to some medical need for himself or possibly for some other person. To my mind it is also more probable than not that once the security of the cage was breached, Mrs Woodford's will was overborne by some physical or other means employed by Davey, to the extent that either she retrieved the keys to the ambulance from their place in the house or Davey himself saw them and took them. In reaching that conclusion I am mindful of the fact that Mr Woodford did not hear anything in connection with Mrs Woodford leaving the premises. I am also mindful of his assertions that he would wake up whenever the doorbell was activated. However, it will be remembered that he was connected to a CPAP machine. It is also of some significance that the impact between the mirror and the floor and the smashing of its glass would undoubtedly have been audible within the house. However, this did not arouse Mr Woodford. It is thus possible that Mr Woodford did not hear anything else connected with his wife's departure from the premises because whatever sound was associated with her departure obviously did not wake him up.

- 3.17. Accordingly, I find on the balance of probabilities that Mrs Woodford opened the cage door in her capacity as the on-call nurse for reasons connected with the purported medical treatment of Davey or possibly of some other person connected to Davey, but most likely Davey himself. I say most likely Davey himself because there is no evidence that Davey was in the presence of or acting in concert with any other person that night. Furthermore, any assertion made by Davey to Mrs Woodford that had enticed her to leave her premises and travel to another location to attend to a person other than Davey would not have required Davey to be admitted to the caged area. There would have been no need for open contact between Mrs Woodford and Davey until they were about to leave her house. Secondly, as already discussed, Mrs Woodford would not have opened the cage and placed herself in the open presence of Davey until she was properly dressed and was about to leave the premises. It is more likely that she opened the cage to admit Davey to the caged area for the purpose of assessing him and if need be providing him with treatment. I find that on a false pretext offered by Davey in respect of medical need, Mrs Woodford was tricked into opening the cage door and was either physically overpowered by Davey or her will was overborne by threats of harm or by otherwise putting her in fear. There may have been

a struggle which resulted in the dislodgement and smashing of the mirror. She was taken by Davey in the ambulance and was then raped and murdered by him.

- 3.18. The ambulance activity records are consistent with Mrs Woodford having been abducted, raped, murdered and buried sometime after 11:25pm when the ambulance ignition is recorded as having been switched on. The precise sequence of events and the location or locations of those events do not require detailed analysis for the purpose of these findings.
- 3.19. I would observe that regardless of whether Davey lured Mrs Woodford from the protection of the cage for a purported medical reason or otherwise, and even having regard to the theoretical but unlikely scenario that Mrs Woodford's abduction by Davey was opportunistic after she had gone out to the ambulance for a purpose unconnected with and without knowledge of Davey's presence, the fact that Mrs Woodford was the on-call nurse with her light on and the ambulance parked at the front of her house exposed her as a likely target of anybody who harboured the intention of molesting a vulnerable female person during the night. Anybody who saw the light and the ambulance would have known that the occupant would undoubtedly respond to an attempt to gain the occupant's attention. And so, while the distinction between the competing scenarios as to whether or not Mrs Woodford left the protection of the cage for medical reasons is a nice one, in my view it is clear that Davey identified and exploited her vulnerability as a female on-call nurse employed by the NHC and that Mrs Woodford was on the occasion in question acting in her capacity as the on-call nurse.

4. The level of violence in the Fregon community

- 4.1. A great deal of evidence was given about this subject matter and in particular by nursing and medical staff who either gave evidence or provided a statement to the inquest.
- 4.2. The level of violence in Fregon has to be examined against the fact that SAPOL did not have a permanent presence in Fregon. The nearest SAPOL permanence was at Mimili, over 70 kilometres distant.
- 4.3. The Court was made aware of a number of incidents involving violence in which staff of the NHC in Fregon were involved. It is not necessary to detail all of them here. I shall mention some examples in this section.

- 4.4. Mrs Woodford's husband gave evidence of numerous occasions in which he had witnessed violence in Fregon. He asserted that violence was common place and that it was part of life there. Police were often not called to respond.
- 4.5. Dr Glynis Johns, a general medical practitioner, gave evidence in the inquest. Dr Johns has worked in remote areas of Australia since 2003. She commenced working for the NHC in 2011. She resigned from her position following Mrs Woodford's death. Dr Johns worked in Fregon from time to time. It was Dr Johns who in her evidence described Fregon as the most violent place she had experienced. Dr Johns asserted that although she had not been concerned for her own safety in Fregon, NHC staff based in Fregon were concerned at the level of violence within the community more than in relation to their own safety. However, it is clear from the evidence that there were a number of violent incidents directly involving staff of NHC from which an apprehension of further violence to them would not be unreasonable.
- 4.6. Ms Belinda Schultz, a nurse who for a time worked in Fregon with Mrs Woodford, gave evidence about domestic violence victims arriving at her house seeking refuge. She described this as a relatively regular occurrence. Although there was a directive not to open the cage to allow these persons entry, there was an impracticality in implementing this especially in circumstances where a woman arrived with children and it was apparent that the perpetrator was not far behind. In those circumstances it was difficult to refuse entry. Ms Schultz said that she was also concerned about possible backlash from the community were something to happen to the victim or their children. As far as she was aware other nursing staff followed the same practice. Ms Schultz described an incident in which an alleged perpetrator had attempted to hang himself in the yard of Mrs Woodford.
- 4.7. In her statement and in her oral evidence Ms Schultz described her own experience with violence or threatened violence. When Ms Schultz was on-call at night a female community member in Fregon presented to Ms Schultz's house and demanded that she drive her home. When Ms Schultz declined, the woman threw rocks at the house and was verbally abusive. On multiple occasions in the subsequent days the woman attempted to physically assault Ms Schultz in the clinic. There was also intimidation from the woman's husband who would sit in the clinic staring at Ms Schultz. On the recommendation of Mr Busuttill, the Health Services Manager of the NHC, and with his assistance, Ms Schultz secured an apprehended violence order or similar through the

police. However, as things transpired, Ms Schultz was still expected to attend this woman as a patient even if it involved a house call. She was told that it would be unethical for the patient not to have access to available health care. Another incident involving Ms Schultz occurred when Ms Schultz was involved in the removal of a child at significant risk. She was verbally abused in the clinic and at her house and a person or persons told her that they would kill her. The involved individuals came to the clinic with large rocks threatening to assault Ms Schultz.

- 4.8. Ms Schultz also gave evidence of occasions of violence in the vicinity of the Fregon clinic which would cause staff to lock the doors as a preventative measure. If there was an incident in the vicinity of the clinic it was likely that it would involve presentations to the clinic. In one incident the Fregon community store was burned down. The burning down of the community store in Fregon resulted in such a scenario unfolding which in turn led to the evacuation of the clinic staff. Ms Schultz also spoke of an occasion when she was slapped on the face. Ms Schultz spoke of a reluctance to report matters to the police due to fear of retribution. Ms Schultz left the employ of the NHC due to the level of repetitive violence in Fregon.
- 4.9. In another section I have described the experiences of another nurse, Ms Tessa Wilkie. The Fregon store was burned down on the day of her arrival in Fregon. In her statement Ms Wilkie also describes other concerning incidents. Ms Wilkie was herself indecently assaulted.
- 4.10. Mr Phibion Takawira, another member of the NHC nursing staff working at Fregon, told the Court that prior to Mrs Woodford's death he had reported a number of violent incidents to NHC management. Mr Takawira said that he received verbal threats almost on a daily basis. He would report physical threats but not mere verbal threats as there were simply too many of them. There were threats to beat him up and on a number of occasions and he was threatened to be killed. That occurred in the context of Mr Takawira providing assistance in a domestic violence incident in which the alleged perpetrator threatened him for helping the alleged victim. Mr Takawira was in Fregon when the Fregon store was burned down causing staff to leave. He told the Court that during that day there had been much fighting in the community with families fighting each other and then presenting to the clinic seeking treatment. There were verbal threats from members of the community based on a perception that staff were not working fast enough to help those who had been injured. Mr Takawira also spoke of occasions when

aggression or violence outside the clinic would result in the clinic being closed to prevent the violence escalating and entering the clinic.

- 4.11. Mr Takawira spoke of a specific incident involving a member of the community apparently suffering from hallucinations and displaying signs of aggression. Mr Takawira had attended to that male person the night before when he had apparently been experiencing a psychotic episode. The next morning he was displaying signs of aggression and agitation and started to hallucinate. The man was given medication to calm him down. At one point the male patient started yelling and shouting and started punching his father. Mr Takawira did not contact the police because everything happened very quickly and he knew that the police would not arrive for at least an hour in any case.¹⁴ Mr Takawira also gave evidence about the activities of a man who assaulted a nurse at Watarru, a matter I have dealt with in another section of these findings. The same man was allegedly involved in sexual assaults on a number of nurses in Fregon including Mrs Woodford herself on 20 November 2014.
- 4.12. The incident in which Mrs Woodford had been indecently assaulted had involved this male person approaching her in the garden of her house in Fregon. She was on-call at the time.
- 4.13. There were other documented incidents involving violence or threats of violence involving NHC staff.

5. The incident at Watarru

- 5.1. Watarru was a small community in the APY Lands. In 2012 an incident occurred at Watarru which involved an assault on an NHC nurse. This incident caused SAPOL to verbally administer a warning to the NHC regarding NHC nursing staff working alone. I deal with the SAPOL intervention in the following section of these findings.
- 5.2. The incident in question occurred on Friday 1 June 2012 at about 2pm at the Watarru Clinic operated by the NHC. The complainant was a female nurse employed by the NHC at the Watarru Clinic. She was working alone. A male member of the community came into a small room in the clinic. The nurse had known this individual for about two years as a mental health patient. As the male person moved into the room the individual closed the door. He then held the complainant's cheek with his right hand

¹⁴ Transcript, page 1008

and pulled her head towards him and said, '*I want to fuck you*'. The individual then grabbed the complainant's left breast with his right hand. The complainant pushed him towards the door but it appears that he blocked her way. She eventually managed to push the man out of the door and locked it. A few days later police arrested the male and charged him with aggravated indecent assault, the circumstance of aggravation being the fact that the complainant was assaulted in the course of her duty as a nurse. The individual made certain admissions in respect of his conduct towards the complainant. This incident culminated in the Watarru Clinic being closed.

6. Police intervention following the Watarru incident

- 6.1. Tendered to the Court was the statement of Senior Sergeant Ann Yeomans.¹⁵ Between January 2010 and April 2014 Senior Sergeant Yeomans was the SAPOL Officer in Charge of the APY Lands. Throughout her tenure she was based at the Umuwa Police Station. She knew Mr David Busuttil as the manager of the NHC based at Umuwa.
- 6.2. In her statement Ms Yeomans recalls that on discovering that the assault on the female nurse at Watarru Clinic had occurred on 1 June 2012, she perceived that the community in Watarru was angered and upset. In the immediate period following this incident Mr Busuttil of the NHC phoned Ms Yeomans about the assault to enquire what could be done about it. Ms Yeomans' recollection is that this call occurred between the incident on 1 June 2012 and the culprit's arrest on 5 June 2012. As a result of that call Mr Busuttil came to see Ms Yeomans in her office. No other person was present for that meeting.
- 6.3. Ms Yeomans asserts that during the meeting with Mr Busuttil the latter suggested that police should be available to attend the Watarru Clinic on any occasion that a nurse was required to attend the clinic alone. To this Ms Yeomans replied that although SAPOL would respond to a report of an offence, they could not act as a security service for the Watarru Clinic or for the NHC.
- 6.4. According to Ms Yeomans' statement, during this meeting she specifically advised Mr Busuttil that the NHC had a duty of care to their employees and that this would need to be addressed by the NHC. She also suggested that the NHC may want to explore the possibility of having a private security guard attend the clinic with the nurses.

¹⁵ Exhibit C55

Ms Yeomans suggested that if this was not a viable option the NHC could consider training and employing a senior Anangu member to assist the nurses.

- 6.5. In her statement Ms Yeomans further asserts that she specifically recalls raising with Mr Busuttil the safety risks posed by NHC nurses attending a clinic and conducting on-call after hours work alone. She illustrated this point by advising Mr Busuttil that despite police officers carrying operational equipment and being trained in personal safety, even police do not attend taskings alone.
- 6.6. Ms Yeomans asserts that she further suggested that SAPOL could provide information sessions for current nursing staff with regard to personal safety and that the same information sessions could be provided to all new medical personnel who commenced on the APY Lands. The information sessions could encompass personal safety issues specific to the APY Lands.
- 6.7. Ms Yeomans asserts that at the conclusion of the meeting with Mr Busuttil he was not satisfied with the outcome of the meeting. I take this to mean that Mr Busuttil was not satisfied by the response that police could not provide ongoing security for nurses working alone in the Watarru Clinic. Ms Yeomans states *'Throughout my time working in the APY Lands it was commonplace that David Busuttil expected SAPOL to comply with all requests of the Nganampa Health Council and would be unhappy if SAPOL did not comply with these requests'*.¹⁶
- 6.8. Mr John Singer who is the Executive Director of the NHC spoke of the Watarru incident in the course of his evidence. The NHC had provided a service to the Watarru community which consisted of about 30-50 community members. Nursing staff would visit Watarru one to two days at a time following which they would return to their main centre. Mr Singer told the Court that he recalled that NHC was advised by the Health Service Manager (Mr Busuttil) and the Medical Director (Dr Torzillo) that following the Watarru incident the nurse should have an escort when attending Watarru. However, a decision was made to close the clinic entirely. Mr Singer said that it had been difficult to secure an escort.
- 6.9. In cross-examination by Mr Kalali, counsel assisting, Mr Singer told the Court that it did not come to his attention that following the Watarru incident Mr Busuttil had

¹⁶ Exhibit C55, paragraph 9

conducted a meeting with a senior police officer.¹⁷ When asked as to whether Mr Busuttil had told him that the police had warned him that nurses should not work alone in clinics or on-call, or whether that information made its way to him, Mr Singer said '*Not that I recall*'.¹⁸ However, he had heard it said that SAPOL could not act as a security service or as security guards in respect of NHC medical staff activities.¹⁹ Pressed by me, Mr Singer reiterated that they were advised by Mr Busuttil and Dr Torzillo that from now on an escort should be provided with staff and that the police would not be able to provide that. He said:

'David and Paul when we were talking because after that incident they came to the board and said 'We want to introduce a policy that doesn't have staff going down on their own'. And then they give a bit of background and we probably were asking 'Well who are we going to send down with them, or if we are do we get the police', and I think at that time they said 'No, we'd have to look at other avenues of sending someone'.²⁰

6.10. In his evidence before the Court Mr Busuttil was questioned about his meeting with Senior Sergeant Yeomans. Asked by counsel for the Commissioner of Police, Mr Mark Roberts, as to whether he had participated in a discussion with Ms Yeomans regarding security guards, Mr Busuttil said that he remembered her saying that the police cannot act as security guards.²¹ However, he said that he could not remember having a meeting specifically about the incident that had occurred at Watarru on 1 June 2012 in which an employee had been sexually assaulted. The following passage of evidence occurred under cross-examination of Mr Busuttil by Mr Roberts:

MR ROBERTS

'Q. At this meeting Senior Sergeant Yeomans raised concern with you about nurses working alone in the clinic.

A. Right.

Q. And also raised concerns with you about nurses attending on-call working alone. Do you remember that.

A. I don't remember the specific meeting, no, I don't sorry.'²²

Immediately following that passage, Mr Busuttil was pressed on the issue and the following passage of evidence ensued:

'Q. Do you remember that discussion that I've just put to you.

¹⁷ Transcript, page 866

¹⁸ Transcript, page 866

¹⁹ Transcript, page 867

²⁰ Transcript, page 867

²¹ Transcript, page 366

²² Transcript, page 367

A. Can you say it again, sorry?

Q. Senior Sergeant Yeomans at a meeting that you had with her - and I appreciate you may not recall where the meeting took place or the exact date - but it's the content of this discussion that is more important.

A. Yeah, okay.

Q. Senior Sergeant Yeomans raised with you her concern about nurses working in clinics along and also attending on-calls alone.

CORONER

Q. Did that happen, that discussion.

A. With Annie Yeomans?

Q. That's what's being put to you; did it happen or not.

A. I think it - I think it did, yes.

MR ROBERTS

Q. So you stated Yeomans told you that not even police officers will attend at incidents alone, notwithstanding the fact that they are armed and have other safety equipment.

A. I can't recall that part of it.

Q. She recommended strongly against you allowing nurses to work in clinics alone or to attend on calls alone.

A. I think we're - yes, I think she did say something like that.

Q. You told Senior Sergeant Yeomans that you wanted police to attend at clinics every time a nurse was required to attend a clinic alone.

A. No, I don't think I said that, no.²³

Mr Busuttill reiterated that he remembered the issue about security guards and Ms Yeomans saying that police could not act as security guards. However, he said that he did not recall any discussion about Ms Yeomans' suggestion that a senior Anangu member be trained to assist the nurses when they are required to be at the clinic alone or on-call.²⁴ He agreed that Ms Yeomans told him that the police were happy to provide training sessions for nursing staff.

6.11. In his evidence Mr Busuttill said that Ms Hammond was present at a meeting where a discussion concerning police having raised their concerns about nurses working alone on the APY Lands had taken place. Mr Busuttill was asked:

Q. Did you raise with management the concern that had been harboured by the police regarding nurses working alone on the APY Lands.

A. I mean Vivien Hammond was at that meeting so if that happened she would have been aware if it happened at that meeting. I can't specifically remember mentioning - discussing it.

²³ Transcript, pages 367-369

²⁴ Transcript, page 370

- Q. You don't recall discussing with Dr Torzillo.
- A. No, I don't specifically recall it. I mean I talk to Dr Paul about a lot of things so - but I don't specifically recall it.
- Q. You don't recall discussing with John Singer.
- A. No, not specifically, no'.²⁵

Asked as to what he had done with the information or the concern that had been expressed to him by police regarding the safety of NHC staff working alone on the APY Lands, Mr Busuttil said that he did not recall doing anything specifically with it.²⁶

- 6.12. In the course of her oral evidence Ms Vivienne Hammond, the Clinical Services Manager of the NHC, was also questioned about her knowledge of the Yeomans meeting in 2012. Asked as to whether Mr Busuttil had told her that he had had a meeting with police and that they had recommended that nurses should not be working alone, Ms Hammond said '*No, not to my knowledge*'.²⁷ Asked as to whether she was present at a meeting with police where police did raise these concerns, she suggested that that may be correct, but that she did not recall it.²⁸ In any event she said that she had no knowledge of the police recommending that nurses not work alone.²⁹
- 6.13. Dr Paul Torzillo, the Medical Director of the NHC, was questioned about any knowledge he may have had of police intervention following the Watarru incident. He told the Court that he had no recollection of any discussion with Mr Busuttil about the latter's communications with Senior Sergeant Yeomans along the lines that nurses should be working in pairs. Dr Torzillo suggested that a requirement that nurses work in pairs would actually require trebling the nursing establishment, not doubling it.³⁰ He said that they had looked at this issue and trebling would be '*...industrially the minimum you could do*'.³¹ This would mean that the nursing budget would have to be trebled as well. The other complicating factor would be the need for more accommodation for nursing staff. Dr Torzillo quoted some figures to suggest that accommodating the necessary nursing establishment would have been '*...simply something that wouldn't be possible, is not going to be possible*'.³²

²⁵ Transcript, page 375

²⁶ Transcript, page 375

²⁷ Transcript, page 1153

²⁸ Transcript, page 1153

²⁹ Transcript, page 1154

³⁰ Transcript, page 545

³¹ Transcript, page 545

³² Transcript, page 545

6.14. Cross-examined by Mr Roberts on behalf of the Commissioner of Police, Dr Torzillo said that he did not recall a police officer by the name of Senior Sergeant Ann Yeomans. Furthermore, he said he could not recall Mr Busuttil saying that police had expressed concern about nurses of the NHC working alone either in clinics or on-call.³³ Dr Torzillo again suggested that although it would be ideal to always have nurses working in pairs, it was not feasible to obtain funding for that. He went on to say that although he could not recall any conversation with police having been relayed to him, he was not saying it did not occur. The following passage of evidence then took place following a question by myself:

'Q. Put it this way; if Mr Busuttil had received advice from police to the effect that the nurses should not work alone, would you have had expected him to tell you that he'd received that advice.

A. Look, I think in most circumstances he might have relayed that conversation but I guess in a way it was hardly news. I mean, did we think it was ideal that even in some circumstance a nurse would be by themselves compared to with another nurse? Of course not. Of course we thought that would have been ideal. Implementing that would require tripling our nursing staff, not doubling it, and building houses for them. It was just never - just never going to be funded. So it's not something that we would have been able to take action on'.³⁴

6.15. I note that it had not been Senior Sergeant Yeomans' advice that NHC double or treble its nursing staff. The advice was simply that nursing staff were at risk working alone while on-call after hours. That does not of itself suggest that there needed to be at least two nurses working together. The advice was couched in terms of possibilities of either a security guard attending the clinic with nurses or if that was not viable, employing senior Anangu members to be trained to assist the nurses. In the event, as will be seen following Mrs Woodford's death, a similar measure was put in place. There was no suggestion following Mrs Woodford's death that nursing staff necessarily needed to be increased. Gayle's Law, which I will discuss more fully in due course, does not expressly require such a measure.

6.16. Following the Watarru incident, as from June 2012 the NHC was on notice that SAPOL regarded NHC nursing staff working alone as generally a dangerous practice. To my mind the NHC was put on notice that in fact it was a dangerous practice.

³³ Transcript, page 586

³⁴ Transcript, page 586

7. NHC policies and guidelines relating to on-call nursing practices

7.1. The NHC promulgated written policies and guidelines relating to the practices and safety of nursing staff working on the APY Lands.

7.2. A number of these documents were tendered to the inquest. These included two versions of a NHC document '*Clinical Staff Safety – Policies and Guidelines*'.³⁵ I shall refer to this document as the Policy Document. The first version of this document is dated 11 October 2011. The second version purports to have been last reviewed on 14 July 2015. This was the current version of the document at the time of Mrs Woodford's death. Both versions of the document deal with safety at the nurses' home and also with on-call practices including attendances at the home and nursing home visits.

7.3. Both versions of the Policy Document under the general heading '*SAFETY AT YOUR HOME*' inform the clinician that their home was not a '*Clinic*'. The more recent version of the document and the one in effect at the time of Mrs Woodford's death stated '*Patients requiring assessment and treatment MUST be taken to the clinic*'.

7.4. Both versions of the Policy Document state:

- Do not see patients inside your house or in your security cage. This gives people the wrong impression, develops unsafe expectations and is clinically inappropriate in most situations.

However, the document then goes on to state:

- Dispensing simple analgesia and doing simple dressings is occasionally unavoidable. Each clinic should have an on-call box containing very basic supplies to cover most minor presentations. Do not store ANY other medication in your house - this makes you and your house vulnerable!

7.5. Under the heading '*SAFETY IN THE WORKPLACE*' there is a section entitled '*On-call and working in the clinic alone – after hours*'. Under this heading there are the following dot points among others: -

- Do not open the cage to your house to abusive or aggressive patients.

³⁵ Exhibit C31, pages 195-199 and pages 201A following

- Do not go to the clinic on your own if you do not feel comfortable with the patient or the carer. Call a colleague or ask the patient to find a trusted (preferably the same sex as you) family member to come to the clinic with you.
- Female staff should not see male patients without a female relative present.
- Do not do house or camp visits on your own at night.

7.6. A further document entitled '*On-call CHN Guidelines*' was tendered to the inquest. I shall refer to this document as the Guidelines Document. This was annexed to the affidavit of Ms Vivien Hammond, the Clinical Services Manager at NHC.³⁶ In this document there is a section entitled '*On-call Assessments and Treatment*'. This document was in effect at the time of Mrs Woodford's death. There are a number of dot points under this heading, relevantly as follows:

- No patients are to be treated at the on-call staff member's home.
- All patients who need further assessment and treatment must be taken to the clinic.
- Where a responsible person informs the on-call nurse that a person is sick and unable to come to the nurse/clinic, after ensuring that it is safe to do so, the nurse should visit the patient at home, make a preliminary assessment and if required take the patient to the clinic for treatment

Within these guidelines there is another section which I set out in full:

- **Minor health complaints or injuries** requiring immediate attention that can be safely and appropriately assessed from the on-call house should be given the minimum treatment and the patient asked to present to the clinic the next morning.

7.7. Under another section in the Guidelines Document entitled '*Psychotic/drunken/aggressive patients*' there are a number of relevant sub-headings as follows:

- Do not attempt to assess psychotic, drunk or aggressive people alone
- Do not allow psychotic, drunk or aggressive people into your enclosure or house

³⁶ Exhibit VAH2 to the affidavit of Ms Hammond (Exhibit C60)

- 7.8. Under another section of the Guidelines Document it is stated as follows:
- **Do not allow victims of domestic violence into your house or enclosure.** Call the police or another staff member for protection. If the victim requires treatment and the perpetrator is not nearby, take them to the clinic for assessment when it is safe to do so.
- 7.9. I will deal with the evidence surrounding the actual nursing practices as they were taking place in the material times. However, the documentation that I have referred to appears to be somewhat contradictory insofar as certain sections of these documents suggest that patients must not be treated at the on-call staff member's home and yet the documentation contemplates minor health complaints or injuries that require immediate attention as involving the nurse assessing the person from the on-call house and providing '*minimum treatment*' to the patient. It is difficult to see how patient assessment and treatment could be provided to a person presenting to the on-call nurse's house without that person being admitted to the caged area of the house. Moreover, the prohibition that nurses were not to allow psychotic, drunk or aggressive people into the enclosure or house seems to imply that any person who did not fit that description, being male or female, might be allowed into the enclosure or house.
- 7.10. Nevertheless, as seen above the Policy Document did state that female staff should not see male patients without a female relative present. This appears to be a general instruction to female staff covering on-call work after hours at their home, at the clinic or indeed on a house call. It will be remembered that Mrs Woodford earlier on the evening in question saw three male persons at the clinic. She was called away that night from her home to attend at the clinic for that purpose. As observed earlier in these findings, there is no evidence that any female person was present. The evidence in fact would suggest that this was probably not the case. When Davey approached the house and did whatever he did to attract Mrs Woodford's attention, he was probably on his own and almost certainly not in the presence of a female person.
- 7.11. It will be noted, however, that the Guidelines Document as distinct from the more general Policy Document is silent about female staff not seeing male patients without a female relative present. This prompted counsel assisting and counsel for Mrs Woodford's family, Mr Blewett, to seek to suggest that this meant in effect that there was no such prohibition as the more specific Guidelines Document appeared to

cover the field of on-call practices. I am not certain if that is a valid observation. The Policy Document in fairly clear terms did state that female staff should not see male patients without a female relative present and did not seek to draw any distinction between practices involving seeing a patient at the on-call nurse's home, whether in the cage or not, at the clinic or in the course of a house visit.

- 7.12. To my mind the more important consideration is what the practices actually were amongst the nursing staff at Fregon, particularly having regard to the practicalities involved in possibly turning single male patients away when they presented at a nurse's home after hours. The associated issue of course is whether the actual nursing practices were known to NHC management and were tolerated or not irrespective of what was contained in written material.

8. Relevant on-call nursing practices in Fregon

- 8.1. This evidence emanates from a number of witnesses who either gave evidence in the inquest and/or provided statements.

- 8.2. I will deal with each of these witnesses in turn.

8.3. The evidence of Mr Keith Woodford

Mr Woodford gave evidence about a number of his wife's practices in respect of on-call work. Mrs Woodford had worked in Fregon for approximately four years. Mr Woodford had been living in Fregon with his wife for the latter three years of that period.

- 8.4. Mr Woodford told the Court that his wife engaged in a number of working practices that included the following:

- Treating patients inside the caged area of the house for minor injuries.³⁷
- Attending the clinic with patients on her own.³⁸ I refer to the fact that Mrs Woodford was at the clinic earlier on the night in question with three male persons.
- Treating male patients alone, although this was uncommon. Male patients uncommonly came to the house on their own and would generally be accompanied

³⁷ Transcript, page 146

³⁸ Transcript, page 146

by a family member.³⁹ Mr Woodford was unaware of any prohibition to the effect that male patients should not be seen alone.⁴⁰

- Mrs Woodford would visit patients' homes while on-call. He said that he believed this was a practice of all on-call nurses based in Fregon.⁴¹
- Community members would attend the on-call house seeking refuge from domestic violence and/or to request police assistance.⁴²

8.5. Mr Woodford told the Court that his wife had raised safety concerns in connection with patients attending the house. He believes that she had raised them with NHC management. She had told Mr Woodford that working from the cage was not the safest environment. Mr Woodford was of the belief that safety concerns had been raised by the Fregon nurses at clinical meetings.⁴³ In this regard Mr Woodford told the Court that Mrs Woodford had told him that the management's response to safety concerns was '*...if you don't like it leave*'.⁴⁴

8.6. I accepted all of Mr Woodford's evidence in this regard. Naturally much of what Mr Woodford believed about his wife raising safety concerns with management was based upon what she had told him. The weight of his evidence is thus limited to that extent. However, it would seem odd and therefore unlikely that Mrs Woodford had invented all of this before imparting it to her husband. As well, as will be seen, what Mrs Woodford told her husband is very much in keeping with the evidence of other witnesses who said they shared her concerns.

8.7. The evidence of Belinda Claire Schultz

Ms Schultz was a registered nurse working for the NHC at Fregon. She was employed in this capacity from October 2012 to December 2015. Ms Schultz lived and worked in Fregon as a single woman. Ms Schultz is the registered nurse referred to earlier in these findings at paragraph 1.7.

³⁹ Transcript, page 142

⁴⁰ Transcript, page 143

⁴¹ Transcript, pages 102-104

⁴² Transcript, pages 151-152

⁴³ Transcript, pages 146-147

⁴⁴ Transcript, page 147-148

- 8.8. Ms Schultz acknowledged that she had received general advice that if one could avoid it then one should try not to see male patients alone.⁴⁵ She said that she was not sure whether that had been in a policy as such.
- 8.9. Ms Schultz told the Court that she received an on-call allowance but that if she needed to call a second nurse to come out there was no roster system for that and no formal process. That said, she acknowledged that another nurse might participate out of their sense of collegiality.
- 8.10. As far as the on-call duty was concerned there was no ability to access patient records or patient alerts from the nurse's house. The lack of equipment at the staff house rendered an on-call medical assessment of patients at that location as inadequate. She told the Court that presentations at the staff house could involve serious or minor matters and could even involve non-medical reasons such as requests to use the telephone or requests to be driven to another location.
- 8.11. Ms Schultz confirmed that minor treatments were carried out in the security cage of the nurse's house. The reader is reminded of her evidence, which I accept, that one could not function in an on-call role without opening the cage. Naturally there was a reluctance to open the security cage door to patients who were aggressive or under the influence. She said that in her view it was preferable to treat a single male patient in the cage rather than be alone with a single male in the clinic.
- 8.12. Asked about the stipulation in the Policy Document that female staff should not see male patients without a female relative present and whether it was practicable to adhere to this, Ms Schultz said that it was rare that one would deal with a male presenting alone, but that it did happen. She said that it was difficult to turn away what appeared to be a genuine presentation of a male who presented alone. She said:
- '... it's very difficult if somebody comes to me with clearly what is a sprained ankle and I say 'No, you need to walk home, get your wife, walk back and then I'll take you to the clinic.' So, there is some significant clinical and ethical considerations there'.⁴⁶
- 8.13. Ms Schultz said that she was not aware of any stipulation saying that they should not do house or camp visits on their own at night. She was not aware of that policy until the relevant document was shown to her in the course of her evidence. She said she

⁴⁵ Transcript, page 164

⁴⁶ Transcript, page 188

‘...certainly wasn’t aware that that was the expectation, I don’t recall ever being told that during my orientation’. Ms Schultz went on to say that as far as her own practice was concerned and from what she saw of her colleagues’ practices, all nurses performed calls at night alone as and when required. Asked if a male community member came to her house alone and asked her to leave her house to see a relative, and asked as to whether she would leave the cage to deal with that matter, Ms Schultz told the Court that it would depend on the circumstances. If she believed it was a genuine serious medical emergency, she would do that.⁴⁷

- 8.14. In her evidence Ms Schultz spoke of circumstances in which a person seeking treatment or other services might use a pretext or false pretence of a medical emergency when in reality the person wanted use of a telephone or a lift to another location.⁴⁸
- 8.15. Ms Schultz told the Court that when she first started work at Fregon she was *‘shocked’* that patients would attend her home after hours. She made the very strong point that this was an inappropriate process and something that would not happen in a metropolitan, regional or even a rural setting.
- 8.16. Ms Schultz spoke of the apparent contradiction in NHC documentation which on the one hand contained the instruction not to see patients inside the house or in the security cage and on the other expressed the assertion that administration of simple dressings in the cage was occasionally unavoidable. She said that it would be very difficult to stay within the guidelines when one was expected to perform simple dressings and provide simple analgesic.⁴⁹ She gave as an illustration of this expectation the fact that chairs were provided in the cage.
- 8.17. Ms Schultz gave evidence about concerns that the nursing staff had raised with persons at NHC in management roles. She said that she and her colleagues, Mrs Woodford and Mr Phibion Takawira, another registered nurse, on a number of occasions raised concerns about the inappropriateness of people attending at their houses.⁵⁰
- 8.18. Ms Schultz asserted that as far as she was aware Mr Busutil, Health Services Manager of the NHC and Ms Hammond, Clinical Services Manager of the NHC, knew that the nursing staff performed house visits at night. As far as Ms Schultz was aware every

⁴⁷ Transcript, page 174

⁴⁸ Transcript, pages 183-184

⁴⁹ Transcript, page 185

⁵⁰ Transcript, page 177

nurse in every community in the APY Lands was doing the same thing and that the practice of performing house visits at night was not isolated to Fregon. Asked if there were any safety concerns for her doing house calls on her own she said ‘*absolutely*’.⁵¹ She said that the raising of the safety concerns was a ‘*regular conversation that we had*’.⁵² This took place especially at clinical meetings. Although it was not necessarily an agenda item at meetings, Ms Schultz maintained that the topic was certainly something that staff on the ground were raising regularly as an issue. This included not only house visits at night alone but on-call work in general,⁵³ meaning presentations to the house and the treatment of people including single responders.⁵⁴ She believed that Mrs Woodford and Mr Takawira shared the same view.⁵⁵ Asked as to the response that these expressions of concern elicited from management she said:

‘Yes, I felt that the regular response was that the solutions are too hard, so regularly we brought up security guards was the common one, we don't have funding to pay their wage, we don't have housing to put them in, we can't access more housing in these lands, and because those solutions were too difficult, you know, there was nothing really done in response to our concerns’.⁵⁶

8.19. Interestingly, Ms Schultz’s recitation in that passage of the reasons NHC management gave for not providing security guards were the very reasons cited in this inquest by the NHC. I have no doubt that the issue of security guards was raised by nursing staff with NHC management.

8.20. Like Mr Woodford, Ms Schultz believed that the management response had involved an assertion to the effect that if staff did not like the situation then they did not have to work for the NHC. She believed that this had been said by Dr Paul Torzillo, Medical Director of the NHC. Ms Schultz expressed her beliefs in the following way:

‘Yeah, so we were having a conversation around the on-call presentations. Paul had given a directive at that point, that every child under the age of five should be taken to the clinic, and almost every other clinical presentation. Linda had bought up her concerns about fatigue management, safety, prank callouts, and how all of these things would be impacted by that directive, and, you know, that she was really concerned that that wasn't a sustainable approach to the on-call system; at which point that was Paul's response to her.’⁵⁷

⁵¹ Transcript, page 189

⁵² Transcript, page 189

⁵³ Transcript, page 190

⁵⁴ Transcript, page 190

⁵⁵ Transcript, page 190

⁵⁶ Transcript, page 190

⁵⁷ The Linda referred to in this passage is a Linda Murphy, another registered nurse

As a result of this, Ms Schultz felt that her concerns had not been addressed at all and that they were made to feel that their concerns lacked validity.⁵⁸ As a consequence she developed a reluctance to raise concerns.

- 8.21. Ms Schultz believed that Dr Torzillo and Mr Busutil would have been made aware that she and her colleagues were going out at night making on-call visits alone.⁵⁹
- 8.22. Ms Schultz also told the Court that there was frequent conversation about safety and the potential strategies to manage it, in particular the question of the provision of a security guard. That issue appears to have been raised in terms of clinic security as distinct from on-call security. As already seen, Ms Schultz asserted that the standard response was that there was a lack of funding for security guards.⁶⁰
- 8.23. In cross-examination Ms Schultz confirmed that if a person presented at the house and required pain medication or needed a wound dressing she would bring the patient into the cage. She understood that the other nurses also adopted that practice. She agreed that there might be occasions where this occurred in respect of a single male who had attended. Ms Schultz said that in those circumstances she would certainly have her guard up a little bit more and would be paying a bit more attention to the potential for volatile behaviour. If she believed it was a genuine presentation she would bring the patient into the cage. She would be more inclined to do that than to take them alone to the clinic. Ms Schultz did say that if she felt comfortable to do so she would take patients in the ambulance to the clinic.⁶¹
- 8.24. Ms Schultz described the level of unease that was occasioned by on-call presentations. She said:

'That's right, yeah. I mean, you often feel a degree of uneasiness. I think anybody that's on call overnight can relate to that heart-in-the-throat feeling when the doorbell goes or the phone rings, and you have no idea, literally, what's coming to your door. You could be called out to a rollover, you could be called to a hanging, it could be a simple headache or a cut on the foot. So, there's always that degree of uneasiness, and I think everybody's tolerance level for how much they're willing to feel that is different, as well, and played into your assessment'.⁶²

⁵⁸ Transcript, page 192

⁵⁹ Transcript, page 254

⁶⁰ Transcript, page 262

⁶¹ Transcript, page 275

⁶² Transcript, page 281

Ms Schulz implied that what could make nurses wary of a particular patient would be a known history of violent offences. Even if she did not know the person presenting, or had very little to do with them, she would be cautious. She implied that it was not so much a question of ever feeling safe in respect of a home visit; it was more a case of the degree of unease one experienced.⁶³

- 8.25. Ms Schultz asserted in cross-examination that there were occasions when she felt that there was no alternative but to see a male patient notwithstanding the absence of an accompanying female. She said that there were times when she would often see male patients alone. Similarly, strict adherence to a prohibition not to perform house visits alone at night would have effectively meant that she could not practice as an on-call nurse.⁶⁴
- 8.26. In the event, Ms Schultz left the APY Lands because she felt quite burnt out from the repetitive violence and threats. She was feeling intimidated and that this was all starting to affect her clinical judgment.⁶⁵
- 8.27. In cross-examination by Mr Gilchrist on behalf of Dr Torzillo, Ms Schultz stated that the policy requiring a female relative to accompany a male was not 100% practical. While acknowledging that this was a guideline it was not Ms Schultz's understanding that it was a strict rule that one had to abide by in all circumstances. She said '*Because the context is so varied out there, you don't know what's going to present and what exceptions you might need to make to those (sic) advice*'.⁶⁶ Ms Schultz did not agree with the suggestion that she always had the option of enlisting the assistance of a colleague. She said that she did not always have access to a colleague, particularly on weekends when her colleagues may have been away from Fregon.
- 8.28. Ms Schultz said that she was not aware of any requirement that she needed to be accompanied by a colleague on a house call at night.⁶⁷
- 8.29. I found Ms Schultz to be a most impressive witness. I believe that at all times she endeavoured to tell the truth as she believed it to be. Ms Schultz did not strike me as a person given to hyperbole.

⁶³ Transcript, page 283

⁶⁴ Transcript, page 286

⁶⁵ Transcript, page 291

⁶⁶ Transcript, page 310

⁶⁷ Transcript, page 311

8.30. The evidence of Mr Phibion Takawira

Mr Takawira is a registered nurse who at the time of the inquest was still employed by the NHC. He commenced his employment as a locum in 2010. He progressed to full time employment in 2013. Mr Takawira has worked in several of the communities in the APY Lands including Fregon. Mr Takawira was one of the three nurses based in Fregon at the time of Mrs Woodford's employment.

8.31. Mr Takawira told the Court that during the course of his induction he had viewed some NHC guidelines.

8.32. Mr Takawira asserted in evidence that he assessed patients inside the staff house security cage and if necessary conveyed the patient to the clinic in the ambulance.⁶⁸ He also treated patients for minor injuries inside the security cage. He conducted house visits whilst on-call. He understood that it was the practice of all nurses to treat patients for minor injuries inside the staff house security cage and to carry out house visits alone if it was safe to do so.

8.33. Mr Takawira also stated that all of the three Fregon nurses had discussed the dangers of working on-call alone. Their concerns were raised with Ms Hammond and Mr Busuttill. He asserted that these individuals were aware that nurses were making house calls alone at night. He said that safety issues were raised with management at clinical meetings at a time prior to Mrs Woodford's death. Mr Takawira said that their concerns were dismissed with words to the effect that if they did not like working there, then do not work there.

8.34. In his oral evidence Mr Takawira confirmed that before taking a presenting patient to the clinic he would sometimes offer the patient a seat in the cage while he assessed them and ascertained what their issues were. He would do all of that if he felt it safe to do so.⁶⁹

8.35. Mr Takawira spoke of an incident that occurred in 2013 when the Fregon store was burned down. During the day there had been much fighting in the community and there had been a number of connected presentations to the clinic. As a result NHC staff were evacuated from Fregon. Following this incident nursing staff raised issues concerning lack of police presence in Fregon and in particular, police not responding to incidents

⁶⁸ Transcript, pages 965 and 1017

⁶⁹ Transcript, page 965

of that nature. However, Mr Takawira stated that between the time of that incident and Mrs Woodford's death not much changed in Fregon. No extra security was provided by NHC.⁷⁰

- 8.36. During his evidence Mr Takawira was asked about the role that he believed a security guard could conceivably have performed at a time prior to Mrs Woodford's death. He said:

'At that time I would have preferred for the security to be accompanying the staff on-call when they go out instead of the staff being on their own when they go out especially at night.'

He suggested that security could be the first port of call if a person was unwell so that nobody would actually need to attend at the nurse's house. The security guard would then pick up the nurse and be taken to the clinic.⁷¹

- 8.37. Mr Takawira, like Ms Schultz, also referred to contradictions in the NHC policy and guideline documentation. He said that providing minor treatment in the caged area was a common practice. It was very contradictory for the assertion to be made that no patients should be so treated when at the same time one was meant to treat minor ailments at home and not take patients to the clinic.⁷²

- 8.38. As far as home visits were concerned, Mr Takawira told the Court that it was very difficult to make any assessment of safety in relation to visits to a person's home. He said that most of the time one could not really ask if it was safe because nobody would tell you. All the presenting person would divulge is that someone was sick and that they needed to be seen immediately. If he was satisfied that the request for attention was genuine, he would invariably go to the home to attend to the patient and would do so even if he had some concerns about his personal safety.⁷³ In my view the point can validly be made that much of a person's assessment as to safety would in many cases be largely based on uninformed guesswork.

- 8.39. Mr Takawira's understanding was that while on-call the only circumstance in which he could seek the assistance of a colleague was when the patient was psychotic, drunk or aggressive or when, due to the complexity of the patient's presentation, it was medically

⁷⁰ Transcript, page 971

⁷¹ Transcript, page 975

⁷² Transcript, page 1016

⁷³ Transcript, page 1019

necessary to engage a second pair of hands. Otherwise, he was expected to treat a patient alone.⁷⁴

8.40. Mr Takawira told the Court that he believed that Mrs Woodford and Ms Schultz were adopting the same practices as his. He gleaned this from morning discussions among staff following on-call shifts.⁷⁵

8.41. In cross-examination by counsel assisting, Mr Kalali, Mr Takawira told the Court that the concerns that were shared by his colleagues about being on-call and alone at night were raised with Ms Hammond. Prior to 2016 there were numerous occasions when they would call and express their concerns about safety issues, especially on-call safety issues.⁷⁶ The calls were made to management, in particular to Ms Hammond and Mr Busuttil.⁷⁷ As far as he was concerned both Ms Hammond and Mr Busuttil knew that staff were going out on home visits at night alone. He was present when these concerns were raised in person. He told the Court that he remembered Mr Busuttil visiting the clinic and that they sat down and raised their concerns with him. All of the nurses participated in this including Mrs Woodford. He did not know exactly when this occurred but it was prior to 2016.⁷⁸ He told the Court that nothing changed following this. He added that at one of the clinical meetings in Umuwa that was attended by all nurses and medical staff a comment was made '*If you are not fit to work in this environment then maybe it's not for you*'.⁷⁹ He could not remember if it was Dr Torzillo or Mr Busuttil who had said this. Asked as to what his attitude to those comments were, he said:

'A. It was hard to hear that because all we wanted was management to do something to ensure that the staff felt safe.

Q. Do you think that comment was dismissive of your concerns.

A. Yes.'

8.42. Mr Takawira said that he recalled the nursing staff talking to Mr Busuttil most of the time when he came to visit the clinic. Asked as to what the nurses were asking to be

⁷⁴ Transcript, page 1021

⁷⁵ Transcript, page 1032

⁷⁶ Transcript, page 1034

⁷⁷ Transcript, page 1035

⁷⁸ Transcript, page 1035

⁷⁹ Transcript, page 1036

done, he said that he remembered specifically asking for health workers to be the first persons on-call so that people did not present directly to the nurses' houses.⁸⁰

8.43. I found Mr Takawira also to be an impressive witness. To my mind at all times he endeavoured to tell the truth as he believed it to be.

8.44. The statement of Tessa Sydney Wilkie

Ms Wilkie is a registered nurse who was employed by the NHC as a locum community health nurse from December 2013 to January 2015. Her duties involved cover of nurses who had taken annual leave. Ms Wilkie worked in a number of communities in the APY Lands including Fregon. She completed approximately five short term contracts with the NHC, variously for periods of ten days to six weeks. Typically, her contracts involved three to four weeks of work in the APY Lands. In 2013 Ms Wilkie was aged 29. She had qualified as a registered nurse in 2009. I take it that she worked in Fregon as a single woman.

8.45. Ms Wilkie provided a statement to SafeWork SA as part of that organisation's investigation into the death of Mrs Woodford.⁸¹

8.46. In her statement Ms Wilkie describes what was for her a baptism of fire as it were. She describes the level of violence in the Fregon community. She describes an incident that occurred on the night that she arrived in Fregon. Due to the level of violence in the community NHC staff were evacuated, ultimately to Alice Springs. I infer that this was the incident in which the Fregon store was burned down. While in Alice Springs, Ms Schultz and Mr Takawira met with Mr Busuttil to discuss safety issues in the community. Ms Wilkie states that she raised her own concerns about the prospect of being on-call during a volatile period in Fregon. She had not worked at all in the community at that stage but was rostered to be on-call on the day that they returned to Fregon. She states, *'I was advised by Mr Busuttil that I didn't have to work for them if I didn't want to'*, a response strikingly similar to those described by others.

8.47. Ms Wilkie returned to Fregon with Ms Schultz and Mr Takawira at around Christmas of 2013. She was placed on-call that day to cover for the annual leave of Mrs Woodford. For these purposes Ms Wilkie was accommodated in Mrs Woodford's house in Fregon for about four weeks. In her statement she describes certain orientation

⁸⁰ Transcript, page 1037

⁸¹ Exhibit C31, page 114-117

procedures. She was advised by Ms Schultz and Mr Takawira that when on-call one should talk to the patient from within the cage and that male patients must have a female escort. Ms Wilkie then states that one would perform an assessment of the risks associated with bringing the patient into the caged area. If it was thought safe to do so one would open the cage, admit the patient and make an assessment to determine whether treatment was required in the clinic or if it could wait until regular clinic hours. She says that she was advised by fellow nurses and by management at NHC that if she did not feel safe she need not open the cage.

- 8.48. However, in her statement Ms Wilkie describes the situation in practice as experienced by her. She said that the instruction not to open the cage when feeling unsafe was ‘*a grey area*’ in respect of which one had to use one’s own judgment, especially when there were presentations involving domestic violence in which the alleged assailant had followed the woman to the nurse’s house.
- 8.49. Ms Wilkie asserts that she was at no stage aware that it was contrary to NHC policy to allow people into the cage. She says that she believed that allowing people into the cage was expected in order to assess patients who potentially needed further assessment or treatment at the clinic. She said it was difficult to make an assessment of the patient’s needs if she did not allow them into the cage. Ms Wilkie states that she felt that allowing patients into the cage for patient assessment was the standard practice among the other nurses. She did not report these circumstances directly to Ms Hammond because Ms Wilkie assumed that Ms Hammond already knew. She was not sure if higher management within the NHC knew of the practice of the nurses but she feels that they did. She says that management were certainly aware that she was seeing patients in the clinic after hours as this was documented. In order to see patients in the clinic after hours she had to open the cage to take the patient to the clinic.
- 8.50. Ms Wilkie states that she was aware that there were policies and procedures available on the IntraNET that dealt with safety at home but she does not recall reading them. Her knowledge of work practices came from other nurses. She felt ‘*the pressure to treat patients who presented to the house whilst I was on-call*’. She says that she felt this pressure from management because if there had been any adverse outcomes from not assessing or treating a patient who presented after hours she may have been liable or may have been blamed. She also naturally felt pressure from within herself out of her desire to help the patients and out of concern about their welfare.

8.51. At two places in her statement Ms Wilkie suggests that she was aware of the stipulation that a presenting male patient needed a female escort during treatment. Her statement is silent as to whether this was adhered to. The impression from her statement is that she felt compelled to deal with presenting patients of both genders.

8.52. Ms Wilkie describes two concerning incidents involving herself that occurred in the Pukajta community. In one incident a male person came to the house that she was staying in and asked to be let in for sex. The male repeated this behaviour through the night and on numerous occasions during the following week. Police were called on multiple occasions and she also reported this to Ms Hammond and Mr Busuttil. She says:

'As a result of this, I was still expected to be on-call by myself, but management asked that when a patient presented to my home for treatment after hours, I would ask them to follow me to the clinic, then back to my home after treatment, to ensure I was not alone at night. Most of the time it didn't happen as the patient simply went back to their own home.'

The second incident occurred at Fregon while Ms Wilkie was on-call dealing with a patient in the clinic. While this was taking place another person was banging on the door. The person alleged that they were a relative of the patient and a 'traditional healer'. The person indecently assaulted her. Police were called and the person was convicted. Following this Ms Wilkie decided to leave NHC employment.

8.53. In her statement Ms Wilkie describes the violence in the Fregon community and the frequent fighting. This caused her to be hypervigilant and incessantly worried that something was going to happen to her. She says that she did not realise how dysfunctional the Fregon community was or how violent many of the people were. She was subsequently diagnosed with Post Traumatic Stress Disorder which she believes was the result of her time in Fregon.

8.54. A common theme in the evidence of the witnesses to whom I have referred is that the on-call nurses in Fregon would see patients on their own in circumstances which necessitated opening the cage to unaccompanied male patients. Another common theme is that they had raised concerns about these circumstances with management of the NHC or were aware that others had done so. The witnesses are unanimous that the response consisted of words to the effect that if they did not like working there, they had the option of not working there.

- 8.55. Having regard to the experiences of these witnesses and the general level of violence and dysfunction in that community, to my mind the fears and concerns entertained by the nursing staff particularly in relation to what they believed they were required to do while on-call, and especially in relation to admitting presenting patients to their cage or breaching the security of the cage generally, were not unreasonably held.
- 8.56. It is necessary here to discuss the responses of witnesses from NHC management positions.
- 8.57. The evidence of Mr John Singer
As already indicated Mr John Singer is the Executive Director of the NHC. Mr Singer provided two statements to the inquest.⁸² Mr Singer also gave oral evidence.
- 8.58. In his witness statement Mr Singer described the NHC as an Aboriginal owned and controlled health service operating in the APY Lands. It was established in 1983. The NHC is governed by a Board that meets several times a year including at an Annual General Meeting. The senior management team that reports to the Board included himself, the Medical Director, Dr Torzillo and the then Health Services Manager, Mr Busuttil. As far as NHC funding is concerned, Mr Singer indicates that the NHC does not own any significant assets or have any ability to generate funds. It is completely reliant on funding provided by external parties, principally the Federal and South Australian Governments. He explained that following the death of Mrs Woodford, the NHC was able to implement additional safety measures to support the on-call service but that this was only made possible as a result of funding received from the Federal Government. Approximately three quarters of the funding for the NHC was provided by the Federal Government, the remaining quarter coming from the South Australian Government.
- 8.59. Mr Singer explained the origins and history of the on-call service which the NHC offers. The initial expectation was that community members who needed treatment outside of clinic hours would first approach a health worker who was a member of the community. Health workers were very limited in the treatment they could provide. In the event that the patient required treatment that a health worker could not provide, the person would visit the on-call nurse. As time progressed community members would increasingly go straight to the on-call nurse for treatment because they knew that the

⁸² Exhibit C50 and C50a

health worker would not be able to assist. In addition, community members were more familiar with the nursing staff. NHC trialled the use of a phone at the clinic to contact the on-call nurse but this was not successful as the phones were often vandalised or used to make prank calls. The idea behind the health worker scheme was that the health worker and the persons seeking medical assistance would either go to the nurse or contact the nurse to have them attend the patient. In due course the health workers were bypassed and community members started to go directly to the nurse. Mr Singer agreed with the proposition that another reason why patients would go straight to the nurses' quarters was that there was an element of unreliability about the availability of the Aboriginal health worker. In addition there might be cultural reasons or business or other reasons whereby the health worker could not be found by the person seeking medical assistance.

- 8.60. To my mind the fact that that at one time there had been a system that prevented or discouraged direct presentations to the on-call nurse at their home was due to the manifest inappropriateness of that practice. The house cages were then introduced.
- 8.61. Mr Singer explained that as there were no mobile phones in Fregon it was necessary for nurses to be available at their residence for the purpose of providing the on-call service. The provision of cages at the nurses' accommodation was meant to allow the nurses to make an assessment as to whether the patient required treatment at the clinic and whether it was safe for them to go to the clinic with the patient. In his statement Mr Singer suggested that there were a number of factors that nurses were instructed to take into account in making an assessment as to whether the person should be taken to the clinic and whether it was safe for them to do so. The factors to be taken into account included the gender of the patient and, if the patient was male, whether he was accompanied by a female relative.
- 8.62. In his evidence Mr Singer told the Court that when community members seeking medical assistance started to bypass the health worker and began approaching the nurses' homes directly, the NHC put in place structures and policies to cater for these new circumstances. It was at this time that the cages were installed at the nurses' homes.⁸³ In addition, policies regarding nursing practices relating to on-call interaction with patients were brought into being. The policies required nursing staff to undertake

⁸³ Transcript, page 855

an assessment upon a patient presentation to determine whether it was safe for them to assess or treat the community member.⁸⁴ It was only after Mrs Woodford was murdered that they reverted to a system involving a strict two-person attendance for on-call work. I take it that this was an acknowledgment by NHC that no such system existed at the time of Mrs Woodford's death. There seems little doubt about that in any case.

8.63. Mr Singer told counsel for Mrs Woodford's family, Mr Blewett, that he had an understanding that when a community member needed assessment or treatment the nurses would tend to find a way to assess or treat that person even if they could not obtain the support of another colleague or the support of a relative; and that these circumstances prevailed before Mrs Woodford's death.⁸⁵

8.64. Mr Singer acknowledged that there was a strong element of violence within the Fregon community. He told counsel assisting, Mr Kalali, that he has seen communities in the APY Lands both with a police presence and without and that he believes that a police presence makes a positive difference. Mr Singer believes that a police presence would create more safety for the clinic and its staff.

8.65. The evidence of Mr David Busuttill

From July 2011 to April 2018 Mr Busuttill was the Health Services Manager of the NHC. He is not a clinician. Mr Busuttill provided a statement in relation to the NHC processes and measures relating to protection and safety of NHC employees at the time of Mrs Woodford's death. The statement also covers processes and measures that have been put in place by the NHC since Mrs Woodford's death.⁸⁶ There were a number of annexures to Mr Busuttill's statement also tendered in evidence. Mr Busuttill gave oral evidence on two separate occasions during the course of this inquest and did so at considerable length.

8.66. Mr Busuttill's statement⁸⁷ makes it plain that if a member of the community needed health care after hours he or she would generally present at the house of the nurse who was on-call. The on-call nurse would be identified by the fact that the ambulance was parked outside the nurse's house and that the light at the front of the house would be on. There was also a doorbell.

⁸⁴ Transcript, page 855

⁸⁵ Transcript, page 859

⁸⁶ Exhibit C45

⁸⁷ Paragraph 40.6

- 8.67. Mr Busuttil's statement also deals with the NHC policies and guidelines. Mr Busuttil asserts⁸⁸ that NHC did require staff to see patients after hours but that the protocols in place were considered to have kept staff safe. He asserts, '*staff were never expected to put their safety at risk when seeing patients*'.
- 8.68. Mr Busuttil's statement deals with a number of the assertions made by the witnesses who were members of the nursing staff and who gave evidence or provided a statement to the inquest.
- 8.69. Mr Busuttil's statement asserts that he could not recall situations where clinic staff specifically raised safety issues at clinical meetings. He points out that he is not a member of the NHC clinical staff and did not sit in clinical meetings for their entire duration.⁸⁹
- 8.70. Mr Busuttil strongly disagrees that NHC had a dismissive attitude to safety.⁹⁰
- 8.71. Mr Busuttil did not reside in Fregon but would visit this and other communities in the APY Lands.
- 8.72. In his oral evidence before the Court Mr Busuttil insisted that he did not know that both Mrs Woodford and Ms Schultz attended home visits at night by themselves.⁹¹ He repeated that insistence under cross-examination by Mr Kalali, counsel assisting.⁹² He also insisted that all nurses working from home were following and applying the guidelines.⁹³ He did not have any recollection of anyone raising the topic as a specific issue.⁹⁴
- 8.73. However, in his evidence Mr Busuttil acknowledged that there were circumstances in which the nurse would have to open the cage to a presenting patient. Those circumstances would include having to administer a dressing.⁹⁵ He acknowledged that dispensing simple analgesia and performing simple dressings was in accordance with the Policy Document where it suggested that treatment of this kind was occasionally unavoidable. He also acknowledged that if people considered it safe they could admit

⁸⁸ Paragraph 63.12

⁸⁹ Paragraphs 68.13- 68.14

⁹⁰ Paragraph 68.16

⁹¹ Transcript, page 352

⁹² Transcript, pages 503 and 506

⁹³ Transcript, page 504

⁹⁴ Transcript, page 507

⁹⁵ Transcript, page 398

the patients to the cage either to provide simple analgesia or to make a quick preliminary assessment to work out whether the patient needed to go to the clinic. However, Mr Busuttil insisted that this was overridden by the stipulation that female staff should not see male patients without a female relative.

8.74. Of significance, Mr Busuttil agreed that nursing practices which were not strictly in accordance with written policy could creep in⁹⁶. He also agreed that the stipulation regarding females not attending a single male alone could have been stronger. He agreed that rather than suggesting that nursing staff '*should*' attend to a male patient with a female relative present, the document should have said '*must*'.⁹⁷

8.75. In this context Mr Busuttil acknowledged that everything that occurred after the patient's presentation at the house depended upon the nurse making an assessment about their own personal safety. Furthermore, the nurse would have needed to weigh up safety considerations against the need or possible need for the treatment of the patient, particularly in a place that had serious health issues among its population. Mr Busuttil was asked as to whether a decision not to treat a patient who presented could give rise to real issues in respect of the nurse's professional duty of care. Mr Busuttil said:

' I guess so, yes. I mean yes a nurse has a duty of care to a patient, but yes, when it's safe.'

Mr Busuttil also acknowledged that a refusal to treat a patient in those circumstances could have serious implications for the patient and have repercussions for the nurse within the community. He said that no one is going to be safer if someone dies on a nurse's doorstep.

8.76. Counsel assisting, Mr Kalali, put it point blank to Mr Busuttil that the NHC nurses working alone had been at risk of sexual assault and injury and that he was aware of this prior to Mrs Woodford's death. To this Mr Busuttil said that he agreed. As to whether that was the case when they were on-call he said '*not limited, but yes, whilst they were on-call*'.⁹⁸

⁹⁶ Transcript, page 403

⁹⁷ Transcript, page 407

⁹⁸ Transcript, page 521

- 8.77. Mr Busuttil said he had no recollection of saying to staff members words to the effect that they did not have to work for NHC if they did not want to.
- 8.78. When Mr Busuttil was recalled to the witness box and the current version of the Guidelines Document produced by and annexed to the affidavit of Vivien Hammond was put to him, Mr Busuttil conceded that his belief that NHC policy was that staff must not do home visits on their own at night was inconsistent with the stipulation in the then current on-call guideline that where a responsible person informs the on-call nurse that a person is sick and unable to come to the nurse/clinic, after ensuring that it is safe to do so, the nurse should visit the patient at home, make a preliminary assessment and if required take the patient to the clinic for treatment. Mr Busuttil also stated that he thought that staff were only performing home visits at night if they were accompanied by another person. It appears from the Guidelines Document that there was no such requirement.
- 8.79. Mr Busuttil also conceded that there was nothing in the guideline about a female nurse not treating a male alone. As to whether female nurses would treat persons in their cages and do so alone, Mr Busuttil conceded that the then current guidelines did not stipulate otherwise.
- 8.80. The evidence of Ms Vivienne Hammond
Ms Hammond is the Clinical Services Manager at the NHC. She provided an affidavit and annexures to the inquest⁹⁹. Her affidavit is dated 17 January 2020. For the first time since this investigation commenced the affidavit produced the current version of the '*On-Call CHN Guidelines*', the Guidelines Document.¹⁰⁰ Ms Hammond is the author of those guidelines.
- 8.81. As the clinical services manager of the NHC Ms Hammond is the direct supervisor of the nursing staff at all communities within the APY Lands. Ms Hammond states that she visits clinics from time to time and attends clinical meetings at Umuwa. Ms Hammond asserts that she has always felt perfectly safe in all APY Lands communities. Ms Hammond did not live in Fregon.
- 8.82. Ms Hammond told the Court that she knew that patients within the APY Lands communities would attend at the houses of on-call nursing staff. She says that

⁹⁹ Exhibit C60

¹⁰⁰ VAH2 to the affidavit of Ms Hammond

emergencies would involve the taking of such patients to the clinic. On a number of occasions in her evidence she stated that males presenting to female nurses without any accompanying female would be regarded as '*culturally inappropriate*'.¹⁰¹ She asserted:

'So it's possibly inappropriate for a male to come to the house of a female without another female present. So generally that male would be asked to go get their partner or their mother and the nurse would then address any health issues the person was complaining about. But in my experience it was very rare for a male to present to a female nurse after hours with a health issue, because it was culturally inappropriate. So my experience was that if a male did knock on the doors after hours at night on his own, he was asked to go away and get a female. He generally didn't re-present, he just went away. If he was in fact sick he would come to the clinic during the day, but most of the time it was not a health issue.'¹⁰²

Ms Hammond was asked a pertinent question, namely as to what nursing staff would be expected to do in a situation where, for example, a male person unknown to the nurse presented alone and it was obvious that they needed medical treatment for a fracture. Ms Hammond suggested that the appropriate course of action would be to seek assistance from one of the other nurses and then take the patient to the clinic together. However, as seen earlier there were certain impracticalities about such a course of action including the unavailability or possible unavailability of the second nurse. To my mind Ms Hammond's answer did not accord with the reality facing nursing staff in Fregon. However, Ms Hammond in her evidence rejected the notion that there were impracticalities about the on-call system in this regard.¹⁰³ She also said that as far as fatigue issues affecting the second nurse was concerned, efforts were made to alleviate that. I have preferred the evidence of the nursing staff who actually worked in Fregon to that of Ms Hammond as far as the practicalities or impracticalities of obtaining the assistance of other nursing staff was concerned.

- 8.83. In her evidence-in-chief Ms Hammond acknowledged that there might be professional repercussions adverse to a nurse if the nurse did not deal with a patient immediately. Ms Hammond said that this was an issue for every remote nurse but that there were ways of managing this, such that if a male patient was obviously injured but they were on their own and the nurse felt uncomfortable dealing with the situation, '*then the nurse could simply ring the police and ask the police to come and escort her and the patient to the clinic*'. The difficulty of course with that as a realistic solution was that there

¹⁰¹ Transcript, page 1120 and 1160

¹⁰² Transcript, page 1120

¹⁰³ Transcript, page 1123

were no police in Fregon, or at least no police within a meaningful distance. I found Ms Hammond's italicised remark above to be naïve and not congruent with the realities as they existed in Fregon.

- 8.84. Ms Hammond suggested that although issues involving on-call presentations were discussed at meetings, they were not frequently discussed. She said that she had no recollection of a nurse, prior to Mrs Woodford's death, ever asking about security guards. She asserts that the issue was discussed at management level but that it was quickly discounted because of the lack of accommodation and funding. Asked as to whether Ms Schultz had ever raised the question of security guards Ms Hammond said '*Not that I remember, no*'.¹⁰⁴ As to whether Mr Takawira had ever raised that issue she said that she had no recollection of that either.
- 8.85. Regarding nursing practices involving the leaving of the caged area and going out alone while on-call, Ms Hammond believed that the NHC policies covered this. She did not believe that the policies permitted this activity. She said:

'Q. When you say cover it, you mean permit it.

A. Well, I don't believe they did. I believe that the policies and various documents that we produced discouraged nurses from going anywhere with a patient after hours if they felt unsafe and specifically said that they should not open their cage to people who were being aggressive, abusive, or who appeared to be inebriated or drug affected'.¹⁰⁵

As well, Ms Hammond said:

'If it's a male on their own I think it's pretty clear that they don't go with them and I think, in general, if you're - from my point of view what I would be looking at is: are they alcohol affected; can I smell alcohol; is their behaviour normal; are they being aggressive; do I feel I'm comfortable with them; and if the answer is 'yes' to any of those things I would not be going with them and I think the general sense of the documents that we produced at the time of Gayle's death was that Nganampa would support a nurse if she made a decision that she could not see that patient and feel safe'.¹⁰⁶

- 8.86. Ms Hammond was closely questioned on the contents of the Guideline Document, a document that she authored.¹⁰⁷ She agreed that the document appeared to indicate that a nurse could attend a community member's home during an on-call period and do so

¹⁰⁴ Transcript, page 1126

¹⁰⁵ Transcript, page 1127

¹⁰⁶ Transcript, page 1128

¹⁰⁷ VAH2

alone.¹⁰⁸ She added that the nurse had to make an assessment about whether it was safe to do so and that in any event to undertake this would only be appropriate in cases of emergency. Home visits were not appropriate for minor matters that could be managed at the house or managed the following day at the clinic.

- 8.87. When asked as to whether Ms Belinda Schultz had ever raised with her any specific suggestions regarding safety of nurses, Ms Hammond said ‘*No, not that I recall*’.¹⁰⁹ Asked as to whether Ms Schultz raised the issue of security staff she said that she had never heard any nurse raise that as an issue and in particular not Ms Schultz. Ms Hammond also said ‘*No, not that I remember, no*’ to the question as to whether nurses had raised with her their concerns about working alone on-call at Fregon.¹¹⁰ Specifically she said that neither Ms Schultz, Mrs Woodford nor Mr Takawira had spoken to her about the dangers and hazards of working on-call alone.¹¹¹ She said that this was something that she would remember.¹¹²
- 8.88. Ms Hammond rejected Ms Schultz’s characterisation of NHC as having a dismissive culture towards safety.¹¹³
- 8.89. Ms Hammond was cross-examined by Mr Kalali, counsel assisting, about the content of the Guideline Document that she authored. She acknowledged that this document suggested that nurses could see patients in the cages for minor health complaints or injuries and that as per the 2012 guideline nurses were seeing patients in their cages at home and if necessary going to houses to see patients alone.¹¹⁴ Notwithstanding this acknowledgement, Ms Hammond maintained that she had no recollection of any of the nurses from Fregon ever raising concerns about working alone at night.¹¹⁵ Ms Hammond suggested that she did not believe at the time that they were living in a particularly dangerous environment and ‘*...we didn’t anticipate a psychopath coming through Fregon and murdering Gayle*’.¹¹⁶ To my mind this gratuitous remark completely missed the point. One did not have to foresee an individual as murderous as Davey killing one of the NHC nurses to know that the on-call practices that nurses

¹⁰⁸ Transcript, page 1129

¹⁰⁹ Transcript, page 1140

¹¹⁰ Transcript, page 1145

¹¹¹ Transcript, page 1146

¹¹² Transcript, page 1146

¹¹³ Transcript, page 1141

¹¹⁴ Transcript, page 1146

¹¹⁵ Transcript, page 1146

¹¹⁶ Transcript, page 1147

were engaging in were inherently dangerous and that the nurses could be harmed in other ways short of being murdered.

8.90. Ms Hammond also stated that she had no recollection that police had raised concerns with NHC about the safety of nurses working alone, a topic that I have dealt with separately. She said it was possible that this had occurred but that she did not recall it. In particular she did not recall Mr Busuttil telling her that he had conducted a meeting with police and that police had recommended that nurses should not be working alone.¹¹⁷ She acknowledged that she may have been at a meeting with police in which police had raised these concerns but did not recall having been present at such a meeting.¹¹⁸ She said '*I have no knowledge of the police recommending that the nurses not work alone*'.¹¹⁹

8.91. On a number of occasions in her evidence Ms Hammond insisted that she had no recollection of having discussions with Ms Schultz about working on her own while on-call. She said that she had discussions with Mr Takawira and Ms Schultz about on-call issues but did not recall them ever raising an issue about their working alone. She said '*...There have been other issues that they raised and we discussed general safety and the issue about whether they should be going or whether they should not be going to see patients*'.¹²⁰ However, they did not raise any issues about being on their own.¹²¹

8.92. Ms Hammond was asked this question and gave this answer:

' Q. If a male person approached a cage alone, not drunk, not intoxicated, not psychotic, and was assessed at least to be safe, could they be assessed and treated for minor injuries inside the cage, as far as these policies are concerned.

A. I haven't really looked at the policies specifically with that scenario in mind, but my interpretation would be no, that it would not let a single female nurse with a single male, regardless of their state of mind and appearance, would not be seen in the cage on their own. It is culturally inappropriate'.¹²²

As to her own practices in this regard she said that men rarely came to the house on their own. She could not recall a specific circumstance involving herself. She had males come to the house with their partner but men rarely came to the house on their

¹¹⁷ Transcript, page 1153

¹¹⁸ Transcript, page 1153

¹¹⁹ Transcript, page 1154

¹²⁰ Transcript, page 1157

¹²¹ Transcript, page 1157

¹²² Transcript, page 1160

own. She never went with a male person on their own because generally she would not feel safe doing so especially if she did not particularly know the male person or trust that person. She acknowledged that she never lived in Fregon.

8.93. It will be observed that many of Ms Hammond's responses to questions about whether staff had raised concerns, particularly with herself, were in the first instance equivocal and did not consist of outright denials as might have been expected if the matters put to her were incorrect.

8.94. The evidence of Dr Paul Torzillo

Dr Torzillo is the Medical Director of the NHC. He has had much experience in the field of Aboriginal medical services. He has been the Medical Director of the NHC since the early 1990s. Following the establishment of the NHC he became a key advisor to the Commonwealth Office of Aboriginal Health and has been a member of over thirty national committees concerned with strategy, funding, medical and public health aspects of Aboriginal health. Dr Torzillo is the recipient of an AM for services to Indigenous health.

8.95. Dr Torzillo provided to the inquest an affidavit dated 24 December 2019.¹²³ Dr Torzillo also gave oral evidence in the inquest. At the time with which this inquest is concerned Dr Torzillo did not live on the APY Lands.

8.96. In his oral evidence Dr Torzillo acknowledged that there has generally been an increase in community dysfunction in communities within the APY Lands. This is reflected in substance abuse, conflict and violence in respect of which there has been an increase in the community. This level of community violence creates difficulty for the delivery of health care services and in particular causes difficulty for nurses and doctors working in the clinics within the APY Lands.¹²⁴

8.97. In his evidence Dr Torzillo was questioned about his knowledge of nursing practices. He asserted that in general terms NHC had attempted to enforce policies to the effect that treatment would not occur inside the cage or the house. However, he guessed that there would be circumstances in which a nurse might administer a band-aid or perform some minor treatment in the cage if they knew the person involved who, for example, had a child presenting with a cut. He believed that the NHC policies were optimal for

¹²³ Exhibit C46

¹²⁴ Transcript, pages 541-542

safety and if nurses were repeatedly performing treatment inside the cage they would be spoken to.¹²⁵

8.98. He said that he was not aware of a practice whereby nursing staff on-call would attend house calls on their own.¹²⁶

8.99. As to treatment within the cage, Dr Torzillo stated NHC believed that allowing patients to come into a house was unsafe and a safety threat. In addition if a person was ill with a serious problem at night the ability to assess and treat that person was much greater at the clinic where there was appropriate equipment. At another point in his evidence Dr Torzillo said that NHC did not want people to be going outside by themselves and that they had '*clear*' policies about that.¹²⁷

8.100. Dr Torzillo was asked about a meeting on 6 April 2016 following Mrs Woodford's murder. In that meeting, which was audio recorded, he appeared to acknowledge that prior to Mrs Woodford's murder the default position as far as on-call nursing practices were concerned had been that nurses would elect to go out at night rather than refrain from doing so. To this Dr Torzillo said:

'I don't think it was a collective attitude of the organisation, but I think there are a number of people who thought that, you know, in circumstances where they were very comfortable, then they might go out, if that was - I didn't know about that particularly, but if it was happening, then I was trying to emphasise that it shouldn't be happening now'.¹²⁸

At another point in his evidence Dr Torzillo added that he thought he had been generally aware that people might be going out.¹²⁹ He said he was not aware of any particular instance of this happening prior to Mrs Woodford's death but it had certainly occurred to him that it could have been happening.¹³⁰

8.101. Dr Torzillo told the Court that he had not seen any need to tighten up practices regarding on-call attendances by nursing staff alone. He said:

'I think quite the contrary. I mean, when I started in 1984 I had a front door, an old mountable, that you could push open and couldn't lock. We had no security policy, there were no police. Since that time we incrementally improved our approach to safety, particularly from the mid-90s. We constantly talked about it. We thought we had the best

¹²⁵ Transcript, page 546

¹²⁶ Transcript, page 547

¹²⁷ Transcript, page 559

¹²⁸ Transcript, page 560

¹²⁹ Transcript, page 562

¹³⁰ Transcript, page 563

safety policy safeguards infrastructure that we could possibly have at that time. And we certainly knew that it was better than comparable health services anywhere in central or northern Australia'.¹³¹

Dr Torzillo denied that he had been dismissive of any person speaking about safety issues.¹³² He also denied using phraseology to the effect that if the nursing staff did not like it then they need not work for NHC.¹³³ He said he could not recall a conversation with a Ms Murphy regarding concerns expressed by her in relation to certain on-call practices.

8.102. Dr Torzillo asserted that he did not think that Ms Schultz had raised the issue of security guards with him. He had no specific recollection of any specific discussion about the topic. He said that he would have thought then as he thought during the currency of his evidence, that the topic of security guards was not something that was possible or feasible for NHC because of the cost.¹³⁴ He acknowledged that there had not been any official costings undertaken in relation to the provision of security guards.¹³⁵

8.103. As to other measures that conceivably could have been contemplated in relation to safety prior to Mrs Woodford's death, Dr Torzillo acknowledged that having two people attend after hours consultations would improve staff safety.¹³⁶ However, Dr Torzillo indicated on a number of occasions during his evidence that if such a procedure had been the norm it would have meant that the nursing staff would have needed to have been trebled with the consequent cost implications.¹³⁷

8.104. Dr Torzillo accepted the proposition that nurses working by themselves was a risk of which the NHC was aware. He said:

'I think that if you mean are nurses working by themselves, is that a - do we think that's a more risky situation than nurses working in pairs? Yes, I'd accept that that's true, yep'.¹³⁸

8.105. Asked as to the measures that had reduced that risk Dr Torzillo cited development of policies around behaviour when on-call, the safeguards in the houses, the introduction of the Navman tracking device in respect of vehicles and emphasising policies around

¹³¹ Transcript, page 566

¹³² Transcript, page 575

¹³³ Transcript, page 573

¹³⁴ Transcript, page 582

¹³⁵ Transcript, page 584

¹³⁶ Transcript, page 577

¹³⁷ Transcript, page 587

¹³⁸ Transcript, page 587

safety and around interaction with a community at the time of an employee's orientation.¹³⁹ Having been involved in the obtaining of funding for the NHC from the Commonwealth for many years, Dr Torzillo stated that he knew, particularly from having spoken the most senior health bureaucrats and ministers, that the NHC would have had no chance of obtaining funding for either security guards or for a larger contingent of nurses that would have allowed them to work in pairs. On this basis Dr Torzillo defended the organisation not having costed such measures.

9. Conclusions in relation to nursing practices

- 9.1. I have accepted the evidence of the NHC nursing staff that there was a general practice whereby on-call nurses at night would admit unaccompanied male patients to the cage for the purposes of assessment and treatment for minor conditions if necessary. I also accept that nursing staff would accompany male patients either to the clinic or to the homes of residents in Fregon. They would do this unaccompanied.
- 9.2. I further find that nursing staff conducted these practices because they thought it unethical or unwise to refuse to do so. In particular, I accepted Ms Schultz's evidence that a nurse in Fregon could not possibly function in an on-call role without opening the cage.
- 9.3. The fact that upon the failure of the health worker practice, the NHC provided cages for nursing staff accommodation was clearly a reflection of the fact that there were inherent dangers involved in presentations at night to the residences of on-call nursing staff. Although there were certain policies and guidelines promulgated in relation to nursing safety, and in particular to nursing safety while on-call, to my mind there were a number of obvious impracticalities in nursing staff adhering strictly to those policies and guidelines. For instance, I do not see how it was in any way practical for an on-call nurse at night to send an unaccompanied male away in circumstances where that unaccompanied male required immediate treatment. It would have been imperative in those circumstances for the nurse to at least open the cage to assess and examine the patient. I do not believe that this could have been completely lost on NHC management.
- 9.4. As far as nursing staff making their own risk assessment as to their safety in admitting a patient in a particular instance is concerned, in my opinion such a scenario required

¹³⁹ Transcript, page 588

the nursing staff to make safety and risk assessments that they were ill-equipped to make in an accurate and meaningful manner. While such an assessment might prove to be accurate in the majority of cases, such accuracy could not by any means be guaranteed in all cases. Any meaningful safety or risk assessment would require the nurse to have greater information than what was presented to the nurse at face value. Information that the nurse would not have possessed would have included knowledge of the propensities and possible criminality of the individual involved. It is difficult to see how a nurse could make such an assessment or judgment in respect of people whom the nurse did not know. Dudley Davey is a classic case in point. The fact that there was no police presence in Fregon must have made any risk or safety assessment even more fraught with difficulty.

- 9.5. In my view the assertions that I heard to the effect that the nursing staff were only expected to do what they had assessed could be done safely was something of a meaningless mantra. They should not have been placed in a position in which they were required to make any such assessment.
- 9.6. It is worthwhile observing on the topic of risk and safety assessment that earlier drafts of what was to become Gayle's Law were considered objectionable because they placed inappropriate burdens upon health practitioners to conduct risk assessments before second responders could be required. I deal with the elements of Gayle's Law as it now exists in another section.
- 9.7. The truth of the matter is that the nursing practices I have described presented possible inherent dangers to nursing staff working alone and at night.
- 9.8. I have accepted the evidence of Senior Sergeant Yeomans that she alerted Mr Busuttil of the NHC to the dangers of on-call nursing staff working alone. This followed the incident at Watarru in June 2012. Although the circumstances of Watarru involved a single nurse working during the day, I do not believe that Ms Yeomans' advice to Mr Busuttil would have been understood as simply relating to those precise circumstances were they to be replicated. Her advice in my view covered a broader field that would have been understood to have included on-call nurses working alone and the inherent dangers presented thereby. Insofar as there is any suggestion that Mr Busuttil did not convey that information on to a higher authority within NHC, I would reject that as being highly unlikely. In any event it would have been an

extraordinary omission for Mr Busuttill not to have drawn the SAPOL advice to any other person's attention within NHC.

- 9.9. As to the measures that were adopted by NHC for the protection of nursing staff working alone at night and on-call, to my mind they were not adequate. The policies and guidelines to a large extent contained ideals that were impractical as to adherence. The cage attached to the nursing accommodation was only adequate to the extent that the cage was kept locked and the presenting patients were kept secluded from nursing staff. I accept the evidence from the nursing staff that there were impracticalities in maintaining the security of the cage when a person presented at their accommodation. It is obvious and I find that on-call nursing staff, particularly female nursing staff, should never have been expected to work alone at night outside of the confines of the cages attached to their accommodation unless they were accompanied by a responsible person such as a responsible member of the Fregon community or another member of the nursing staff.
- 9.10. I do not believe that the management of the NHC was oblivious to the fact that nursing staff in Fregon were seeing male patients at night and on-call without a female companion. To my mind any stipulation in the policy documentation to the contrary contained a strong element of naivete. The stipulation did not accord with real life and existed more or less as a platitude only. These considerations led to the undeniable acknowledgement by Mr Busuttill in his evidence that there was a greater emphasis placed by the NHC on the need for treatment of the patient than upon the safety of the staff.¹⁴⁰
- 9.11. I accept the evidence that I heard from a number of witnesses that they made their concerns about on-call work at night known to persons in authority within the NHC. I have taken into account the possibility that since Mrs Woodford's murder the persons who testified about these matters may have come to an exaggerated view of the perils that they believe they were working in. But I do not believe that to be the case. I also acknowledge that there is no documentary evidence that supports their evidence, say as may have been provided by clinical meeting minutes. The evidence of the nursing witnesses is not sufficiently precise to establish exactly who within the NHC management structure knew of the dangerous nursing practices in 2016, but I am

¹⁴⁰ Transcript, page 397

satisfied that persons within that structure knew of those practices. One matter, however, in my opinion is telling. It will be remembered that all of the witnesses were unanimous that when concerns were expressed about the safety or otherwise of their work practices while on-call, they were met with a response to the effect that they did not have to work in Fregon. I have accepted that evidence. I am not certain who it was that expressed that view, but I am sure it was expressed. I am also not certain that it should necessarily have been interpreted other than in the sense that working in a place like Fregon presented challenges that were not for everyone. However, the fact that anything such as that was said by persons in authority in the NHC to nursing staff, which I find was the case, is highly supportive of the evidence that nursing staff did in fact express concerns about their safety to persons in authority within the NHC. After all, why would such a retort have been elicited if it was not in response to the concerns that the nurses were expressing in relation to their safety. I find that they did express those concerns in the manner that the witnesses have stated in their evidence. I also find that elements within the NHC management structure were aware of their concerns.

- 9.12. The observation can be made that without further safety measures being implemented the only step that would realistically have mitigated the dangers for on-call nursing staff working at night would have been the enforcement of a blanket prohibition on nurses attending to unaccompanied male persons while on their own. From the point of view of practicality that would have meant that the nurse would simply refrain from opening the cage at all when an unaccompanied male person presented at the home. Otherwise, there was in my view a need for either a security guard to become involved in any presentation, another nurse to be involved, or a known and responsible member of the community to be involved.
- 9.13. The obvious solution for the NHC would have been to make provision for nurses to be accompanied by another person when working on-call at night and to have called for the necessary funding, a measure that took Mrs Woodford's murder to come to realisation. Mrs Woodford's death could thereby have been prevented.
- 9.14. I heard what Dr Torzillo said in evidence about the difficulties regarding funding in respect of security guards and additional nursing staff. But in many ways the NHC had the whip hand as it were. The NHC was a non-government entity. A withdrawal of NHC's medical services from the APY Lands or from any of the communities therein

on grounds of staff safety would have placed the Federal and State Governments in a very awkward position regarding the continued administration of those communities.

10. The section 23 issue

- 10.1. This issue concerns whether Dudley Davey could have been kept in prison beyond the expiration of his sentence in 2015.
- 10.2. From 26 September 2015 onwards Davey was free of any sentences of imprisonment and from parole. This is due to the fact that the head sentence in respect of the 2012 offence expired on that date.
- 10.3. Section 23 of the Criminal Law (Sentencing) Act 1988 as it then was¹⁴¹ empowered the Supreme Court in certain circumstances to order a person to whom the provision applied to be detained in custody until further order and beyond the expiration of a prison sentence that the person was undergoing. The suggestion here is that having regard to all of the circumstances including Davey's history of sexual offending, an application under this provision could and should have been made either at the time Davey was originally sentenced in 2013 in the Adelaide Magistrates Court or later during the currency of his term of imprisonment and before his release. The further suggestion is that if such an order had been made, Davey is likely to have been detained in custody sufficiently beyond the expiration of his head sentence in September 2015 to have prevented his murder of Mrs Woodford in March of 2016.
- 10.4. In assessing this claim it is necessary to discuss the legislative requirements that section 23 imposed at different times in history. This owes itself to the fact that in December 2013, which was during the currency of Davey's sentence, the terms of section 23 were amended in a significant way.
- 10.5. Broadly speaking section 23 applied to persons who had been convicted of a '*relevant offence*' which by definition included the offence of indecent assault, the offence of which Davey had been convicted and sentenced in the Adelaide Magistrates Court in 2013. A relevant offence for these purposes also included by definition '*any other*

¹⁴¹ The measure contained within this provision was amended in December of 2013 and is now housed in section 57 of the Sentencing Act 2017

offence where the evidence indicates that the defendant may be incapable of controlling, or unwilling to control, his or her sexual instincts'.¹⁴²

10.6. As at the time of Davey's sentencing on 18 August 2013, section 23 enabled either the Magistrates Court or the prosecutor to take action in respect of a person to whom the provision applied. Section 23(2) stated as follows:

- '(2) If, in proceedings before the District court or Magistrates Court, a person is convicted of a relevant offence and-
- (a) the court is of the opinion that the defendant should be dealt with under this section; or
 - (b) the prosecutor applies to have the defendant dealt with under this section,
- the court will, instead of sentencing the defendant itself, remand the convicted person, in custody or on bail, to appear before the Supreme Court to be dealt with under this section.'

It can be seen from this provision that the Supreme Court's jurisdiction could be enlivened simply on the basis of an application by the prosecutor in which case the Magistrates Court had no discretion other than to remand the defendant to the Supreme Court for the defendant to be dealt with under this provision. The Magistrates Court could of its own motion also remand the defendant to the Supreme Court.

10.7. Pursuant to section 23(5), the Supreme Court had power to order that a person to whom the section applied be detained in custody until further order if after considering certain matters it was satisfied that the order was appropriate. Before making such an order, the Supreme Court was mandated pursuant to section 23(3) to direct at least two legally qualified medical practitioners nominated by the Court to enquire into the mental condition of the person in question and to report to the Court on whether the person was incapable of controlling, or was unwilling to control, his or her sexual instincts. For these purposes the definition of the expression '*unwilling*' has remained unaltered, namely:

'unwilling – a person to whom this section applies will be regarded as unwilling to control sexual instincts if there is a significant risk that the person would, given an opportunity to commit a relevant offence, fail to exercise appropriate control of his or her sexual instincts.'

¹⁴² Section 23(1), definition of relevant offence item (c)

10.8. Once those reports were obtained the Supreme Court pursuant to section 23(5) might order that a person to whom the section applied be detained in custody until further order if:

- '(a) the Court, after considering the medical practitioners' reports and any relevant evidence or representations that the person may desire to put to the Court, is satisfied that the order is appropriate; or
- (c) the person refuses to cooperate with an inquiry or examination under this section and the Court, after considering any relevant evidence and representations that the person may desire to put to the Court, is satisfied that the order is appropriate.'

An order of the Supreme Court that a person be detained until further order in practical terms enabled a person to be detained in custody beyond the expiration of his or her sentence of imprisonment.

10.9. When Davey was convicted and sentenced by the Adelaide Magistrates Court in August 2013 neither the Magistrates Court nor the prosecutor raised any question about the applicability of section 23 to Davey. There is no material to suggest that at the time Davey was dealt with any consideration was given to the operation of section 23 in his case. The Magistrates Court sentencing remarks¹⁴³ contain no reference to section 23 and accordingly he was dealt with and sentenced by that Court. However, militating against the potential success of a section 23 application if made at that time were a number of factors. Firstly, Davey had been in custody as a remand prisoner for several months leading up to his being dealt with in the Magistrates Court and as a consequence he had not participated in any rehabilitation programs. Also, at the time of his sentencing it could not have been predicted whether Davey would undergo a rehabilitation regimen during the course of any further sentence of imprisonment. In addition, his response to that could not have been predicted. Secondly, at the time Davey was dealt with, a custodial sentence could reasonably have been anticipated which meant that for the time being the public would be protected by the sentence imposed. Thirdly, the fact that no reference to the Supreme Court was made by the Magistrates Court at the time of Davey's sentencing did not preclude a later section 23 application being made by the Attorney-General to the Supreme Court before the expiration of Davey's sentence. Section 23(2)(a) enabled an application by the Attorney-General to the Supreme Court for an order under the provision to be made at

¹⁴³ Exhibit C51d

any time ‘*while the person remains in prison serving a sentence of imprisonment*’.¹⁴⁴ Such an application by the Attorney-General could later have been made in the light of any rehabilitative measures or otherwise that Davey had participated in or had undergone during the currency of his sentence and taking into account any other relevant matters. Fourthly, as framed at the time of Davey’s sentencing in August 2013, section 23 did not contain the later legislative command enacted in the December 2013 amendment that the paramount consideration of the Supreme Court in determining whether to make an order pursuant to the provision must be the safety of the community.

10.10. I make no finding in relation to whether or not an application pursuant to section 23 could and should have been made at the time Davey was dealt with in the Magistrates Court in August of 2013.

10.11. I now deal with the question as to whether an application of the Attorney-General could and should have been considered during the currency of Davey’s incarceration and before his release. On 12 December 2013 section 23 underwent a number of significant amendments taking effect from that date. Whereas the original section 23 mandated the Supreme Court to take in to account the matters contained within section 23(5), that subsection was replaced with a new section 23(5). In addition, new sections 23(5a), (5b) and (5c) were enacted. I set these out as follows:

- (5) The paramount consideration of the Supreme Court in determining whether to make an order that a person to whom this section applies be detained in custody until further order must be the safety of the community.
- (5a) The Supreme Court must also take the following matters into consideration in determining whether to make an order that a person to whom this section applies be detained in custody until further order:
 - (a) the reports of the medical practitioners (as directed and nominated under subsection (3)) furnished to the Court;
 - (b) any relevant evidence of representations that the person may desire to put to the Court;
 - (c) any report required by the Court under section 25;
 - (d) any other matter that the Court thinks relevant.
- (5b) A copy of a report furnished to the Supreme Court under subsection (5a) must be given to each party to the proceedings or to counsel for those parties.
- (5c) If a person to whom this section applies refuses to cooperate with an inquiry or examination for the purposes of this section, the Supreme Court may, if satisfied that

¹⁴⁴ Section 23(2)(a)

the order is appropriate, order that the person be detained in custody until further order having given –

- (a) paramount consideration to the safety of the community; and
- (b) consideration to any relevant evidence and representations that the person may desire to put to the Court.'

10.12. It will be seen that the predominant element of section 23 is that the paramount consideration of the Supreme Court in determining whether to make the order that a person be detained in custody until further order must be the safety of the community. That is so regardless of whether or not the person has cooperated with an inquiry or examination and in particular that conducted by the two legally qualified medical practitioners as to whether the person is incapable of controlling, or unwilling to control, his or her sexual instincts.

10.13. It will also be seen from the amended provisions that the reports of the medical practitioners as to whether or not the person is incapable of controlling, or unwilling to control, his or her sexual instincts are not of themselves determinative of the application. The contents of those reports are one of a number of matters that the Court must take into consideration.

10.14. As indicated earlier, at the time at which Davey was originally dealt with in the Magistrates Court in August of 2013 the amended version of section 23 would not have been available to the Supreme Court had the matter been referred to that Court. However, by the time consideration was being given to Davey's parole, and before the expiration of his head sentence in September 2015, the amended provision would have been available to the Supreme Court if any application had been made by the Attorney-General. The application could have been made while Davey was in prison serving his sentence of imprisonment between August 2013 and September 2015, but would have needed to have been made prior to his release on parole. I see no reason why consideration of parole could not have been postponed pending the outcome of that application had it been made. Such an application would have taken into consideration relevant material regarding Davey that had been gathered in that period, including of course his response to any rehabilitative programs.

10.15. At no stage after Davey's sentencing in the Magistrates Court was an application made by the Attorney-General. There is no evidence that the issue was even considered. I note that neither in section 23 and its associated provisions, nor in any other legislation

is there any mechanism as to the manner in which the Attorney-General's interest in making an application under that provision might be piqued.

- 10.16. It will be observed from the structure of section 23 that the enquiry by the two legally qualified medical practitioners into the issue as to whether the person is incapable of controlling, or unwilling to control, his or her sexual instincts occurs upon the order of the Supreme Court after the matter has been referred to it by another court or after an application has been made by the Attorney-General. These reports are not commissioned as part of any determination on the part of the Attorney-General as to whether an application under section 23 should be made to the Supreme Court. Thus, it is not as if the contents of those reports and the opinions contained within them have any bearing on whether an application under section 23 should be made by the Attorney-General. The reports do not come into existence until the application is made to the Supreme Court. However, if previous reports which directly or indirectly touch on the person's control of sexual instincts are already in existence, they could be taken into consideration by the Attorney-General, or those advising the Attorney-General, when consideration is being given as to whether a section 23 application should be made or not. In Davey's case, it cannot be known with certainty what the outcome of the inquiries conducted by the two legally qualified medical practitioners would have been in terms of Davey's capacity in relation to his sexual instincts. Nor can it be said with certainty as to whether or not the two practitioners would even agree. Nor indeed can it be known with certainty whether Davey would have cooperated with those inquiries. However, as alluded to earlier, the contents of the reports are not the sole determinative of any application. Naturally their contents would be given significant weight in determining whether or not the safety of the community would be protected by anything other than an order under section 23.
- 10.17. It is worthwhile examining Davey's circumstances in the period prior to his first release on parole and in particular whether or not he had undergone any meaningful rehabilitative programs that may have engendered confidence in his capacity to control his sexual instincts.
- 10.18. Dr Henry Pharo is a clinical psychologist employed as the Director of Offender Rehabilitation Services at the Department for Correctional Services (DCS). He commenced that role in July 2015. Dr Pharo was previously employed by the DCS in the Sentence Management Unit (SMU) both as the Manager of Assessment and

Sentence Planning and as a Senior Psychologist. In his role as the Director of Offender Rehabilitation Services he is responsible for a number of business units related to the provision of rehabilitation services for prisoners. He also has professional oversight of education and vocational training services. The role of the Offender Rehabilitation Services is to provide a range of rehabilitative services to offenders in prison in order to attempt to reduce their risk of offending, to teach them to modify their behaviours and to teach new skills that may better prepare them to return to the community.

10.19. Dr Pharo provided an affidavit and annexures to the inquest and he gave oral evidence.

10.20. Dr Pharo gave evidence about a number of rehabilitation programs that during the currency of Davey's incarceration were generally available. I do not need to go into the details of those programs. Some of them involve the correction of sexual behaviour. One matter that was relevant to Davey's ability to participate in these programs was his problematic literacy. Dr Pharo explained to the Court that Davey operated at a very basic non-functional literacy level. Literacy and proficiency with the English language is an important factor as far as participation in rehabilitative programs is concerned. Davey was ineligible to take part in mainstream programs that the Department was running. In one assessment for participation Davey fell asleep. In respect of another assessment he indicated that he would not be comfortable answering questions regarding his sexual offender behaviour if the exercise involved a female assessor. Accordingly, the assessment conducted was a '*static*' assessment only which I take to mean was one based on objective factors without recourse to current circumstances.

10.21. By reference to the report dated 10 July 2014 of Ms Christine Curran who is a Senior Psychologist in the SMU of the DCS, Dr Pharo explained that Davey was estimated to be at high risk of violent reoffending should he not receive treatment. The dynamic risk factors identified as areas of concern in relation to Davey's risk of reoffending were a history of violent behaviour including interpersonal aggression strategies, reduced ability to control and cope with heightened emotions, some use of violence during incarceration, impulsivity, some criminal attitude supportive of the use of violence, a poor employment history, susceptibility to negative peer influence, drug and alcohol use, a propensity for his use of violence to occur under similar circumstances, a propensity to carry and use weapons and a poor history of non-compliant behaviour while under supervision. In addition, and tellingly, Ms Curran's report stated that based

on static risk factors Davey was estimated to be at high risk of sexual reoffending.¹⁴⁵ The report of Ms Curran went on to indicate that based on that high risk of violent and sexual reoffending he was eligible for certain programs. However, due to significant deficits in his literacy and language abilities he was considered to be unsuitable for program involvement at that time. The report did add that Davey should be encouraged to engage in education services and that his suitability could be reconsidered if he demonstrated significant improvement in literacy and verbal language.

10.22. Dr Pharo also explained that a program entitled SBC-me may have been suitable for Davey as it is designed for persons with a cognitive deficit. However, with the time remaining on Davey's sentence there was no available program in which he could have taken part. There was also an issue as to whether Davey's deficit in English language was a matter that fell within the category of cognitive deficit. In any event it was the only program in which Davey could conceivably have participated. He did not participate in it prior to his release on parole. Dr Pharo told the Court that release on parole can be deferred to enable participation in programs.

10.23. Dr Pharo indicated that participation in rehabilitative programs is voluntary. He said '*...naturally, there is a degree of coercion within the system by way of parole applications and so on, that mean that an individual has some pressure, I guess, to take part but we cannot force someone to take part*'.¹⁴⁶ It occurs to me that in assessing a prisoner's motivation to participate it would be difficult to distinguish a genuine desire to rehabilitate from a desire simply to secure earlier release from prison.

10.24. Ms Curran's report did not address any issue as far as section 23 of the Criminal Law (Sentencing) Act was concerned.

10.25. In his evidence and in his statement Dr Pharo dealt with the section 23 question. He indicated that the Attorney-General might make an application under section 23 on recommendation from DCS. He indicated that while offenders are in custody DCS are able to identify those who might meet the statutory criteria of a section 23 application and recommend to the Attorney-General through the Crown Solicitor's Office those whom it considers may be the subject of such an application. Dr Pharo's statement also indicates that the Parole Board is also able to identify persons who may meet the

¹⁴⁵ Exhibit C56, Annexure HP4

¹⁴⁶ Transcript, page 890

statutory criteria for a section 23 application and make the appropriate recommendation to the Attorney-General. Dr Pharo suggested that Ms Curran's report of 10 July 2014 could have contained a recommendation concerning section 23. Dr Pharo told the Court that he had reviewed Ms Curran's report and it was his responsibility to have done so prior to it being sent to the Rehabilitation Programs Branch.

10.26. Dr Pharo was asked by counsel for DCS, Mr Roberts, whether there had been sufficient information contained within Ms Curran's assessment and in additional material that identified Davey as a potential section 23 candidate. Dr Pharo candidly told the Court that in his view there had been sufficient information at that time.¹⁴⁷ Indeed, Dr Pharo stated that in his opinion there had been a missed opportunity to identify Davey as a potential section 23 candidate.¹⁴⁸ However, Dr Pharo suggested that an application by the Attorney-General to the Supreme Court for Davey to be detained beyond the expiration of his sentence and until further order may not have been successful. He asserted this based on uncertainties surrounding the test of willingness or unwillingness or the inability to control sexual urges. He suggested that complexities would have been '*...a real challenge for the court to work through*'.¹⁴⁹ Dr Pharo indicated that in his professional experience he did not believe that Davey's antecedents would constitute evidence for the Supreme Court to make a section 23 order.

10.27. While I hear Dr Pharo's views as to a section 23 application's chances of success, they seem to have been expressed in ignorance of the legal requirement that the paramount consideration in any section 23 application is the safety of the community.¹⁵⁰ For reasons that will become apparent I agree with Dr Pharo's observation that there had been a missed opportunity to identify Davey as a section 23 candidate. Davey's circumstances should at least have been drawn to the attention of the Attorney-General. In the course of his evidence Dr Pharo outlined the process in respect of the manner in which the Attorney-General would be made aware of a case such as Davey's. The matter would go through the hands of a number of units or committees within DCS, including through the Chief Executive of the Department. The recommendation would then be forwarded to the Attorney-General's Department. Dr Pharo suggested in his evidence that he could not think of any reason why the Serious Offender Committee

¹⁴⁷ Transcript, page 897

¹⁴⁸ Transcript, page 898 and 901

¹⁴⁹ Transcript, page 902

¹⁵⁰ Transcript, page 905

would not have endorsed a recommendation that Davey was a potential section 23 candidate. Similarly, he could not think of any reason why the Chief Executive Officer of DCS would not have accepted the endorsement of the Serious Offender Committee to that effect.¹⁵¹

- 10.28. Ms Jane Farrin who is the Director of the DCS Sentence Management Unit (SMU) was also called to give oral evidence at the inquest. She also provided a statement. Ms Farrin is also a registered psychologist.
- 10.29. In the material produced to the Court by Ms Farrin it is evident that the SMU of which she was the Director conducts risk assessments in relation to prisoners and coordinates professional oversight of such assessments. The SMU also provides administrative support to other committees and is responsible for the oversight of case management across the custodial system.
- 10.30. Ms Farrin explained that each prisoner undergoes an initial assessment once they are sentenced. This includes the creation of an individual development plan (IDP) which is completed by an SMU assessment clinician. That plan is completed within eight weeks of sentencing. There is also the creation of a Risk of Reoffending - Prison Version (RoR-PV) screening tool. There is also a process known as the ORNI-R which is an Offender Risk Needs Inventory – Revised assessment. This is also conducted by DCS assessment clinicians.
- 10.31. These assessments as they relate to Davey were produced as part of Ms Farrin's evidence and are attached to her statement.
- 10.32. Ms Farrin explained that these assessments include a Sexual and Violent Offending Risk Assessment. This provides a comprehensive assessment of criminogenic risk and will set the rehabilitation pathway for a prisoner or offender throughout their involvement with DCS. The information collated in the assessment will determine the intensity and type of intervention provided to the prisoner or offender based on individual need. These processes had been put in place in relation to Davey.
- 10.33. Ms Farrin also spoke of Ms Curran's report in which the latter had estimated that Davey was at high risk of violent and sexual reoffending. Ms Farrin indicates that this document was sent to the Parole Board on 6 August 2014. This of course was at a time

¹⁵¹ Transcript, page 900

prior to Davey's eventual first release on parole in early 2015. The Parole Board requested a Treatment Plan for Davey on 14 October 2014. Mr Chris Clark, a social worker at the Port Augusta Prison, forwarded to the Parole Board a document known as a '*Throughcare Plan*' for Davey. The plan proposed that upon any release of Davey on parole he should participate in the Cross Borders Family Violence program. The plan was dated 5 January 2015.

10.34. I have examined all of these documents.

10.35. The Assessment Report of a Ms Emily Walker dated 25 November 2013¹⁵² described Davey's Offender Risk Need Profile: Assigned General Recidivism Risk as 'Medium'¹⁵³. It recommended that Davey be referred to prison education for assistance with improving his literacy and numeracy skills.¹⁵⁴ I have already referred to Ms Curran's document dated 10 July 2014 as containing the observation that Davey's risk of sexual offending was high.

10.36. The Throughcare Plan of Mr Clarke, dated 5 January 2015¹⁵⁵, addressed to the Secretary/Executive Officer of the Parole Board is an anodyne document that speaks of Davey's insights into his offending placing much emphasis on assertions from Davey himself regarding his intoxication and its impact on his behaviour with the added assertion from Davey that this would not happen again. The document recommends Davey for the Cross Borders Family Violence program upon his release. I observe that family violence was not the key element of Davey's recidivism which in fact was sexual violence.

10.37. In her statement Ms Farrin deals with the section 23 issue. Ms Farrin suggests in her statement that it was not clear to her whether a recommendation had been made to the Attorney-General to apply for an order pursuant to section 23 at any point in time throughout Davey's incarceration. In fact there is no evidence of any such recommendation. I am confident in saying that no such recommendation was made or indeed even considered.

10.38. Attached to Ms Farrin's statement is a DCS Local Operating Procedure entitled '*Oversight of Prisoners Pursuant to s23 of the Criminal Law (Sentencing) Act 1988*'.

¹⁵² Exhibit C36, Annexure JF3

¹⁵³ Exhibit C36, Annexure JF3, page 7

¹⁵⁴ Exhibit C36, Annexure JF3, page 11

¹⁵⁵ Exhibit C36, Annexure JF5

This document is dated 6 June 2013 and was in operation at the time of Davey's incarceration. It is an important document because in my view it clearly dictated what should have happened in respect of Davey. The document points out a number of highly pertinent matters in relation to the operation of section 23. It includes reference to the duties and responsibilities of DCS in respect of the administration of this provision. The document points out that in respect of '*serious repeat sexual offenders constituting a high risk*', it is '*imperative that DCS responds appropriately to this prisoner group in the interests of public protection and community safety*'.¹⁵⁶ Clearly enough, Davey fitted the description of, and had been identified within DCS as, a serious repeat offender constituting a high risk. The document placed an important onus on any person, naturally meaning any person within DCS who has relevant knowledge, to identify potential section 23 candidates following which certain procedures should occur. The relevant requirements concerned section 23 processes as they might apply at the time of sentencing as well as during the currency of any incarceration of the offender. We are concerned here with the latter of those two scenarios. The requirement was that if a section 23 candidate was identified during the IDP assessment phase, the IDP must identify the sexual offender as such so as to ensure that sentence planning takes into account appropriate timing of treatment and information exchange. If a prisoner was so identified during the course of his or her sentence, the Serious Offender Committee should be advised via a special case review to ensure sentence planning considers those matters. Where a prisoner was considered a potential candidate for an application to the Supreme Court under section 23, certain processes were required within DCS that involve both the Serious Offender Committee and the SMU. The process as seen earlier would also involve the Chief Executive of DCS and the Attorney-General's Department.

- 10.39. Thus, during Davey's incarceration, DCS' own documented internal procedures dictated that consideration needed to be given to the operation of section 23 in relation to him. The necessary consideration ought to have triggered certain processes culminating in a referral to the Attorney-General. As seen, in my opinion these processes during the IDP assessment phase were enlivened by Ms Curran's assessment that Davey was estimated to be a high risk of violent and sexual reoffending. Moreover, there was nothing in Davey's history during his DCS incarceration nor in any

¹⁵⁶ Section 3 of JF8 attached to the statement of Jane Farrin

rehabilitative processes, which as seen he had not undertaken, that could sensibly have altered such an assessment either during the course of his incarceration or at its conclusion. Thus, Dr Pharo's candid acknowledgement that there had been a missed opportunity within DCS to enliven section 23 in respect of Davey was well-made. In my opinion DCS should have engaged their well-documented processes in respect of Davey to ensure that the Attorney-General was made aware of the fact that he was a section 23 candidate. The question as to whether an application was to be made by the Attorney-General would have been a matter for the Attorney-General taking advice from the Crown Solicitor.

10.40. On 22 August 2014 Davey applied for release on parole. His application indicated that he had not undertaken relevant rehabilitation programs.

10.41. I should pause here to observe that this Court did not undertake any investigation in relation to, nor engage in any critique of, the merits of Davey's release on parole. The principal reason for this was the fact that by March of 2016 when Mrs Woodford was murdered, Davey's head sentence had expired. There was no question of him still being on parole, or alternatively still in prison actually serving a sentence, at that time. Rather, it is pertinent to observe that the Parole Board was yet another entity along with SAPOL and DCS that had either generated or been placed in possession of information that if conveyed to the Attorney-General could have triggered consideration of a section 23 application in respect of Davey.

10.42. At the time at which Davey's parole was being considered in 2014, a submission was prepared on behalf of SAPOL pursuant to section 77(2) of the Correctional Services Act 1982. Mr Drew Bynoe is an experienced police officer of approximately 30 years standing. His experience has included ten years in general patrols, approximately 12 years in various criminal investigation branches, including the Serious and Organised Crime Branch and four years in the Police Corrections Section. Brevet Sergeant Bynoe was stationed in the Police Corrections Section between December 2012 and March 2017. Brevet Sergeant Bynoe prepared the SAPOL submission to the Parole Board.

10.43. Mr Bynoe provided a statement to the inquest¹⁵⁷. Attached to the statement is his Parole Board submission. Mr Bynoe's statement indicates that when preparing a submission

¹⁵⁷ Exhibit C71

to the Parole Board he would routinely enquire into and assess a number of matters including the subject offender's criminal history, the type and circumstances of offending, whether the offending was escalating in nature and frequency, the offender's criminal associations, the offender's prior history during release on parole, history of compliance with bail, whether the offender has stable family and social ties and support and the similarity of all those matters to other known offenders.

10.44. In assessing the available information regarding Dudley Davey, Mr Bynoe had indicated that he was very concerned about his release on parole. The terms of his submission to the Parole Board explain the reasons for that concern. In particular Mr Bynoe stated in his submission that he regarded Davey's profile as not unlike that of another notorious murderer known to him as well as that of other serious criminal offenders in regard to their patterns of offending.

10.45. The parole submission was contained within a proforma document that is regularly provided by SAPOL to the Parole Board when a prisoner's release on parole is being considered. The salient features of Mr Bynoe's document were:

- Davey had a belligerent attitude towards police and was easily angered;
- Davey had a significant history for sexual offending and offending of a violent nature dating back to 1996. His criminal history included 17 prior convictions for like offences including armed robbery, aggravated assault and sexual offences;
- That having regard to Davey's long criminal history, Mr Bynoe expressed the belief that there was a '*high likelihood that he will reoffend in a like nature*';
- Davey had been itinerant between Adelaide and the APY Lands for a significant period of time and had offended in whatever location in which he has lived;
- Davey's significant history of sexual and violent offending had been perpetrated on females who were strangers to him;
- That police had assessed Davey as being at '*HIGH risk of offending if released into the community*';
- Mr Bynoe stated as follows:

'For a person of only 33 years of age, DAVEY has a long criminal history of very serious offending. His main target appears to be women and his offending toward them being of a sexual nature. His offending appears to be completely random and unprovoked and has been escalating in seriousness. Grave fears for the safety of

members of the community are held by the author if DAVEY is released. His pattern of offending is similar to those who have subsequently been arrested for murder'.

- Mr Bynoe indicated that he could not recommend Davey for release on parole as he believed the risk to the community was '*too great*'.

10.46. In my view Mr Bynoe's description of Davey, his criminal history and of his risk was warranted and is consistent with the risk assessment conducted within DCS.

10.47. In his witness statement Mr Bynoe indicates that it was not part of his role to consider section 23 of the Criminal Law (Sentencing) Act 1988 or to make any recommendation to the Attorney-General in respect of the operation of that measure. While accepting that this may not have been a stipulated part of his role, there was nothing preventing SAPOL corporately from drawing a potential section 23 issue to the Parole Board or indeed to the Attorney-General. I intend making a recommendation that SAPOL General Orders are amended to reflect this.

10.48. The material contained within Mr Bynoe's submission to the Parole Board in my opinion squarely raised an issue as to whether Davey ought to be kept in custody, and indeed, kept in custody beyond the expiration of his head sentence if possible.

10.49. DCS also prepared a submission to the Parole Board pursuant to section 77(2) of the Correctional Services Act. The submission did not make any mention of the possible use of section 23 in respect of Davey. The report was prepared by a Mr Mark Wiggin and was submitted to the Parole Board on or about 24 September 2014. The report makes reference to Ms Curran's document dated 10 July 2014, which was also received by the Parole Board. The report set out a number of personal circumstances relating to Davey including an observation that he did not have a suitable address for parole. However, as far as Davey's offending was concerned the report stated as follows:

'He has an extensive history of sexual offending dating back to childhood and the current offences are a continuation of this pattern of offending. It is the writer's belief that Mr Davey is fully aware of the principal motivating factor for his offending i.e. his need for sexual gratification however as in the past he sought to avoid responsibility by attributing his offending behaviour to substance abuse.

Whilst substance abuse may have been a factor in Mr Davey's offending it is the writer's belief that this issue is secondary to his need for sexual gratification and is no excuse for his appalling behaviour. In light of his poor history of response to intervention and lack of motivation to address his substance abuse, it is the writer's opinion that referral to substance abuse counselling on release may be of limited value.

On the basis of the information presented, it is the opinion of the writer that the risk presented by Mr Davey far outweighs any positive aspects of his application and he is considered an unsuitable candidate for release onto parole.'

- 10.50. The passage from Mr Wiggin's report set out above refers to Davey's need for sexual gratification as being a significant factor in Davey's offending as well as to the unlikelihood of that behaviour being altered by addressing the issue of substance abuse. Of course, this report and the opinions contained within it were corroborated by those expressed on behalf of SAPOL and were borne out by Davey's criminal history.
- 10.51. On 13 January 2015 Davey was brought before the Parole Board in person. A transcript of his interview with the Board was tendered to the inquest.¹⁵⁸ It is evident from the terms of the interview that the principal concern on the part of the Board was the possibility that Davey would reoffend, particularly when affected by alcohol.
- 10.52. Ms Francis Nelson QC is the Chair of the Parole Board. Ms Nelson provided an affidavit to the inquest and also made an oral submission on behalf of the Board. Ms Nelson did not accept the notion, as advocated by counsel assisting, that the Parole Board was the '*last bastion*' preventing the release of a dangerous prisoner where a section 23 application comes to be considered. She points out that the Board does not have the power to make an application for an extended supervision order of a prisoner or to make an application relating to a person's release on licence when they are mentally impaired. She points out that other entities such as DCS have greater facility to gather relevant information in relation to a prisoner and in particular to the prisoner's behaviour while incarcerated.
- 10.53. In her affidavit Ms Nelson QC asserts that when a person is being considered for parole it is not the role of the Parole Board to consider a submission to the Attorney-General relating to section 57 of the Sentencing Act 2017, the precursor to section 23. She also asserts that the Board does not have the resources to make the necessary assessment to support such an application.¹⁵⁹ The affidavit states that the Parole Board relies on submissions from a range of agencies and specialists to determine suitability for parole and that it is not the function of the Board to direct the desirability of a section 23 application to the attention of the Attorney-General. If the Board were made aware that an application had been directed to the Attorney-General by another appropriate

¹⁵⁸ Exhibit C72

¹⁵⁹ Exhibit C66

agency, the Board may support that application if the Attorney-General invited a comment from the Board.

- 10.54. I observe that it is true that there is nothing in the Correctional Services Act to suggest that the Parole Board has any specific function in relation to initiating or recommending applications under section 23, now section 57 of the Sentencing Act. Equally, however, there was nothing in section 23, nor is there anything in the new section 57, describing how the Attorney-General is to be made aware of the need for an application under those provisions to be considered, meaning that any person or entity is at liberty to so inform the Attorney-General including but not limited to DCS, SAPOL and the Parole Board. It seems to me that the Parole Board is probably in no worse position than any other entity involved in the administration of criminal justice to at least bring to the attention of the Attorney-General that a particular prisoner is a potential candidate for a section 57 application.
- 10.55. I have already referred to the opinions that were entertained in respect of Davey within DCS. I have also referred to the DCS Local Operating Procedure that dictated that consideration needed to be given to the operation of section 23 in cases involving high risk prisoners. Ms Nelson QC told the Court that had DCS provided the Parole Board with an assessment that Davey was unwilling or incapable of controlling his sexual impulses, he would not have been released on parole. However, information in those terms was not made available to the Board and such an assessment was not undertaken.
- 10.56. Ms Nelson QC made a further relevant submission to the Court that I did not accept. Her submission was that in her experience the current Supreme Court was unlikely to make an order that would enable the indeterminate detention of someone like Davey beyond the expiration of their head sentence. Ms Nelson added that there was a reluctance on the part of the Bench to make an order for indeterminate detention because there is a view that when a person completes their head sentence they have done their time and that an indeterminate detention sentence is a punishment over and above the punishment awarded for the crime that the person had committed. Insofar as this submission implies that section 23 orders (and now section 57 orders) are not made despite their appropriateness in given cases, I do not accept that submission. Examples of instances in which the Supreme Court has made an order pursuant to section 23 or section 57 as it now is, or has refused release on licence from indeterminate detention imposed pursuant to those provisions, include **R v Modra** [2009] SASC 68,

R v Humphrys [2009] SASC 198, **R v Wichen (No 2)** [2011] SASC 194, **R v Hore** [2016] SASC 21, **Attorney-General v Kelly** [2017] SASC 164, **R v Iwanczenko** [2019] SASC 140, **Wichen v R** [2020] SASC 157 and **Hore v R** [2020] SASC 194. It is correct that there are several instances in which the Supreme Court has refrained from making orders pursuant to section 23 or section 57. In more recent times these cases need to be examined against the now availability of the extended supervision order that may be imposed pursuant to section 7 of the Criminal Law (High Risk Offenders) Act 2015 which came into effect on 25 January 2016. This measure, which is not a custodial measure, enables the Attorney-General to apply for, and the Supreme Court to grant, an order for the extended supervision of a high-risk offender in the community beyond the expiry date of their sentence. It can be seen from some of the more recent cases in which applications either under section 23 or section 57 have been made that the availability of the extended supervision order and the protection that it can provide to the community is considered to be a relevant matter in considering whether the more draconian indeterminate detention order should or should not be made. I think it is fair to say that if the protection of the public can be secured by an extended supervision order, the Supreme Court would be less likely to impose indeterminate detention. The cases of **Attorney-General v Tipping** [2019] SASC 133 (per Kelly J) and **Thomas v Attorney-General** [2019] SASCFC 21 (CCA) exemplify this approach. It may be that this is what Ms Nelson QC had in mind when she asserted that the Supreme Court was reluctant to make orders under the now section 57 for indeterminate detention.

- 10.57. The ability of the Supreme Court to impose an extended supervision order as housed in the Criminal Law (High Risk Offenders) Act did not come into operation until after the expiry date of Davey's head sentence. The measure therefore could not have been applied to him.
- 10.58. In her written submission to the Court, Ms Nelson drew to my attention the fact that the Parole Board had been in possession of the psychological assessments of Mr Richard Balfour and the psychiatric assessments of Drs Craig Raeside and Ken O'Brien regarding Davey and that in none of them had any opinion been expressed that Davey was unable to control his sexual instincts. All three professionals had recommended that Davey undergo some treatment for his offending behaviour and substance abuse. However, I accept the submission of Mr Roberts of counsel for the Police

Commissioner that these reports, having all been written in 2001 and 2002, could have been of limited value in considering the risk that Davey presented in 2014 and 2015. I would also observe that many of Davey's serious sexual offences occurred after 2001 and 2002. I was not persuaded that these historical reports would necessarily have defeated or impinged adversely on the chances of an application under section 23 in 2014 or 2015. As indicated earlier, Davey's ability and willingness to control his sexual instincts would have needed to be examined afresh for the purposes of any such application.

- 10.59. The outcome of the inquiries by two legally qualified medical practitioners into the mental condition of Davey and in particular their opinions as to whether Davey was incapable of controlling, or unwilling to control, his sexual instincts cannot now be known. This naturally means that the outcome of a section 23 application to the Supreme Court if made by the Attorney-General prior to Davey's release also cannot be known with certainty.
- 10.60. When Davey was sentenced for the murder of Mrs Woodford another report of Mr Balfour was tendered.¹⁶⁰ This report was prepared in the context of the fact that Davey's most recent and most serious offence was the murder. The report did not specifically deal with Davey's propensities or with the issue surrounding the control of his sexual instincts at the time of his incarceration in 2014 and 2015, but it does speak generally of his '*appalling history of sexual violence towards women*' quite apart from the murder. Dr Balfour's report did suggest that successively long prison sentences had done nothing to deter Davey from reoffending and that he had been released into the community without any preparation or rehabilitation. He reported that a '*succession of mental health experts*' had shared the common concern that Davey's sexually violent behaviour had escalated and suggests that a prescient view had been held that someone was going to be seriously injured. It was certainly the case that when Davey had finally been released in 2015 he had indeed been released without preparation or rehabilitation. As will be seen in another section of these findings Dr Balfour is critical of the fact that Davey had not been subjected to what he believes were necessary rehabilitative measures and that the safety of the community had been jeopardised as a consequence. Be that as it may, it would follow from Dr Balfour's observations that at the time Davey was released he was, and was recognised as, a danger to the community. At that time,

¹⁶⁰ Exhibit C72

as to how and why the danger he presented to the community had not been ameliorated while he had been in prison was, in reality, largely beside the point. His danger to the community was by far and away the key element in his then current presentation. This circumstance alone should, as a matter of priority, have stimulated anxious consideration being given to measures that were available to possibly significantly delay his immediate release.

- 10.61. What can be said is that with Davey's sexual criminal history and his poor prospects of rehabilitation there was a missed opportunity for an application to have been made to keep him in custody beyond the expiration of his sentence. Given its well-documented procedures covering the section 23 issue, in my opinion the failure of DCS to bring to the attention of the Attorney-General the fact that Davey should attract serious scrutiny pursuant to section 23 was a particularly egregious oversight.

11. Dudley Davey's rehabilitation in prison

- 11.1. I have touched upon this element of the case in the previous section. In particular I have referred to the evidence concerning the lack of rehabilitation programs that were or would have been available to Davey. I need not make further comment on that evidence. All that needs to be said is that when Davey was released in 2015 he was not in any sense rehabilitated and remained a danger to the community.
- 11.2. I also have referred in part to some of the observations and opinions expressed by the psychologist Mr Balfour in respect of Davey at the time of Davey's sentencing for murder. I have also referred to his criticisms. I here set out his observations in full.

'Clearly, successively longer prison sentences have done nothing to deter Mr Davey from reoffending. I believe the problem is that he has never been given intensive rehabilitation for his core criminogenic risk factors, and sexually deviant behaviour. There has been a succession of mental health experts who have serially assessed Mr Davey and have outlined detailed rehabilitation plans that were never implemented. These experts have also shared the common concern that Mr Davey's sexually violent behaviour has escalated, and someone was going to be seriously injured.

Mr Davey has to be held accountable for his current serious offending behaviour that has deprived a family and the APY Land's community of much loved and valued member. However, the failure of the system to act on earlier recommendations has placed the community at-risk, and done nothing to prevent Mr Davey's escalating sexual offending behaviour. For example, in my report dated the 26/09/2002, I provided a detailed rehabilitation plan for Mr Davey that would have contributed to also protecting the community against further sexual violence from him. To the best of my knowledge, none

of those recommendations were every implemented. All that seems to have happened is that he has received successively longer prison sentences, and then been released into the community without any preparation or rehabilitation. Furthermore, I do not know if the Department of Correctional Services has ever assessed his eligibility for both the Violence Prevention Programme and the Sexual Behaviour Clinic.'

In another section of his report he states:

'Without the assistance of a comprehensive rehabilitation programme, I believe that Mr Davey's prognosis to cease offending in the short-term is poor (i.e., on a prognosis rating scale of poor, fair, and good). He is clearly a high risk offender, and a sexual criminal recidivist.

My recommendations regarding Mr Davey's rehabilitation are largely the same as outlined in my report dated the 26/09/2002.'

- 11.3. Mr Balfour appears to be of a view that rehabilitative programs over time may have altered Davey's recidivist sexual behaviour. Mr Balfour appears to maintain that level of optimism even in his most recent report regarding Davey. When Davey was sentenced by Justice Vanstone, Her Honour made this observation regarding Mr Balfour's report:

'He says you should have received intensive rehabilitation for your sexually deviant behaviour, but you have not. Without it, you are at high risk of reoffending. It seems to me that even if you had such intervention, there could be no confidence about your future.'

- 11.4. While clearly attempts should have been made to subject Davey to rehabilitative measures during periods of incarceration, I do not share Mr Balfour's optimism that they would have altered his behaviour.
- 11.5. I make no finding or comment in relation to Davey's failure to rehabilitate.
- 11.6. It is impossible to determine whether or not Mrs Woodford's death would have been prevented if earlier rehabilitative intervention in respect of Davey had taken place. What can be said, however, is that if a section 23 application had been made, the identification of Davey as an offender who had not participated in rehabilitative programs but who remained a danger to the community would among other considerations have been a highly relevant factor operating in favour of a section 23 order for indeterminate detention being made.

12. Child Sex Offender Registration

- 12.1. This subject is governed by the Child Sex Offenders Registration Act 2006 (The CSOR Act). This legislation and its requirements should have been imposed on Davey when he was dealt with in the Adelaide Magistrates Court in August of 2013. It was not imposed upon him, either at the time of his sentencing in 2013 or at any time following his ultimate release from prison.
- 12.2. The female victim involved in the offence for which Davey was sentenced in August of 2013 was 17 years of age at the time of the offence. This circumstance enlivened the measures housed within the CSOR Act. The stated object of the CSOR Act¹⁶¹ is to protect children from sexual predators by requiring certain persons who may have a propensity to commit sexual offences against children to keep the Commissioner of Police informed of their whereabouts and of other personal details for a period of time in order to reduce the risk of such offences being committed and to facilitate the investigation and prosecution of any offences that are committed. A child is defined in the Act as a person under the age of 18 years.
- 12.3. Davey had been convicted of the offence of indecent assault in respect of the 17-year-old female. This meant that pursuant to Schedule 1 to the CSOR Act he had committed a Class 2 offence under the Act. Davey's offence had been committed against a child. Davey was therefore a '*registerable offender*' under the Act.
- 12.4. The failure of Davey to be identified as a registerable offender owes itself to the failure of various authorities to establish or recognise that the victim of Davey's offending, an immigrant from Kenya, was a person under the age of 18 years. The prosecution of Davey proceeded on the basis that the indecent assault committed by him upon the complainant had taken place without the complainant's consent. This meant that her exact age was not of special relevance as it would have been if the complainant had been under the age of 17 years in which case consent is not an element of the offence of indecent assault and would not have to be proved by the prosecution. However, it is clear that as part of the investigation of the offence the complainant's age should have been investigated and established in any event. It is a routine enquiry in the investigation of a sexual offence. There were potential sources of information as to her age such as her own assertions, her passport and other records that might have related

¹⁶¹ Section 3

to her age, including the age that the hospital to which she was taken and where she was examined had on its records. Ultimately, and at a time after Mrs Woodford's death, the complainant's age, and therefore her status as a child, would readily be established through Australian immigration records.

- 12.5. The sentencing remarks of the Adelaide Magistrates Court when Davey was dealt with in August of 2013 do not discuss the complainant's age. Her age was also not recorded in SAPOL holdings. Thus, at all material times prior to Mrs Woodford's murder, Davey had the ability to pass through the criminal justice system undetected as a registerable offender.
- 12.6. The question is, following Davey's ultimate release from prison what impact, if any, did the failure to classify Davey as a registerable offender have on his ability to move around the State. An associated question is whether or not his recognition as a registrable offender would have had some impact, either directly or indirectly, on his behaviour within the APY Lands.
- 12.7. Firstly, at the time Davey was sentenced there was an obligation contained within the CSOR Act for the Registrar of the Australian National Child Offender Register (ANCOR) to be advised of a relevant conviction. The ANCOR unit was not advised in respect of Davey's conviction and thus his status as a registerable offender at the time he was dealt with in the Magistrates Court was not recognised.
- 12.8. DCS was also unaware of Davey's status as a registerable offender. This meant that at the time of his release from prison nothing was undertaken to ensure Davey's registration.
- 12.9. At the time Davey was dealt with in the Magistrates Court in August of 2013 the CSOR Act imposed an obligation upon a registerable offender to report his or her personal details to the Commissioner of Police each year. The personal details included the address of each premises at which the person generally resided, or if he or she did not generally reside at any particular premises, the name of each of the localities in which he or she generally could be found.¹⁶²
- 12.10. In 2014 certain amendments were made in respect of the CSOR Act. For the first time the status of '*serious registerable offender*' was created. Section 10A of the Act

¹⁶² See sections 13 and 15 of CSOR Act

enabled the Police Commissioner to declare a registerable offender as a serious registerable offender. The Commissioner could do so if satisfied that a registerable offender was at risk of committing further Class 1 or Class 2 offences. Section 15A of the Act enabled the Commissioner to make a further declaration imposing additional reporting requirements on the serious registerable offender in circumstances where the Commissioner has reason to suspect that a serious registerable offender may fail to comply with the Act or might impose a risk to the safety and wellbeing of children. For these purposes, as seen, a child is a person under the age of 18 years. The additional reporting requirements would include more frequent reporting of personal details.

- 12.11. There were other additional measures introduced in the 2014 amendments.
- 12.12. It was regrettable that Davey was not identified as a registerable offender which was due to the fact that his victim in the 2012 offence for which he was imprisoned was not identified as a child, especially so given that ultimately the victim was easily identified as a child through immigration records. The process involved in establishing this was by no means complicated.
- 12.13. However, I was not persuaded that even if Davey had been identified as a registerable offender, or even declared as a serious registerable offender, this would necessarily have meant that he would not have been in Fregon in March of 2016, or by extension, have prevented Mrs Woodford's death. Looking at the matter realistically, I do not believe it likely that any measure under this legislation would have resulted in Davey being prevented from residing on the APY Lands and in Fregon in particular. I also seriously doubt whether Davey's status as a registrable offender of any type would have had an impact on his behaviour.
- 12.14. Between 2010 and 2017 Detective Sergeant Noel McLean was a Registrar of ANCOR. As such he was also a delegate to the Commissioner of Police in respect of the Commissioner's powers under the CSOR Act. Mr McLean gave some detailed evidence about the operations of this legislation. He provided an explanation as to how the shortcomings in the system as it existed in 2013 when Davey was sentenced meant that he was not identified as a registerable offender. In short, as already alluded to, the difficulty stemmed from the fact that the victim of the offence in respect of which he was imprisoned in 2012 to 2015 was not identified as a child. Owing to the sensitivity of police methodology in relation to the manner in which the CSOR Act is administered,

Mr McLean gave part of his evidence in closed court. This evidence related to what control, in practical terms, could have been exercised in relation to Davey had he been recognised as a registered offender after his release in 2015. Suffice it to say Mr McLean's evidence did not inspire confidence that even if Davey had been identified as a registerable offender or a serious registerable offender it would have had any impact on his whereabouts in March of 2016 or have provided police with any power to deal with him if they had established his whereabouts at that time.

12.15. I should add here that the SAPOL Officer in Charge of the APY Lands at the time of Mrs Woodford's death, Mr Scott Barker, who gave oral evidence in the inquest, told the Court that he did not know who Davey was and did not know that as of March 2016 he was residing in the APY Lands. He could not say whether upon Davey's release from prison SAPOL were informed that he had been released to the APY Lands. Mr Barker did say that if Davey had been on ANCOR and other agencies had been aware that he was being relocated to Fregon, he would have been advised.

12.16. I agree with counsel assisting, Mr Kalali, who has argued in his final submission that high risk offenders, and particularly those who have a history of sexual predation and violence, should not be allowed anywhere near the APY Lands. Mr John Singer, the Executive Director of the NHC, and himself an Indigenous man who has a strong cultural and residential connection with the APY Lands, expressed himself likewise. In his statement tendered to the inquest¹⁶³ he asserts:

‘It is my opinion that a person with a criminal history such as Dudley Davey's (**‘Davey’**) should not have been allowed to travel to the APY Lands. The lack of any permanent presence of DCS, in addition to the lack of SAPOL resources in the region, makes it virtually impossible to monitor a person such as Davey.’

‘I consider that it would considerably improve safety in the APY Lands if the Department for Correctional Services were to have a permanent presence in the APY Lands and invest in the Communities to assist with the integration of people back in the Communities after they have served their sentence.’

13. The warrant for Davey's arrest

13.1. On the 29 November 2015 Davey was arrested at Coober Pedy for being unlawfully on premises and providing false particulars. As a result he was bailed to appear in the

¹⁶³ Exhibit C50

Mimili Magistrates Court on 10 February 2016. Davey failed to appear on that date. He was thus in breach of his bail conditions.

- 13.2. Another condition of his bail had been that he was obliged to reside at a particular address in Mimili.
- 13.3. When Davey failed to appear in the Mimili Magistrates Court on 10 February 2016 a warrant was issued for his arrest. The warrant was never executed.
- 13.4. Ms Karen Stormonth who is a DCS Community Corrections Officer was in attendance at the Mimili Magistrates Court on 10 February 2016 in her official capacity. Ms Stormonth provided a statement to the inquest.¹⁶⁴
- 13.5. As it so happened Ms Stormonth had been the DCS Community Corrections Officer responsible for Davey's supervision when he had been released on parole. Thus it was that Ms Stormonth knew Davey. Ms Stormonth had no involvement with Davey after he had been paroled for the first time and then re-arrested for breach of that parole.
- 13.6. Ms Stormonth did not attend Mimili Court in connection with Davey. Ms Stormonth has asserted that she has no recollection of Davey being required to attend Mimili Court on the day in question. If she had been so aware and if she had known of his whereabouts at that time she would have informed that court or the prosecutor.
- 13.7. The warrant for Davey's arrest was never executed. It is apparent that no active steps were taken to execute the warrant at any stage prior to Davey's ultimate arrest for the murder of Mrs Woodford. There is no evidence that Davey came into contact with police at any stage while the warrant for his arrest was extant. There was also no evidence that all police officers in the APY Lands who conceivably could have come into contact with Davey would inevitably have known of the existence of the warrant off-hand, that is to say without making the relevant electronic enquiries as to whether any warrants for his arrest were in existence.
- 13.8. Chief Superintendent Dean Miller who at the time at which this inquest is concerned was the Coordinator of the State Operation Service of SAPOL and as such the officer responsible for the provision of policing services in regional communities in South Australia, in his evidence informed the Court of the usual processes in relation to the

¹⁶⁴ Exhibit C69

execution of a warrant issued by a court for breach of bail. He explained that all first instance warrants are the subject of an assessment as to risk and, I assume, priority of execution. The response of police in respect of the execution of a warrant would depend on the offence for which the warrant was issued. Mr Miller suggested that in the case of Davey's warrant for non-attendance at the Mimili Court, the warrant would be processed as part of normal patrol duties. In other words, if Davey had come under the notice of police for one reason or another the warrant would have been executed. However, in the normal course of events no active measures would be taken to execute the warrant.

- 13.9. Sergeant Duncan Gerrie was the Sergeant in Charge of the Mimili police station at the time at which this inquest is concerned. Sergeant Gerrie has provided two statements to the inquest.¹⁶⁵ He explains that it was standard practice on the APY Lands for a warrant such as this to be dealt with as part of normal patrol duties and that the warrant would have been executed if Davey had come to the attention of police in relation to other matters such as further offending. This evidence accords with that of Chief Superintendent Miller.
- 13.10. I am bound to say, however, that the circumstances regarding Davey's warrant were hardly routine. Given that Davey was obliged to reside in Mimili at a certain address which was clear from the court record, it is conceivable that the warrant could have been executed by attending his address. On the other hand, there was no guarantee that Davey would have been at that address in any event. For instance, the fact that he had to reside at an address in Mimili did not deter him from being in Fregon in March for several days in connection with men's business in and near Fregon. Other matters for consideration are that even if Davey had been arrested on the warrant there is no certainty that he would not have been immediately dealt with by the Mimili Court by way of a non-custodial sentence. As well, the warrant authorised bail. That said, Davey would hardly have been a strong candidate for bail having failed to appear at a court appearance.
- 13.11. Mr Carl Roberts is an Indigenous man who was a Traditional Community Constable (TCC) employed by SAPOL in the APY Lands. Mr Roberts had a strong connection with Fregon as a resident but was stationed and living in Mimili. He knew Davey. As

¹⁶⁵ Exhibit C63 and C63a

of 23 March 2016 Mr Roberts was on leave and was on that day in Fregon. Men's business was taking place in and around Fregon. Mr Roberts gave evidence that he saw Davey on 23 March 2016 in Fregon only a matter of hours before Davey would abduct and murder Mrs Woodford. Mr Roberts maintains that he saw Davey drinking alcohol in Fregon which was in violation of the lawful restrictions relating to the consumption and possession of alcohol in communities on the APY Lands. This would have been a matter that was worthy of police attention. Being a TCC only, Mr Roberts did not have any power of arrest.

13.12. Mr Roberts testified that on seeing Davey that day he contacted Sergeant Gerrie at the Mimili police station by phone and informed him that Davey was drinking in Fregon. In his statements Sergeant Gerrie states that he did not receive any such call from Mr Roberts prior to the murder of Mrs Woodford. Sergeant Gerrie maintains that he had left Mimili on 18 March 2016 and did not return to the APY Lands until 24 March 2016 when he returned in direct response to Mrs Woodford's disappearance. Sergeant Gerrie maintains that he had no knowledge of Davey's whereabouts in the period between 10 February 2016 when the warrant for his arrest was issued and 23 March 2016.

13.13. To my mind the evidence is insufficiently clear to enable any finding to be made as to whether or not Mr Roberts is correct as to the occasion on which he had seen Davey at Fregon drinking or as to when it was that he may have informed a police officer at Mimili as to that observation.

13.14. In the circumstances it is difficult to be certain as to whether there had been an opportunity for SAPOL to arrest Davey prior to the murder.

14. Police presence in Fregon

14.1. At the time of Mrs Woodford's death there was no permanent presence of police in the Fregon community. No police officers actually resided in or were stationed at Fregon. I have already referred to Mr Carl Roberts who was at the time of Mrs Woodford's death employed by SAPOL as a TCC. He held a position as a TCC between 2014 and 2017. Although Mr Roberts had lived in Fregon for most of his life, as a TCC he resided in Mimili which is approximately 74 kilometres from Fregon. Mr Roberts told the Court that he visited Fregon on a weekly basis on a Tuesday or Wednesday and on other occasions when called to Fregon to perform duties. Mr Roberts knew Mrs Woodford.

As already indicated, he also knew, and knew of, Dudley Davey. Mr Roberts knew of Davey and believed that it was necessary to keep away from him. He believed Davey to be a petrol sniffer and he had seen him to be aggressive when high on the fumes of petrol.

- 14.2. Mr Roberts was one of a number of people who had connections with the Fregon community who believed that there should be a permanent police station in Fregon. I will come to those views in a moment.
- 14.3. Evidence was given in the inquest about the issue of policing in the APY Lands by Chief Superintendent Miller of SAPOL. At the time at which this inquest is concerned Mr Miller held the position of Coordinator of the State Operation Service of SAPOL. That entity was responsible for the provision of policing services in regional communities in South Australia including the far north local service area which encompasses the APY Lands. Mr Miller prepared a witness statement that dealt with the issue of police presence on the APY Lands both historically and at the time with which this inquest is concerned. In summary, as of March 2016 SAPOL had twenty full time equivalent (FTE) sworn positions permanently allocated to the APY Lands. The twenty SAPOL members worked a three-week cyclic roster which meant that they would be away from the APY Lands for part of the roster. Operationally, and subject to leave and other contingencies, there were two police officers at each of the locations of Amata, Ernabella, Mimili and either one or two police officers at Murputja. In addition, operational assistance could be provided from other members based at Umuwa if they were present. There are other FTE sworn positions based elsewhere outside of the APY Lands which provided police services to other communities within the APY Lands. From 1996 there were ten FTE Traditional Community Constable positions, but as at the time of the inquest only four of those positions were filled. Mr Miller points out in his statement that there are a number of challenges which impacted on the ability of TCCs to deliver a service to the community and to SAPOL including their obligations to tradition and kinship that can influence the incumbent to withdraw from involvement in matters or to take sides based on family ties. As indicated, Mr Miller confirmed that there was no police compound in the Fregon community or permanent police accommodation. Mr Miller also pointed out that maintaining the FTE staffing level had been challenging due to the harsh and isolated location which made living and working in the APY Lands demanding. Additionally,

the majority of officers opted to work remotely from their families. It appears to be the position of the Commissioner that, subject to a measure that SAPOL have recently contemplated, and which I will discuss, Fregon has been adequately policed.

- 14.4. As indicated earlier, the views of people who lived and worked in Fregon as well as those persons who were involved in the management of the NHC and the provision of medical and nursing services, were unanimous in their view that there was and is a need for a permanent police presence in Fregon. I have already referred to Mr Carl Roberts, an Indigenous man and former TCC who had spent most of his life in Fregon. Mr Roberts articulated his reasons for holding this view. Firstly, he said that it would obviate the need for the Fregon community to have to wait ‘...two to three hours for police to come from Mimili’.¹⁶⁶ He suggested that there were circumstances in which it might take four or five hours for police to attend situations involving drunkenness and violence. In addition, Mr Roberts was of the view that a police presence would benefit children in the community in that it would be safer for them as they would live in a better community.
- 14.5. Mrs Woodford’s husband Keith Woodford expressed the view that a permanent police presence would be more effective in deterring alcohol and drug consumption and in suppressing violence and disorder. I pause here to observe that although the APY Lands communities are meant to be dry, this is not always necessarily the case in practice.
- 14.6. Dr Johns to whom I have referred expressed the opinion that violence in the Fregon community, which she described as completely lawless and inadequately dealt with by police, Federal and State Governments, was contributed to by lack of community councils and the leadership of elders.
- 14.7. Mr Singer in his evidence advocated for a permanent police presence. Mr Singer is an Indigenous man. He believes that a permanent police presence in Fregon with its violence, antisocial behaviour, drinking and drug taking within the community, would make a difference. Mr Singer has observed that in APY communities where there is a police presence, the communities are able to build up a good relationship or a stronger relationship with SAPOL. Mr Singer referred to the adverse distances between the communities and agreed with the proposition that a police presence would create a

¹⁶⁶ Transcript, page 686

greater level of safety for clinics and NHC staff. In particular, a police presence would protect on-call nurses on duty. He said: -

'I think you've got a presence there that's right sort of in the community and I just think that individuals would be more aware with that police presence there'.¹⁶⁷

14.8. Mr Busuttil of the NHC gave evidence in respect of efforts that were made between 2006 and 2017 to secure a permanent police presence in some of the communities on the APY Lands. In his witness statement Mr Busuttil produced correspondence that he had entered into with the Minister for Police in April 2015 about police resources in the APY Lands. In a letter dated 1 April 2015 the NHC wrote to the Minister for Police, Mr Tony Piccolo MP, pointing out the inadequacy of policing in the APY Lands. Although the letter dealt with issues such as inadequate police response times due to long travel times and high workloads that exist for police on the APY Lands, the letter did not draw to the Minister's attention any safety concerns that were expressed or held within the NHC. The letter expressed the opinion held by NHC that police stations with permanently staffed police officers were required in each of the six major communities on the APY Lands. The letter also stated that NHC had been advised by the Commonwealth Government that it had made an offer of capital funding to the South Australian Government so that more police stations could be constructed on the APY Lands, but that the NHC understood that the offer had been rejected by the South Australian Government as the State was not willing to provide the recurrent costs involved. The reply of Mr Piccolo dated 8 June 2015 explained that in October 2014 the State Treasury had advised that if South Australia was provided with Commonwealth funding, the State would have the equivalent amount deducted from its payment of GST revenue. Therefore, the offer of Commonwealth funding was declined as not being a viable option at that time. Other efforts by way of correspondence with the relevant Minister designed to secure a greater police presence have been made by the NHC since Mrs Woodford's death.

14.9. In his oral evidence Mr Busuttil told the Court that both during his tenure at the NHC and now he believed that a permanent police presence in the six communities was required.¹⁶⁸

¹⁶⁷ Transcript, page 865

¹⁶⁸ Transcript, pages 490 and 495

14.10. As well as providing his detailed statement, Superintendent Miller gave oral evidence in the inquest about a number of matters connected with policing in the APY Lands. It was pointed out to him by Mr Bonig of counsel for Mr Takawira, that the Mullighan Inquiry¹⁶⁹ had recommended that fully operational police stations and an adequate number of police personnel be established at all of the main communities on the APY Lands which he listed. There were six in all which included Fregon and Mimili. Following this a police station was established in Mimili and two others were built with Commonwealth Government funding. The three stations were Mimili, Amata and Ernabella as they were considered to have had the most victim reported crimes. Between 2008 and 2019 Fregon accounted for about 9% percent of victim reported crime compared to Mimili at around 12% percent and with Amata and Ernabella at around 22% and 24% respectively. Mr Miller's statement and his evidence are replete with statistical comparisons between crime rates in the various APY Lands communities. I confess to not finding this evidence particularly helpful. The issue is not a comparative one. The issue is simply whether a police presence in Fregon is required. What the situation is in other APY Lands communities is somewhat beside the point.

14.11. However, Mr Miller explained that as at the time of the inquest SAPOL had resolved to supply and deliver police facilities at Fregon that would include an office, accommodation, kitchen and lounge facilities. This establishment would provide SAPOL with the ability to accommodate officers in Fregon overnight, the initial proposal being that two police officers would attend at Fregon on two days per fortnight. It was intended that they would attend as much as possible at Fregon as part of their general patrol duties.

14.12. Mr Bonig asked Mr Miller why SAPOL were not proposing a permanent residence in Fregon given that they were constructing housing and office facilities in that location. Mr Miller's answer was as follows:

'The situation with Fregon is that geographically located, and where we have police stations at Mimili, Ernabella and Amata, the geographic location of Fregon enables an appropriate response from Mimili. What we intend to do though is by enabling the officers to have accommodation so that they can stay longer in Fregon provides what we would

¹⁶⁹ The children in State Care Commission of Inquiry conducted by the Hon E P Mullighan QC in accordance with section 11 of the Commission of Inquiry (Children in State Care and Children on APY Lands) Act 2004

consider is a better service to the community than they already get which is through an office-type situation; an old shed where they can take statements and so forth.¹⁷⁰

He went on to say that the twenty FTE positions on the APY Lands provide a balanced service across the Lands, taking into account perceived and actual risk, distances, response times and crime rates. He asserts that the SAPOL Commissioner was '*quite strong*' on suggesting that at the moment the police presence of twenty FTEs, which reflects a 1 to 109 population according to the APY Census, provides a very good police response. The point, however, is that while there may be a certain number of police officers per capita in the APY Lands as a whole, they are not in Fregon.

14.13. Superintendent Miller was questioned about a number of policing matters including the reporting of offences and deterrence. Assertions made by Superintendent Miller in this regard included that it was challenging for police to have crime in the APY Lands communities reported to police. However, in my view the point is well made that the lack of enthusiasm to report crime could very well be a reflection of the fact that there is no immediate police presence to report it to. Asked as to whether it was more likely or less likely for a crime committed in a community such as Fregon to be reported to police if there was an actual police presence in that community, as distinct from a police presence in a more remote community, Superintendent Miller suggested that it would not make any difference whether there was a police presence that enabled a person to walk to the police station or phone the police to report a crime. It was difficult culturally to have the local community to report crimes to SAPOL in any event.¹⁷¹

14.14. Superintendent Miller was also questioned about response times. He suggested that a response time for police to respond from Mimili to Fregon was approximately 40 minutes on average.¹⁷² Other evidence suggested that this would be an unrealistic assessment as on some views it takes longer to drive from Mimili to Fregon than 40 minutes. The other point worth making is that the response time would obviously depend on the then current activities of police in Mimili who might or might not be in a position to respond in that timeframe or at all.

14.15. It also occurs to me that police who are actually working and living in a community would have a greater opportunity to familiarise themselves with the characteristics of

¹⁷⁰ Transcript, page 729

¹⁷¹ Transcript, page 774

¹⁷² Transcript, page 775

the individual members of that community, and whether for instance a known criminal is residing in that community.

- 14.16. Also, as a matter of commonsense and human experience, one would have thought that a permanent police presence in a community would have a deterrent effect on criminality and other misbehaviour. While much was said in Superintendent Miller's evidence about the ability of police to respond from a remote community to Fregon, the issue is not so much a question of response but a question of deterrence by having police actually visible in a community. The evidence of those witnesses who were called and who expressed a view about police presence in the Fregon community having regard to the level of lawlessness within it, would suggest that a permanent police presence would be essential.
- 14.17. The proposition that a community in which certain of its members need to be protected by cages does not require an immediate police presence within that community would, I think, strike the ordinary man or woman in the street as perverse. It is a notion that has its manifest difficulty.
- 14.18. As counsel assisting Mr Kalali points out, there is nothing new in the call for a permanent police presence in the communities of the APY Lands. It will be remembered that the then State Coroner, Mr Chivell, in an inquest held into deaths by petrol sniffing within the APY Lands in the early part of this century strongly endorsed community sentiment that a much greater permanent SAPOL presence in the APY Lands was called for.
- 14.19. In my view, similarly in this case, the views of people living and working in these communities should be preferred to those of people who do not.
- 14.20. As to whether a greater police presence in the Lands generally or a presence in Fregon in particular would have prevented Mrs Woodford's death is a difficult question to determine. An actual police presence in Fregon of permanent sworn officers actually living in the community may not have deterred any of Davey's activities. However, there would have been a greater likelihood of his presence in the Fregon community being known and therefore a greater likelihood that his criminal propensities would have been understood among the NHC staff. It is unthinkable that if police knew of his presence in Fregon and knew of his criminal past that this information would not have

been shared by people who needed to know about it and who were at risk of harm from a person such as Davey.

15. Information to be provided to persons living in remote communities regarding the criminality of a person in that community

- 15.1. During the course of this inquest there was a great deal of debate as to whether it would be necessary, desirable or appropriate for persons providing services to a community such as Fregon to be informed of the presence of a known and possibly dangerous criminal in that community.
- 15.2. Given that convictions and sentences in respect of that criminality are imposed in an open forum such as a criminal court, the criminality of an individual is for the most part a matter of public record. That being the case, there does not seem to be any sensible reason why information about that should not be made available by police or some other authority to persons providing health and other services in a community in which that criminal resides or of which that person is an habitue. To suggest that privacy considerations might stand in the way of such disclosure is to my mind a fallacy. If a police officer working in the APY Lands came to know of the presence of a person such as Davey on the APY Lands, one would think that in all of the circumstances the information would at least be shared with people who might need to know about it.
- 15.3. I have little doubt that if Mrs Woodford had known of the background and propensities of Dudley Davey she would never have engaged with him without the walls of the cage at all times intervening between the two of them.

16. Gayle's Law

- 16.1. Gayle's Law is a reference to legislative measures that are designed to enhance the safety of health practitioners who are required to attend out of hours callouts in remote areas including the APY Lands. Those measures are contained within Part 5A of the Health Practitioner Regulation National Law (South Australia) Act 2010 and regulations 11A to 11H of the Health Practitioner Regulation National Law (South Australia) Regulations 2010.

- 16.2. The legislative measures were put in place in response to the murder of Mrs Woodford. I should note that following Mrs Woodford's death, the NHC to its credit took steps to ensure that nursing staff employed in remote places did not provide after hours services unless accompanied by another person. This practice is now encompassed in Gayle's Law.
- 16.3. Essentially, Gayle's Law stipulates that a health practitioner to whom the legislation applies must not attend a callout to which the legislation applies unless the health practitioner is accompanied by a second responder. The callout to which the legislation applies includes an out of hours callout where the attendance occurs or is to occur between the hours of 5pm and 8am or on Saturdays, Sundays or public holidays and where the place at which the health practitioner is to attend is in a remote area. It can be seen from this that the legislative requirement is intended to apply to the work of a health practitioner in a remote area where the work does not occur in ordinary office or clinic hours.
- 16.4. A second responder for these purposes need not be another health practitioner. However, a second responder, with some exceptions stipulated by regulation, must hold a current Australian drivers licence, must be the subject of a working with children check and must not be prohibited from working with children under various laws.
- 16.5. It will be seen from this body of legislation that the health practitioner has very little in the way of a discretion to dispense with accompaniment by a second responder. Suffice it to say, the legislation appears to prohibit an attendance by a health practitioner at a location in a remote area unless the health practitioner is in the presence of or is in the vicinity of another responsible person during the attendance on a patient.
- 16.6. These legislative measures would naturally apply to employees of an organisation such as the NHC.
- 16.7. The consensus among those involved in this inquest was that Gayle's Law achieves the aims of providing adequate protections for health practitioners working in remote areas for out of hours and unscheduled callouts. Gayle's Law has not been the subject of any strident criticism by witnesses or entities who have participated in this inquest. The

supporters of Gayle's Law include the NHC and its staff and the Australian Nursing and Midwifery Federation (SA Branch) (the Nursing Federation).

- 16.8. The Nursing Federation provided a submission to the inquest.¹⁷³ That submission took the form of a statement from Mr Robert Bonner who is the Director, Operations and Strategy for the Nursing Federation. Mr Bonner has worked in senior industrial and strategic roles within the Nursing Federation for more than 30 years.
- 16.9. Consistently with the evidence that I heard in this inquest, Mr Bonner points out that health professionals, including nurses in remote communities, are occasionally in a position where they are unable to meet the perceived needs for service which at times creates conflict with consumers. This can create circumstances of tension and conflict between the health professionals and members of the community. This observation supports evidence given by nursing staff in the inquest that they felt obliged to provide clinical services at night and when on-call out of a sense of their professionalism and also to avoid ostracisation or other negative consequences at the hands of the community they serve.
- 16.10. Mr Bonner also points out in his statement that the number of serious assaults on nurses is rising not only in remote areas. These assaults are often fuelled by drugs and alcohol.
- 16.11. Mr Bonner asserts that following the death of Mrs Woodford the Nursing Federation along with Mrs Woodford's family and others, both at a National and State/Territory level, lobbied for a legislative response to improve safety at work for nurses in rural and remote locations.
- 16.12. Mr Bonner passes comment on the relevant features of Gayle's Law. He indicates that the Nursing Federation believes that the regulations are consistent with the objective of ensuring that the employer establishes and maintains safe systems of work and prohibits single nurse callouts after hours. In the case of nurses employed on the APY Lands, as a result of the new law no nurse will attend a callout alone after hours; either a second responder will attend the nurse's location or will meet the nurse at the location where the patient is to be seen. Mr Bonner indicates that in practice the person seeking

¹⁷³ Exhibit C61

treatment will be told that the nurse will meet him or her at the relevant location with the second responder. Mr Bonner indicates that it is his understanding that the final regulations provide for the nurse or other health practitioner to take another trusted person such as a family member or respected elder to ensure their safety as distinct from the formally accredited second responder such as police and the like.

- 16.13. Mr Bonner points out that except in the case of Saturdays, Sundays and public holidays, Gayle's Law only takes account of nursing activities after daylight hours. However, Mr Bonner points out that in very small communities in remote areas it is likely that support systems during the day and particularly on weekends may not be substantially different from those available at night. He says '*in an ideal world we would want the legislation amended to protect nurses and other health professionals at all times of the day and week. This would in effect prohibit single nurse posts or visits where a second responder was not available*'.
- 16.14. In the written final submission submitted to the Court on behalf of Mrs Woodford's family it is indicated that Mrs Woodford's family agrees with the submission of counsel assisting, Mr Kalali, that Gayle's Law and the regulations made under it, and its implementation by NHC, provide adequate protection for on-call nurses working after hours. However, their submission indicates that in their view there remains an issue in respect of performance of callouts during the lunch time period of the day during which time there is no support person available to a nurse. Therefore, it is asserted, any callout by a nurse in that time is conducted alone. Mrs Woodford's family submits that the NHC should put in place processes which ensure that during the day nurses are accompanied on callouts so that those callouts are not performed alone. This submission accords with that of the Nursing Federation.
- 16.15. For my part I would wish to point out two matters relating to Gayle's Law that might constitute matters of concern. Firstly, pursuant to section 77E(2) of the Act the second responder need not accompany a health practitioner attending a callout during the journey '*to the place at which health services are to be provided in relation to the callout*'. It is conceivable that the request for health services might still involve a personal attendance at the nurse's home by a person on behalf of the intended patient. Such a request might be bogus. If the health practitioner was required to accompany

that person to another location rather than the second responder, the health practitioner might still be at risk.

- 16.16. The other matter worthy of consideration should this legislation be reviewed is that it is silent as to the question as to what should take place when the patient personally attends at the health practitioner's home after hours seeking treatment. In those circumstances there is no callout as such. The legislation as currently crafted appears to contemplate that a callout involves a journey on the part of the health practitioner from one place to another. That is not the only circumstance in which danger might be posed to a health practitioner in a remote area. Mrs Woodford's is a case in point. To my mind her abduction occurred at her home.
- 16.17. I intend to make a recommendation that in any review of Gayle's Law these matters are taken into consideration.

17. Recommendations

- 17.1. 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.
- 17.2. The following recommendations are directed to the attention of the Minister for Police and the Commissioner of Police. It is recommended that:
- 1) Renewed consideration be given to establishing a permanent police presence in Fregon that would consist of officers residing in and being stationed at Fregon.
 - 2) Police General Orders be amended to impose an obligation upon Police Corrections Section personnel to consider the possible application to a prisoner of Part 3 Division 5 of the Sentencing Act 2017 when providing advice to the Parole Board of South Australia in relation to the release of that prisoner on parole.
 - 3) Police General Orders be amended to impose an obligation upon Police Corrections Section personnel to consider the possible application to a prisoner of Part 3 Division 5 of the Sentencing Act 2017 and, if appropriate, to notify the Attorney-General accordingly.

- 4) Police General Orders be amended to impose an obligation upon Police Corrections Section personnel to consider the possible application to a prisoner of the Criminal Law (High Risk Offenders) Act 2015 when providing advice to the Parole Board of South Australia in relation to the release of that prisoner on parole.
- 5) Police General Orders be amended to impose an obligation upon Police Corrections Section personnel to consider the possible application to a prisoner of the Criminal Law (High Risk Offenders) Act 2015 and, if appropriate, to notify the Attorney-General accordingly.

17.3. The following recommendation is directed to the attention of the Honourable the Attorney-General. It is recommended that:

- 6) The Attorney-General introduce legislation to amend Part 3 Division 5 of the Sentencing Act 2017 to impose obligations upon SAPOL, the Department for Correctional Services and the Parole Board in appropriate cases to advise the Attorney-General that a particular prisoner should be considered as the possible subject of an application to the Supreme Court pursuant to section 57 of the Sentencing Act 2017 for an order that the prisoner be detained in custody until further order.

17.4. The following recommendation is directed to the attention of the Chief Executive of the Department for Correctional Services. It is recommended that:

- 7) Relevant staff of the Department for Correctional Services should be reminded of the terms of DCS Local Operating Procedure entitled '*Oversight of Prisoners pursuant to section 23 of the Criminal Law (Sentencing) Act 1988*' (or its current version) relating to serious repeat sexual offenders constituting a high risk and of the obligations contained within that document concerning the operation of section 57 of the Sentencing Act 2017.

17.5. The following recommendations are directed to the Executive Director and Medical Director of the NHC. It is recommended that:

- 8) Notwithstanding the requirements contained within the relevant provisions of the Health Practitioner Regulation National Law (South Australia) Act 2010 and the

Regulations made thereunder (Gayle's Law), that the NHC establishes processes to ensure that its health practitioners are accompanied by a responsible person en route on any callout regardless of the time of day or night.

- 9) The Executive Director and Medical Director of the NHC if necessary amend their policies and guidelines to ensure that presentations of persons seeking the services of health practitioners employed by the NHC in remote areas are not made in person by a direct approach to the home address of the health practitioner.

17.6. The following recommendation is directed to the attention of the Premier of South Australia and the Attorney-General. It is recommended:

- 10) That in any review of the operation of the relevant provisions of the Health Practitioner Regulation National Law (South Australia) Act 2010 and the Regulations made thereunder as they apply to health practitioners providing services in remote areas of South Australia, that consideration be given to clarifying whether the requirements in respect of a second responder should apply to presentations by a patient to the home of the health practitioner. The other matter that should be considered in any such review is whether health practitioners should be accompanied by the second responder during any journey to the location where the health service is to be provided.

17.7. The following recommendations are directed to the attention of the Premier, the Attorney-General and the Minister for Police. It is recommended that:

- 11) The State Government consult with APY communities and relevant authorities concerning the implementation of measures regarding the release of offenders at high risk of serious offending to the APY Lands, such measures to include the precluding of such an offender from residing on the APY Lands, the placement of conditions on the offender if residing on the APY Lands and the provision of advice to service providers on the APY Lands in respect of the offender and the risk of reoffending identified by the authorities.

- 12) That no person who is the subject of an extended supervision order imposed pursuant to the Criminal Law (High Risk Offenders) Act 2015 should be permitted to reside or otherwise be present on the APY Lands.

Key Words: Homicide; APY Lands; Criminal Law (Sentencing) Act; Gayle's Law

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

Seal the 15th day of April, 2021.

Deputy State Coroner

Inquest Number 39/2019 (0555/2016)