

CORONERS COURT OF SOUTH AUSTRALIA

DISCLAIMER - Every effort has been made to comply with suppression orders or statutory provisions prohibiting publication that may apply to this judgment. The onus remains on any person using material in the judgment to ensure that the intended use of that material does not breach any such order or provision. Further enquiries may be directed to the Registry of the Court in which it was generated.

INQUEST INTO THE DEATH OF MICHAEL LIONEL RICHARD WEETRA

[2025] SACC 9

Inquest Findings of his Honour Deputy State Coroner White

6 May 2025

CORONIAL INQUEST

Examination of the cause and circumstances of the death of Michael Lionel Richard Weetra, an 18-year-old indigenous man who was released from prison on home detention bail and was found hanging three days later. The Inquest examined the time he spent in custody and the series of events that led to him taking his own life.

Held:

1. Michael Lionel Richard Weetra, aged 18 years of Elizabeth South, died at Elizabeth South on 14 September 2019 as a result of hanging.
2. Circumstances of death as set out in these findings.

Recommendations made.

Counsel Assisting: MR P LONGSON

Family: MS J HAVEA

Counsel: MS L BOWERING WITH MR C CHARLES – Solicitor: ABORIGINAL LEGAL RIGHTS MOVEMENT

Interested Party: DEPARTMENT FOR CORRECTIONAL SERVICES, CENTRAL ADELAIDE LOCAL HEALTH NETWORK, NORTHERN ADELAIDE LOCAL HEALTH NETWORK

Counsel: MS S MITCHELL – Solicitor: CROWN SOLICITOR

Interested Party: THE LAW SOCIETY OF SOUTH AUSTRALIA

Counsel: MR J MARSH – Solicitor: THE LAW SOCIETY OF SOUTH AUSTRALIA

Witness: MS T BOLT, MS K BEAGLEY, MR L WILLIAMS

Counsel: MS S MITCHELL – Solicitor: CROWN SOLICITOR

Witness: MR B TAYLOR

Counsel: MS H ROGERS – Solicitor: TINDALL GASK BENTLEY LAWYERS

Witness: DR O NWACHUKU

Counsel: MR J HOMBURG – Solicitor: GILCHRIST CONNELL

Hearing Date/s: 22/02/2023, 24/02/2023, 27/02/2023-02/03/2023, 16/03/2023-17/03/2023, 21/03/2023, 30/03/2023, 26/04/2023 & 28/04/2023

Inquest No: 01/2023

File No/s: 1915/2019

This judgment contains discussion of suicide and may be distressing to some people

There is always help available

If you need support, contact

Lifeline Australia

Call 13 11 14 or Text 0477 13 11 14
or chat online at www.lifeline.org.au/crisis-chat

Aboriginal & Torres Strait Islander Support

Call 13YARN (13 92 76)

Kids Helpline

Call 1800 55 1800

MensLine Australia

Call 1300 78 99 78

**INQUEST INTO THE DEATH OF
MICHAEL LIONEL RICHARD WEETRA
[2025] SACC 9**

Introduction and cause of death

- 1 It was the sad duty of this Court to conduct an Inquest into a death in custody of an 18-year-old Aboriginal man, Michael Lionel Richard Weetra. The Court was given permission by his family to refer to his name as Michael Weetra or Mr Weetra in evidence and in this Finding.
- 2 Mr Weetra took his own life at his sister's house at Elizabeth South in the early hours of Saturday, 14 September 2019. He did so by hanging himself in her backyard. A post-mortem examination of Mr Weetra was performed at Forensic Science South Australia¹ by Associate Professor Neil Langlois, consultant forensic pathologist, on 17 September 2019. He determined the cause of death was 'compression of the neck in keeping with hanging'. I accept his evidence as provided in the post-mortem report² and find the cause of death is hanging.

Reason for Inquest

- 3 Mr Weetra was residing at his sister's house having been granted home detention bail³ by the Elizabeth Magistrates Court⁴ on 11 September 2019. The HD bail was related to charges of affray and property damage allegedly committed on 29 August 2019. Under the Coroners Act 2003,⁵ a person on HD bail is defined to be in custody. The Act stipulates that a death in custody must be subject to an Inquest. Accordingly, it was mandatory to hold an Inquest into Mr Weetra's death.

Background

- 4 On 29 August 2019 Mr Weetra was arrested by South Australia Police⁶ at the alleged crime scene in Elizabeth South and taken into police custody. I have seen the video recording of the arrest. He was behaving consistently with being intoxicated.
- 5 He was transported from the alleged crime scene to the Lyell McEwin Hospital⁷ after complaining of being hit with a brick during the alleged criminal behaviour. A blood alcohol test was conducted and showed a reading of 0.126%. A portion of his time in the LMH Emergency Department⁸ was subject to CCTV recording. I have seen the video recording of his time in the ED. He was seemingly at ease with many people with him as support.
- 6 Upon completion of his assessment in the ED, Mr Weetra was taken to the Elizabeth Police Station. He was not eligible for bail due to a warrant issued by the Youth Court

¹ FSSA

² Exhibit C2a

³ HD bail

⁴ EMC

⁵ the Act

⁶ SAPOL

⁷ LMH

⁸ ED

on 21 August 2019 for his failure to appear at a court hearing. He participated in a record of interview which I have also seen.

- 7 The following day, 30 August 2019, he appeared in the EMC. The Court indicated that HD bail would be the only acceptable form of bail that would be considered. As this takes time to organise and includes an assessment of the suitability of the address proposed, the next hearing was set for 5 September 2019. Mr Weetra's mother's address was nominated for HD bail, but it proved to be unsuitable.
- 8 Consequently, at the next hearing on 5 September 2019, his sister's address was nominated as a substitute. This address proved to be suitable. At the subsequent hearing on 11 September 2019, Mr Weetra successfully applied for HD bail at that address and was released from immediate custody. His solicitor for these hearings only had a brief opportunity to see him in person on one occasion, being in the EMC cells immediately prior to the hearing on 30 August 2019. He had appeared via video link from Yatala Labour Prison⁹ for the hearings on 5 and 11 September 2019. She had no independent memory of him. Evidently in the recording of the hearing on 5 September 2019, she had conveyed a comment by Mr Weetra to the Court that he felt 'not well in the head and the heart' and that he was 'requiring some cultural healing'.¹⁰
- 9 HD bail was quickly granted.¹¹ I make no criticism of the conduct of the solicitor. To the contrary, the application of bail was successful, meaning the Department for Correctional Services¹² would still be supervising him under HD bail in the community. I find the HD bail was appropriate given all the factors that the Court had been asked to consider. However, the Court had not been informed of his struggles at Yatala.
- 10 As is customary for HD bail, Mr Weetra was subject to strict conditions by DCS including electronic monitoring via an ankle bracelet, to remain at the premises unless given permission to leave by DCS or in the case of an emergency, and to be subject to drug and alcohol testing.¹³

Evidence at Inquest

- 11 In this Inquest evidence was presented concerning Mr Weetra's time spent in *SAPOL* custody and DCS immediate custody at Yatala, and their respective involvement with him following his release on 11 September 2019. The Court also heard evidence from his sister and her partner regarding his behaviour at the house. Medical evidence was also presented from Yatala, in relation to his mental health, and from a locum general practitioner¹⁴ who briefly visited him at the house in relation to his physical health.

⁹ YLP or Yatala

¹⁰ Exhibit C31b

¹¹ See affidavit of solicitor, Exhibit C31 and audio recording of EMC hearings, Exhibit C31a

¹² DCS

¹³ Exhibit C14d

¹⁴ GP

- 12 Additionally, expert psychiatric evidence was given by Dr Lynette Rose who conducted an overview of Mr Weetra's behaviour and the care he received between his arrest until the time of his death.

Hindsight and outcome bias

- 13 I warn myself concerning two vital considerations in the assessment of the evidence and any potential criticisms of witnesses in this Inquest, namely hindsight bias and outcome bias.

- 14 The Australasian Coroners Manual describes 'hindsight bias' as being:

'... the tendency after the event to assume that events are more predictable or foreseeable than they really were. What is clear in hindsight is rarely as clear before the fact. If it were, there would be far fewer mistakes made. It is an obvious point, but one that nonetheless bears repeating, particularly when coroners are considering assigning blame or making adverse comments that might damage a person's reputation.

...

Hindsight, of course, is a very useful tool for learning lessons from an unfortunate event. It is not useful for understanding how the involved people comprehended the situation as it developed. This distinction needs to be understood and rigorously applied.¹⁵

- 15 As stated, I am very mindful of this warning when considering evidence of what efforts were made by DCS, medical carers and his family from the time of his arrest until his death.
- 16 I also am very mindful of outcome bias. That is, the terrible outcome of Mr Weetra's death should not lead me to more harshly assess the evidence of attempts to help him and further issues, particularly his supervision, of which I will identify in this Finding. In other words, the outcome of Mr Weetra's death must not overwhelm or unduly influence my task of assessing the evidence about the issues in this Inquest.

Witnesses called at Inquest

- 17 Oral evidence was heard from the following witnesses:
- Luke Williams, Manager, High Dependency Unit, YLP
 - Kerry-Anne Beagley, Intensive Compliance Officer, DCS
 - Terah Bolt, Psychiatric Nurse, Northern Community Mental Health Centre
 - Brendan Taylor, Intensive Compliance Officer, DCS
 - Tanya Weetra, sister of Mr Weetra
 - Wayne Willis, partner of Tanya Weetra
 - Dr Okechuku Nwachuku, general practitioner, National Home Doctor Service
 - Dr Lynette Rose, Consultant Psychiatrist, Marion Psychosis Unit

¹⁵ Hugh Dillon and Marie Hadley, *The Australasian Coroner's Manual* (The Federation Press, 2015), page 10

Mr Luke Williams

- 18 Mr Williams was a registered psychologist and Manager of the High Dependency Unit¹⁶ and Health Centre at YLP in September 2019. At that point he had been an employee of DCS for nine years. Mr Williams undertook a range of duties as the Manager of HDU, including managing the clinical staff and the prisoners in their care, providing oversight of custodial operations, as well as clinical oversight of prisoners in HDU and prisoners in Yatala more broadly.
- 19 When Mr Weetra was admitted to Yatala on 30 August 2019, a notice of concern¹⁷ was raised following his admission interview. It is routine for each incoming prisoner to partake in an admission interview. It involves an assessment in which the prisoner is asked questions set out in a DCS document called the ‘Prisoner Stress Screening’ form. I have detailed the importance of this document at length in the Finding of the Inquest into the death of the late Mr Joshua Marek Stachor.¹⁸
- 20 This document is pivotal as to the way a prisoner is first cared for in immediate custody. It asks standard questions focusing on a prisoner’s physical and mental health, as well as any fears for safety regarding a prisoner or group of prisoners. Each question carries a score to be determined by the interviewer. Some questions concern what is regarded as ‘critical items’, to which any affirmative answer should cause a NOC to be raised.
- 21 A NOC must also be raised for scores of eight or above. Mr Weetra attained a score of seven in his assessment and, although this did not meet the minimum threshold to warrant a mandatory NOC, he had provided an affirmative answer to one of the critical questions which prompted the interviewer, Mr Darren Hills, to raise a NOC. In his evidence, Mr Williams said this was an entirely appropriate response made by a very experienced DCS officer.¹⁹
- 22 Mr Williams explained that when NOCs are raised by DCS staff at Yatala, this triggers a sequence of actions within the prison. Firstly, a responsible officer would arrange for the prisoner to be held safely until he can be assessed by medical staff. The medical staff and responsible officer would then devise an initial response plan setting out how the prisoner would be managed to mitigate any risks they have to themselves. Thereafter, the NOC is emailed to the High-Risk Assessment Team²⁰ and the prisoner is added to the HRAT list for allocation to a member of the Offender Development staff for further assessment. Accordingly, Mr Weetra was referred to the HRAT for monitoring.
- 23 HRAT is a multidisciplinary team comprising institutional social workers, case management consultants, members of the SA Prison Health Service,²¹ Aboriginal Liaison Officers, and psychologists. They oversee the management of prisoners who have been identified as being at risk of self-harm or suicide.
- 24 For the purpose of the weekly HRAT meetings, the Offender Development manager compiles every assessment made for each prisoner on the list so that they can be reviewed. A discussion is held to make determinations as to how each prisoner is to be managed in

¹⁶ HDU

¹⁷ NOC

¹⁸ Delivered 28 June 2021

¹⁹ Transcript, page 418; Exhibit C22, pages 53-54

²⁰ HRAT

²¹ SAPHS

the coming week. Separate assessments are conducted by relevant disciplines within the prison for the individual prisoner. For example, indigenous or First Nations prisoners would generally be assessed by an Aboriginal Liaison Officer.²²

- 25 Mr Weetra was assessed on 9 September 2019 by both Mr Edward August, a social worker, and Mr Patrick Sumner, an ALO. He was further assessed by Mr Williams on 10 September 2019. It was Mr Williams' impression that the purpose for this occasion was an emergency triage assessment because a staff member had brought Mr Weetra to him in the Health Centre after having concerns about his presentation. Mr Williams stated with certainty that Mr Weetra was clearly experiencing psychotic symptoms. Cognisant of the fact that symptoms manifest differently in different cultures, Mr Williams was mindful to factor this into his assessment of Mr Weetra as a very young indigenous man.
- 26 With the view this was an emergency triage assessment, Mr Williams needed to make a relatively quick decision on Mr Weetra's placement, hence he did not access Mr Weetra's history to inform his assessment at the time. It was likely only after the assessment that he would have accessed Mr Weetra's SAPHS records and information on the Justice Information System.²³ I believe this was a good initiative by Mr Williams.
- 27 During the assessment Mr Williams arranged for Mr Weetra's brother, who was also a prisoner at Yatala, to be brought to the Health Centre. It was Mr Williams' belief that familial support is important in situations where an individual is experiencing what appears to be a mental health crisis. In this instance, he believed Mr Weetra's brother would be able to offer him support, as well as provide Mr Williams with some insight into family and cultural matters.
- 28 Having identified Mr Weetra was presenting with acute mental health symptoms, Mr Williams felt it was appropriate to transfer him to the Acute Unit within HDU to ensure there was adequate clinical oversight of his management. He adopted a risk-averse approach in managing his self-harm risk. In the Acute Unit cells, Mr Weetra was placed under camera observations and on a canvas regime overnight. Mr Williams' plan ultimately was that when Mr Weetra's risk had stabilised enough such that it was no longer necessary to monitor him through camera observations, he would be placed in a cell with his brother.
- 29 Dr Rose's expert report criticised Prison Mental Health for not referring Mr Weetra for urgent psychiatric assessment at this point, with transfer to the Royal Adelaide Hospital or the LMH ED, despite the staff being concerned enough to order for a camera and canvas regime overnight. In response to this criticism, Mr Williams explained he and other staff at the prison were not classified as authorised medical officers under the Mental Health Act 2009. This meant they would not have been able to impose an inpatient treatment order²⁴ on Mr Weetra, which would have been required to facilitate his transfer to hospital for assessment. Instead, their usual practice was to flag any concerns with SAPHS, who would then arrange for an authorised medical officer to conduct an assessment and impose an ITO if it was necessary.
- 30 Despite this, in the past there had been exceptional cases where they utilised authorised medical officers from the Emergency Response Group to exercise care and control

²² ALO

²³ JIS

²⁴ ITO

powers to transport prisoners to hospital for assessment. However, this approach was considered as a last resort for the Prison Mental Health staff because it had previously proved problematic as the treating doctors and psychiatrists at the prison were unable to conduct medical handovers with those at the hospital. In his assessment of Mr Weetra on 10 September 2019, he determined Mr Weetra did not meet the threshold that would compel him to undertake that course of action, in that Mr Weetra had not exhibited persistent self-harming behaviour or property damaging behaviour such that prison staff could not safely manage the risk any longer.

- 31 When asked whether it would have been helpful if he could readily access Mr Weetra's records to inform his assessment, Mr Williams stated more information is always helpful, but that he did not believe it would have changed his ultimate decision in relation to Mr Weetra's placement.
- 32 Mr Williams was cross-examined on whether he took a different approach when assessing indigenous men within Yatala. He agreed that he would interpret certain indicators differently if he was assessing an indigenous person as opposed to a non-indigenous person. For example, an indigenous person avoiding eye contact would not be as noteworthy as a non-indigenous person displaying the same behaviour, and Mr Williams would likely attribute this to being a cultural difference. Further, he would be more aware of the importance of cultural or family supports for indigenous people, and whether they were available to them. Mr Williams was clear in his evidence that he would always seek the assistance of other staff, such as an ALO, who would be better placed to provide cultural context to information the indigenous prisoner may reveal during their assessment. He said he would welcome an additional tool similar to psychometric testing which could assist psychologists in determining whether a symptom is culturally appropriate, rather than a sign of psychosis, as this could affect how a prisoner is subsequently managed.
- 33 Mr Williams explained that HDU staff were generally aware of upcoming court dates for the 30 high-risk and complex prisoners they were responsible for managing. However, because these dates were subject to change at short notice and there could be multiple changes within the group of 30 on any given day, with some being discharged and new ones being admitted, Mr Williams could not guarantee HDU staff were aware of every court appearance, let alone the purpose of the court hearing. The staff would normally be apprised of prisoners being released from prison after the event.
- 34 He testified it was 'very common' for HDU prisoners to be released on bail into the community.²⁵ It was only occasionally that DCS officers would contact HDU to request information as material for a bail inquiry report or a home detention report, such as the reason the prisoner is being managed by HDU and whether the prisoner might need structural support in place for when they were released. DCS would have access to JIS case notes, which allowed them to gain the information they required in the first instance, though Mr Williams is not aware of any policy or procedure in this regard.
- 35 As the Manager of the HDU, Mr Williams would be involved in discussions with HDU clinicians to share their concerns when prisoners with complex needs were released at very short notice, sometimes on the day of their admission. In his experience, this would happen frequently. It did not appear as though a prisoner being in HDU was factored into

²⁵ Transcript, page 425

consideration when deciding to release them. According to Mr Williams, this is unsatisfactory as this puts the prisoners at risk of their mental health deteriorating. It was his belief that the more time HDU staff are allowed to plan for a prisoner's discharge, the more comprehensive supports they can ensure are in place for their release.

- 36 Given a hypothetical scenario of what would happen had Mr Weetra attempted to commit suicide whilst in HDU, Mr Williams response was that with Mr Weetra under CCTV observations and placed in a cell specifically designed to minimise a person's ability to harm themselves, with no ligature points and no sharp edges, this would have minimised his ability to harm himself. In all the time the HDU had been operating at the time up to this Inquest, there had not been a single case of a prisoner ending his own life when under that level of observation.²⁶
- 37 Mr Weetra was released on HD bail only one day after Ms Nicola Galatis, a psychologist in HDU, reported his psychotic features. His poor engagement and rapport had rendered her unable to complete a comprehensive Suicide Assessment Manual for Inmates assessment. With reference to case notes, Mr Williams agreed that prior to his release, no-one had ascertained whether Mr Weetra's risk had subsided after being subjected to a camera and canvas regime overnight. Mr Williams had attempted to facilitate a session with a psychiatrist for Mr Weetra, but this did not eventuate before his release. Inadvertently, Mr Weetra was released without any referral to see a psychiatrist.
- 38 Mr Williams, together with other DCS officers caring for Mr Weetra, were subject to criticism by Mr Weetra's family.

Ms Kerry Beagley

- 39 Ms Beagley worked at the DCS Elizabeth office as an Intensive Compliance Officer²⁷ and was assigned as case manager for Mr Weetra's HD bail. She met him at the DCS Elizabeth office on the afternoon of 12 September 2019. He arrived with his sister, Ms Tanya Weetra. Almost immediately he began to make concerning statements including about harming others and being possessed by the devil. He was talking to himself whilst Ms Beagley attempted to question him.
- 40 Due to Mr Weetra's behaviour, she contacted another ICO to sit in with her. When that happened, he told them that 'he does not want to be Aboriginal anymore'²⁸ and that he saw Aboriginal people standing behind them.
- 41 After checking the DCS notes from his time in custody at YLP, Ms Beagley contacted the DCS area manager. During their conversation it was decided that she should call the Acute Crisis Intervention Service,²⁹ which she promptly did. She spoke to Mr Andrew Fort, the call-taker on duty for ACIS, about her concerns regarding Mr Weetra. As Mr Weetra was reporting thoughts of hurting other people, Mr Fort advised her to call SAPOL on 131 444 to request they conduct a welfare check on him.

²⁶ Transcript, page 428

²⁷ ICO

²⁸ Exhibit C32 at [5]

²⁹ ACIS

- 42 Following Ms Beagley's contact with ACIS, an automatic referral was made for Mr Weetra to the Northern Community Mental Health Service.³⁰
- 43 After approximately an hour, she concluded the appointment with Mr Weetra. When Ms Beagley walked out of the room, Ms Weetra approached the reception counter. Ms Beagley asked her if she had any concerns regarding her brother's behaviour and presentation. Ms Weetra said she would keep talking to him and that she was hoping a cultural healer could see him that night or the following morning. Ms Beagley gave Ms Weetra contact numbers for ACIS, DCS and SAPOL.
- 44 Once Ms Beagley waited for confirmation, via GPS tracking, that Mr Weetra had returned home, she called SAPOL as advised by ACIS and relayed his comments about hurting others and her concern that he would do so. She was provided with a formal reference number for her report.³¹ It was recommended to Ms Beagley as a critical safeguard, but SAPOL never conducted this welfare check, thus losing the chance to change the course of events by making a potential assessment and ensuring follow-up care.
- 45 I found Ms Beagley to be a caring ICO and an impressive witness. Her conduct in the appointment with Mr Weetra was appropriate and she responded to his presentation swiftly. She correctly escalated further actions concerning his welfare and those that may be in danger from him at the house.

Ms Terah Bolt

- 46 In September 2019, Ms Terah Bolt was employed in two different roles at the NCMHS. She was employed 0.5 full-time equivalent³² as the associate nurse unit manager,³³ being her substantive role, and 0.5 FTE as a nurse practitioner for the Cultural Healing Team.³⁴ On any given day she would undertake both roles simultaneously depending on the tasks allocated to her.³⁵ She had commenced her role as ANUM in 2014, but it was not until January or February 2019 that she had taken on the role of nurse practitioner for the CHT.
- 47 Mr Weetra's referral came through the CHT. The CHT worked across three different teams, which were the Salisbury, Playford, and North-East teams. Their focus was entirely on servicing these three teams in assisting Aboriginal and Torres Strait Islanders obtain mental health treatment. The 'consumers' of their service would be referred to their team. Ms Bolt, as the clinician, would devise appropriate treatment plans for each referral. These treatment plans would then be finalised at a multidisciplinary clinical review meeting involving the five disciplines staffing each centre, namely psychiatrists, mental health nurses, social workers, occupational therapists and psychologists.³⁶
- 48 The Playford team was staffed seven days a week from 8am to 9pm. However, team members would work different shifts on a rostered basis, and the CHT members did not work on the weekends. Ms Bolt worked 8:30am to 5:30pm Monday to Friday.

³⁰ NCMHS

³¹ No.1578

³² FTE

³³ ANUM

³⁴ CHT

³⁵ Transcript, page 141

³⁶ Transcript, page 143

- 49 Ms Bolt explained they would receive referrals from Mental Health Triage,³⁷ which is a 24-hour referral service that connects people in need of mental health support with a mental health service.³⁸ CHT would be notified of these referrals when MHT sent a record to their team by an electronic system called ‘Community-Based Information System’³⁹ which all clinicians employed in mental health are able to access.⁴⁰ These referrals would already be coded by MHT with either an emergency response, rapid response, tier 1, tier 2, or non-urgent tier rating to indicate priority or urgency, with each having a corresponding recommended response time to be met by NCMHS. The referrals would sometimes, but not often, be presented to the team’s consultant psychiatrist to have the referral re-triaged if they thought it was appropriate to do so.
- 50 Mr Weetra’s non-urgent referral was received by NCMHS at around 5pm on Thursday, 12 September 2019, but it was not until midday on Friday, 13 September 2019 that the committee passed the referral to Ms Bolt personally.
- 51 When gathering information and context surrounding any referral, Ms Bolt would consult CBIS to obtain the consumer’s background and the reason for referral, as well as the Open Architecture Clinical Information System,⁴¹ which would display all inpatient records and discharge summaries from hospitals. NCMHS does not have access to DCS records. It was from the demographic information screen within CBIS that Ms Bolt accessed Mr Weetra’s telephone number and residential address.
- 52 In line with normal practice, once Ms Bolt received Mr Weetra’s referral on 13 September 2019, she attempted to ring his phone number to notify him she had received it and to arrange for a suitable time to meet for an assessment. An assessment involved a mental state examination, an assessment of that person’s risk both to themselves and to other people, and of their vulnerability. The purpose of these assessments was to explore any delusional or psychotic thought patterns that the person might be having. Ms Bolt’s practice was to ask a variety of open-ended questions to assist in determining what the next treatment step would be.
- 53 When there was no answer on the number she dialled, she went to visit Mr Weetra’s home address in an attempt to see him in person. She recalled leaving the office in company with ALO Richard Smith to attend the recorded address of 94 Ridley Road, Elizabeth South at approximately midday.⁴² Before they departed, Mr Smith commented that he thought the house at the recorded address had burnt down.⁴³ Upon arriving, they discovered Mr Smith was correct; the house had burnt down and was boarded up. Mr Smith told Ms Bolt he believed that the family had since moved to Port Adelaide.
- 54 Because Port Adelaide fell outside their team’s catchment area, Ms Bolt resolved to return to the office and submit a Safety Learning System⁴⁴ report to indicate the referral contained an incorrect address. It was her intention upon returning to the office the following Monday to obtain the correct address for Mr Weetra and redirect the referral to another team if appropriate. Ms Bolt justified leaving this task to the following Monday,

³⁷ MHT

³⁸ Exhibit C33 at [7]

³⁹ CBIS

⁴⁰ Transcript, page 146

⁴¹ OACIS

⁴² Transcript, page 153

⁴³ Transcript, page 155

⁴⁴ SLS - Exhibit C39

rather than later that afternoon on the Friday, by reasoning that Mr Weetra had been triaged as requiring a non-urgent response within 72 hours of referral and, therefore, it was not absolutely necessary for her to actively search for him that day.

- 55 In September 2019 CHT was composed of the team manager, Ms Bolt as the only nurse practitioner, and three ALOs, making a total of five members within NCMHS that were part of CHT. The team manager did not carry out a clinical role as he did not have a mental health care background.
- 56 Ms Bolt agreed that Mr Weetra's symptoms, as described by Ms Beagley, including past self-harm and having relatively new thoughts to hurt other people, would ordinarily necessitate a rapid response, contrary to the non-urgent response that was assigned to Mr Weetra's referral. Ms Bolt said this is the conclusion you would properly come to if you were considering a referral in isolation, but that this is not their practice to do so. When evaluating a referral, she would consider the referral as a whole and the person's symptoms in combination with the chart. It is on a case-by-case basis that they approach each referral they receive.
- 57 It was Ms Bolt's understanding that the only new symptom Mr Weetra was presenting with was his intention to hurt other people, which was a feature that had already been appropriately addressed by way of the referrer having already reported this to SAPOL. Aside from this, all other symptoms were longstanding and chronic in nature as they had been present for at least a year by this point. In terms of Mr Weetra's risk of self-harm, Ms Bolt explained this presented on only one occasion while he was in the Adelaide Youth Training Centre, around the age of 14 or 15 years, which he later revealed was a ruse in the hope he would be released afterwards. Ultimately, Ms Bolt did not believe it was necessary to re-triage the referral. She described the process as being more fluid than concrete.⁴⁵
- 58 In the next stage of her evidence Ms Bolt's attention was turned to CBIS notes pertaining to Mr Weetra's risk assessment conducted by Ms Beagley.⁴⁶ Ms Bolt agreed that Mr Weetra scored moderate ratings for two of the criteria, in line with warranting a rapid response, and a 'not known' rating for the other four criteria. Although her overall position is to take a risk-averse approach, it is not the case that just because they do not have the information for certain criteria regarding an individual, that they are automatically regarded as being at high risk. Rather, although unknowns are treated as contributing to high risk until that information becomes available, Ms Bolt maintained that they look at the referral as a whole. She deemed it was unnecessary to facilitate a re-triage of the non-urgent referral for two reasons:
1. As already stated, the only new presenting symptom of wanting to hurt others had already been addressed by the referrer when they advised SAPOL; and
 2. Ms Bolt was aware Mr Weetra was living with his sister on HD bail and that he would be monitored by DCS. With this support network in place at the time, Ms Bolt did not feel it was necessary to heighten the urgency of the referral such that it had to be attended to within an hour.

⁴⁵ Transcript, page 191

⁴⁶ Exhibit C21, pages 36-37

- 59 Given a response was required, the 72-hour timeframe commencing from Mr Weetra's referral received by NCMHS at 5pm on Thursday, 12 September 2019 would have ended at 5pm on Sunday, 15 September 2019. Ms Bolt was queried why she postponed the task to the following Monday. She clarified it was only necessary that she undertake some kind of action in relation to the referral within the time of response to satisfy the policy. In Mr Weetra's case, Ms Bolt had attempted to ring Mr Weetra and had visited the recorded address without success. So, although she was unsuccessful in establishing contact with Mr Weetra, Ms Bolt explained the policy did not obligate her to see him face-to-face within the response time. According to her, she needed to have had at least tried to make contact within those first 72 hours to satisfy that criterion of the non-urgent tasking.⁴⁷
- 60 Ms Bolt agreed that once she realised the address they had on record was incorrect, it was open to her to make phone calls to either Ms Beagley, the referrer from DCS, or Ms Tanya Weetra, Mr Weetra's sister, whose number was listed on CBIS, to try and acquire Mr Weetra's correct address. She was informed that Mr Weetra was potentially living outside of their designated zone, based on Mr Smith's comment he believed the family had moved to Port Adelaide. This meant to her she would not only have to obtain the new address and drive to Port Adelaide to physically verify where he lived, but would also have had to send the referral on to the appropriate team. She stated it would have taken a 'whole day' to find Mr Weetra.⁴⁸
- 61 Furthermore, she had other tasks scheduled for the remainder of the day that needed her attention. It was open to her to handover to Mr Smith, as the ALO, or perhaps the afternoon staff or weekend staff to make those phone call inquiries. She did not opt to do so but decided to leave these tasks for the following Monday when she would be back on shift. She explained that this referral was received on a non-urgent basis, thus there was nothing apparent to indicate it was absolutely necessary she investigate this issue before she was due to return to work following the weekend. Ms Bolt commented on the hypothetical situation where, if these events had transpired on Thursday, she would have made further attempts to make contact with Mr Weetra on Friday. In light of the failed visit to the wrong address, on balance and acknowledging hindsight bias, I believe a check on him on the weekend was warranted despite the lack of urgency classification.

Mr Brendan Taylor

- 62 Mr Brendan Taylor was an employee of DCS in September 2019. He was an ICO working in the Intensive Compliance Unit of Edwardstown Community Corrections.⁴⁹ Edwardstown Community Corrections serviced most of South Australia.
- 63 As an ICO Mr Taylor would conduct home visits, welfare checks, breath analyses, drug testing and other duties as tasked.⁵⁰ He could receive anywhere between two and fourteen tasks on any given day, which he would attend in a pair alongside another ICO. Duties would be clearly divided between the partners, with the driver's responsibilities being to organise operational equipment, prepare radios, duress straps and monitoring equipment, and the passenger being responsible for documents, taskings and computer case entries.⁵¹

⁴⁷ Transcript, page 205

⁴⁸ Transcript, page 216

⁴⁹ Transcript, page 219

⁵⁰ Exhibit C34 at [3]

⁵¹ Transcript, page 221

- 64 Mr Taylor's daily taskings were allocated to him by the team leader. The taskings would generally be created by the monitoring centre officer who had deemed it necessary for an ICO to attend. Upon commencing a shift, ICOs would log on to their computer and access taskings allocated to them within a shared drive folder.
- 65 'Participants' or 'offenders' whom ICOs attend upon are persons on HD bail, parole, court-ordered sentencing, intensive correctional orders and extended supervision orders. It was not an unusual occurrence for him in his work to encounter participants suffering from poor mental health, whether diagnosed or not. Mr Taylor was not a mental health professional.⁵²
- 66 On Friday 13 September 2019, Mr Taylor and fellow ICO Robert Hutchison were tasked by their team leader, Garry Cobb, to attend at Mr Weetra's residence to conduct a welfare check and a home visit.⁵³ The purpose of the visit was to ascertain his wellbeing on HD bail and ensure he was living in a safe environment with no potential hazards or risks to himself. On home visits, Mr Taylor's role is to investigate and address factors which do not appear ideal by either taking further action to make it safe, or eliminate any risks posed to the participant or offender, or to cause a shift to another residence if necessary.
- 67 ICOs carry mobile rugged tablets⁵⁴ in their vehicles which they use throughout their shifts to upload case notes, access information on the JIS and receive additional taskings. At the time of giving his evidence, Mr Taylor did not have an independent recollection of whether he accessed JIS, either in his Edwardstown office or on the MRT, to check if Mr Weetra had any warning information against his offender record. He agreed it was safe to say no-one had passed that information on to him because if they had, he would have remembered something that significant.⁵⁵
- 68 Upon arriving at Mr Weetra's residence, Mr Taylor met his sister, Tanya Weetra, who was there with her young children. He observed Mr Weetra sitting on a couch in the lounge room by himself. He was watching television and eating a bowl of cereal. He appeared quiet, withdrawn and sad. Mr Weetra acknowledged Mr Taylor and Mr Hutchinson. He was calm and polite when they engaged him in conversation. Despite his calm and polite reactions, it was apparent from Mr Weetra's demeanour he was suffering from some kind of mental health condition as he was very still, staring straight ahead and speaking in monotone. During the conversation, the ICOs asked Mr Weetra as to how he was feeling and why he had left the residence earlier that morning. This had been alerted to DCS by the monitoring system of the ankle bracelet. It was Mr Taylor's recollection that they were not emphasising to Mr Weetra he had breached his HD conditions, but rather were just inquiring what had happened to cause him to leave momentarily, and to remind him he was not to leave unless authorised to do so. In response, Mr Weetra admitted he had left to go on a walk, but that he had returned home. He informed the ICOs everything was fine.⁵⁶
- 69 Mr Weetra made various comments to Mr Taylor and Mr Hutchinson, including that he wanted to go out to the lands and had 'walked through the valley of the shadow of death',

⁵² Transcript, page 227

⁵³ Transcript, page 228

⁵⁴ MRT or MRTs

⁵⁵ Transcript, page 256

⁵⁶ Transcript, page 235

in reference to a biblical verse.⁵⁷ Mr Weetra also stated to them at one point ‘I should have been dead a long time ago’. Mr Taylor asked what he meant by that. He probed Mr Weetra with a series of yes/no questions such as ‘Are you hearing voices?’, ‘Are there voices telling you things?’, ‘Are you planning on harming yourself?’,⁵⁸ all to which Mr Weetra simply responded to the effect of ‘No, everything’s fine, I’m fine’.⁵⁹ They discussed whether he had a treating GP, whether he had been prescribed any medication, whether he had had a depot injection which may be wearing off, and whether there was any plan in place to help him manage his mental health.

- 70 Mr Taylor suggested that Mr Weetra make an appointment to see his local GP and construct a mental health care plan.⁶⁰ This was received well by Mr Weetra and Ms Weetra.⁶¹ However, Mr Taylor was not meaning for Mr Weetra to obtain a mental health care plan in the traditional sense, which would involve seeking psychological support or some counselling sessions, but rather that he was referring to constructing a strategy or a ‘game plan’ in general to receive ‘immediate assistance’ in addressing his mental health issues.⁶² Mr Taylor then explained to them both how to facilitate an urgent authorised pass out so that Mr Weetra would avoid breaching his bail conditions for when he does need to leave the premises to consult his local GP. His advice to see a GP was intended to be conveyed as requiring action without delay, but Mr Taylor was concerned Ms Weetra would not make the arrangements straight away as she seemed more ascribed to cultural healing.
- 71 Throughout his attendance it was apparent to Mr Taylor that Ms Weetra was very supportive of Mr Weetra and wanted what was best for him. At the time, she believed he was fine and did not disclose anything to the contrary, but was receptive of the ICOs’ suggestion for Mr Weetra to see his GP. She mentioned she would also be seeking help from a cultural healer.⁶³ While Mr Taylor considered Mr Weetra was likely suffering from some mental health issues, he did not consider he was at risk of self-harm or that he posed a risk to others.⁶⁴
- 72 A series of propositions were put to Mr Taylor during evidence to establish what information he was aware of prior to attending the tasking. He explained that on the morning of 13 September 2019 he had been called in at short notice to cover a staff absence which meant he arrived late to the shift and had to leave the office promptly. Furthermore, on the drive to Mr Weetra’s HD address, the MRT was malfunctioning so he attempted to call the office to obtain more information, however his call went unanswered.⁶⁵ In answer to these propositions, Mr Taylor revealed he was only privy to the fact he was tasked to conduct a welfare check as Mr Weetra had left the residence earlier that morning and had since returned; all other information was gained by way of his interaction with Mr Weetra and his sister. He simply could not recall what he did and did not know at the time.

⁵⁷ Exhibit C34 at [14]

⁵⁸ Transcript, page 235

⁵⁹ Transcript, page 236

⁶⁰ Exhibit C34 at [19]

⁶¹ Transcript, page 239

⁶² Transcript, pages 237-238

⁶³ Transcript, page 240

⁶⁴ Transcript, page 241

⁶⁵ Transcript, page 259

- 73 Mr Taylor's perception of Mr Weetra's mental wellbeing was that 'something was amiss, and he needed some medication'⁶⁶ despite him constantly reassuring Mr Taylor and Mr Hutchinson he was fine. However, he was unable to pinpoint what the issues were as he was not an expert. Mr Weetra did appear as though he was delusional as he was quoting biblical verses, but he would alternate this nonsensical speech with logical speech, which Mr Taylor said happens quite frequently with people who are experiencing mental health issues.
- 74 Throughout his evidence Mr Taylor maintained Mr Weetra needed immediate assistance and could not be left untreated. He said this was especially so considering he was on the strictest form of bail and confined in a small house with young children, which meant his circumstances were dynamic and could change rather quickly. It was then proposed to Mr Taylor that if he genuinely believed this was the case, rather than referring him to a GP, an alternative open to him at the time would have been to accompany Mr Weetra while he attended hospital voluntarily to be psychiatrically assessed there. Although Mr Taylor agreed this alternative was open, he would have needed to have obtained authority from his team leader or manager before transporting Mr Weetra, as this had gone awry when doing so with offenders in the past. Hence, he explained why such a procedure was reserved for exceptional circumstances.
- 75 Mr Taylor said that even if they did have express authority to detain offenders and transport them to undergo a mental health assessment, their vehicle was not equipped or secure to take a person in custody as it is 'just an average family sedan', not a cage car or a purpose-designed conveyance vehicle.⁶⁷ He also mentioned that while there is a duress button for emergencies located within the vehicle, pressing it would not materialise immediate assistance. Ordinarily they would not carry equipment such as handcuffs, a taser, a spray or any weapon, which meant that transporting people in custody would present a real risk to the ICOs. Such equipment was only brought along in cases of revocation tasks where the ICOs were tasked to attend and revoke an offender's bail to have them returned to custody if so ordered.
- 76 He agreed that, alternatively, it was open to him to call SAPOL and request a patrol attend and assess Mr Weetra. However, Mr Taylor did not think police attendance was warranted as the circumstances did not meet the criteria of section 57 of the Mental Health Act 2009, these being that Mr Weetra was not presenting as a threat to himself, nor was he at immediate risk of harm to others at the time. Mr Taylor explained that when SAPOL had been contacted in the past, they would resist attending when the ICO was not able to prove criteria to detain someone.
- 77 While not a requirement of ICOs, Mr Taylor, of his own volition, educated himself on this part of the legislation so that he had better knowledge to perform his job, knowing that domestic violence and mental health encompassed the vast majority of what he encountered daily in his line of work. He has advocated for training of ICOs to include education on the legislation as he believes it is lacking in this regard. He detailed that, firstly, there was no training on what signs and symptoms the ICOs needed to look out for under section 57 and when it would be appropriate to make the call for a mental health assessment to be conducted. Secondly, there was no training about what options ICOs have when confronted with this situation, which could be anywhere from transporting

⁶⁶ Transcript, page 265

⁶⁷ Transcript, page 296

that person directly to the hospital, or making a request for SAPOL to do so, down to the lower options such as encouraging them to see their GP. As there was no formal practice or training that provided guidelines for ICOs in carrying out their role in this regard, they simply relied on word of mouth between officers and team leaders which were based on their own experiences.

- 78 Although he was not qualified to make an assessment whether someone should be detained under the Mental Health Act, he did effectively have to make assessments about a person's presentation to decide whether they needed to be assessed by a professional. He agreed it would assist if the 'Intensive Compliance Unit – Daily Tasking's Service Record' document⁶⁸ provided specific prompts for when the ICOs attend welfare checks, particularly a reminder to consider any other information that might be available on JIS in relation to the health of the person.⁶⁹
- 79 It was Mr Taylor's recollection that Ms Weetra was very engaged and supportive of Mr Weetra during his visit. When Mr Taylor probed Mr Weetra with a series of questions after he had made the comment 'I should have been dead a long time ago', and assured Mr Taylor he was fine, Ms Weetra appeared concerned, but not alarmed. Her reaction suggested to Mr Taylor that she accepted this was his normal behaviour and that she was already aware he was struggling with something. She seemed satisfied at the time that it was an effective course of action for Mr Weetra to voluntarily attend a GP to be assessed and generate a plan.
- 80 Mr Taylor was very upset about Mr Weetra's death, which at one point he displayed in his evidence. He was asked about his reaction when he learnt of his death. His response was:

It's been very hard and I'm not in the job - I'm here to make a difference in a positive light, not have things like this happen, and I believe I do my job thoroughly and above and beyond at times to make sure that things like this don't eventuate, and it's been quite hard to process. It's been on my mind for months, years, and then each time you do a welfare check, it always comes to the front of your mind to reinforce that you perform your job correctly.⁷⁰

- 81 He was highly upset and emotional in giving his response. I found him to be a caring and impressive witness. This is so despite alleged mistakes he may have ultimately made and criticisms about him. If he did make mistakes, it was not through a lack of care for Mr Weetra. His actions need to be evaluated without any hindsight or outcome bias. With that warning in mind, I find his response to Mr Weetra on that visit to be professional, caring and reasonable. He was satisfied by Ms Weetra's words and actions about her brother, in particular about seeing a GP as he suggested. He is now full of regret due to the outcome of Mr Weetra's death.

Ms Tanya Weetra

- 82 Ms Tanya Weetra was the seventh eldest of 12 children. She was the older sister of Mr Weetra, who was the second to youngest child.⁷¹ She described Mr Weetra as being the big uncle to all his nieces and nephews. He enjoyed taking care of them. He was very

⁶⁸ Exhibit C34, Annexure A

⁶⁹ Transcript, page 275

⁷⁰ Transcript, page 252

⁷¹ Transcript, page 307

protective and did everything for them. He loved music and dancing,⁷² and was always the happy one who lit up the room when he walked in.⁷³

83 Ms Weetra recalls that at one stage her brother was living at their older sister Lavinia's house on HD bail. This was the house that DCS had on their record as accessed by Ms Bolt that had burnt down.

84 In September 2019 Ms Weetra had four young children. When Mr Weetra was arrested in late-August 2019 and sent to Yatala, Ms Weetra attended one of his court hearings alongside another one of their older sisters, Roma. Ms Weetra provided a written address to be read out during the hearing in the hope that Mr Weetra could be placed to stay with her on HD bail.

85 When DCS officers attended Ms Weetra's house on 13 September 2019 to visit her brother, she thought that they would have 'picked something up too because [of] the way he was just looking at them', like how she thought he was looking through her when he spoke to her.⁷⁴ As a witness in the Inquest, she was not able to recall whether the DCS officers discussed taking Mr Weetra to see a doctor to put a plan in place to help him with his mental health, or to ring an ambulance for him to get assessed, nor much else of the conversation. She did recall, however, that just as they went to leave, Mr Weetra made a comment to the officers along the lines of 'I should have died a long time ago' which caused them to turn around and come back in to speak with him further.⁷⁵

86 Later that night at about 6:30pm she called the 13SICK number, which offers after hours GP services,⁷⁶ to request a doctor to conduct a home visit for her brother. Dr Nwachuku attended their house to assess Mr Weetra, for which she was also present. She estimated this consultation lasted no longer than five minutes. While she was slightly distracted and preoccupied with her children, she remembers the doctor giving Mr Weetra two diazepam pills, instructing him to 'take one now, and then one tomorrow in the morning'.⁷⁷ This was after Ms Weetra informed the locum doctor service that her brother had just been out of prison and was now on home detention, and that he needed medication to help relax as he had not been sleeping for the last one to three days. Overall, it was a short visit where the doctor mainly dealt with his sleeping issues and did not probe Mr Weetra at length about how he was feeling.

87 On the Friday the DCS officers attended, Ms Weetra recalled her brother standing in her backyard holding a rope that her children had been playing tug-of-war with earlier. He was staring at the tree and twisting the rope around his hands. She believed she asked Wayne, her partner, to grab the rope off him as she felt something was not right and her instinct was to remove the rope from him. She was not sure if this incident took place before or after the DCS officers had attended. As this event was not mentioned to Mr Taylor, it was more likely to have happened after the DCS visit.

88 When Mr Weetra returned home from prison, Ms Weetra said she struggled to have open conversations with him as she had before. It was hard to get a smile from him.⁷⁸ She was

⁷² Transcript, pages 310-311

⁷³ Transcript, page 325

⁷⁴ Transcript, page 341

⁷⁵ Transcript, page 357

⁷⁶ Also known as locum service

⁷⁷ Transcript, page 348

⁷⁸ Transcript, page 362

‘lucky to get two words out of him’. It was ‘like talking to a brick wall’, and that when he made eye contact it was like he was looking right through her.⁷⁹ Other things she noticed that were out of character upon his return was that he would mumble to himself sometimes, and that when he would use the toilet, he would leave the door open as if he was still in prison.⁸⁰

- 89 The day she accompanied her brother to the Elizabeth Corrections Centre, the ICO Ms Beagley had asked if Mr Weetra was okay, and Ms Weetra informed her that he was not well and needed to be checked over by an Aboriginal healer. Other than this detail, Ms Weetra could not recall much else regarding the conversation with Ms Beagley.
- 90 Ms Weetra became very upset on a few occasions throughout her evidence. A compelling piece of her evidence was when she spoke of the day she saw her brother with the rope in the backyard. She believed that if she had not been so sleep-deprived after staying up with Mr Weetra all night following the GP visiting their home, that maybe she would have told someone about it, and he would still be alive today. Had she not been so exhausted and rundown caring for her four children and her nieces and nephews that day, she believed things may have been different. She said:

‘Yeah, if I'd had a sleep I probably would have been - he would have been still alive today ... I want to ... the bloody ...’⁸¹

This answer was broken up due to her understandable emotional state in expressing her sorrow. It was sad to see her blame herself in this way given everything she did for him. I hope she realises that her brother’s death was not her fault in any way. She loved and cared for her little brother very much and did all she could for him in my opinion.

- 91 Ms Weetra had to be consoled by an Elder during her evidence. It was difficult for her as she had nowhere to recompose herself other than in Court, which was less than ideal for her. I appreciate her courage to continue and finish her evidence in very trying circumstances.

Dr Okechuku Nwachuku

- 92 Dr Okechuku Nwachuku worked for the National Home Doctor Service in 2019.⁸²
- 93 At the commencement of his shift on 13 September 2019, as the locum doctor on duty, he logged on to the National Home Doctor Service app on the mobile device he carried to check calls received by the service. The software displays calls logged by the service which have been assigned and dispatched to a doctor to attend to. It provides the patient’s details and presenting complaint, but not access to the patient’s medical history.⁸³
- 94 When Tanya Weetra’s request came through for an after-hours doctor to visit her brother, Michael Weetra, the app displayed the patient details as being a Michael Havea residing at 48 Jeffries Road, Elizabeth South. His presenting complaint was ‘Just out of prison, home detention, not sleeping and requesting relaxant medication 13/09/2019’.⁸⁴ This

⁷⁹ Transcript, page 339

⁸⁰ Transcript, page 340

⁸¹ Transcript, page 342

⁸² Exhibit C18 and Transcript, page 386

⁸³ Transcript, page 388

⁸⁴ Exhibit C20 and Transcript, page 389

information was communicated to Dr Nwachuku via the app. Mr Weetra's symptoms had been recorded⁸⁵ as 'Not sleeping (1-3 Days), Symptoms Worsening', but it was Dr Nwachuku's evidence that that information was not communicated to him that evening. He presumed that section of the app was utilised only by the call centre to categorise calls.

- 95 According to the electronic audit trail, Ms Weetra's request was dispatched to Dr Nwachuku at 18:27:35 on 13 September 2019 via mass dispatch. The visit was completed later that night at 19:46:58, a time which Dr Nwachuku entered himself into the system at the end of the consultation.
- 96 Dr Nwachuku relied heavily on his statements provided to SAPOL and what he had recorded electronically to refresh his recollection of the events of that night. He was unable to recollect 'the fine details of the discussion' between himself and Mr Weetra.⁸⁶ Therefore, whilst he agreed that it would have been essential to obtain a history from Mr Weetra prior to prescribing him diazepam, an addictive Schedule 4 drug, he could neither confirm nor deny he had asked Mr Weetra if he had experienced sleeping problems in the past. Dr Nwachuku prescribed only two tablets of diazepam, just enough to 'tide him over that night', with the expectation that Mr Weetra would follow-up with his regular GP who would make the ultimate decision as to whether it was necessary to prescribe him more tablets. He reasoned those two tablets of diazepam 'would not cause an addiction'.
- 97 Dr Nwachuku explained that although he omitted to include in the electronic record any details of their discussion regarding Mr Weetra's past medical history, or lack thereof, it should not be assumed he failed to carry out his due diligence in treating Mr Weetra and prescribing a drug like diazepam. He also emphasised it should not be assumed he failed to check whether Mr Weetra had any history of sleeping problems, or whether he had previously taken any types of drugs to assist him to sleep. He believed he 'probably did' ask him and had simply forgotten to document these things. This was especially so considering it was Dr Nwachuku's usual practice to only document history that he considered was 'very significant' to a patient's consultation.⁸⁷ He concluded that Mr Weetra had 'insomnia' and gave him limited access to diazepam to relieve that condition.
- 98 In the end, his memory of this consultation was scant at best. I take into account his role as a locum service doctor, to assist Mr Weetra to 'tide him over to until he could consult with his regular health providers'.⁸⁸ I also note he was experienced with Aboriginal prisoners having provided GP services to Port Augusta Prison in 2008 and 2009. He had seen prisoners with poor sleep and anxiety due to the very fact of their circumstances of being in DCS custody.

Mr Wayne Willis

- 99 Wayne Willis has been Tanya Weetra's partner since 2008. They share five children together.⁸⁹ The children and Tanya Weetra resided at 48 Jeffries Road, Elizabeth Vale. Mr Willis only lived there part of the time. He had become acquainted with Mr Weetra

⁸⁵ The electronic 'Audit Trail'

⁸⁶ Transcript, page 392-393

⁸⁷ Transcript, page 393-394

⁸⁸ Exhibit C18a at [22]

⁸⁹ Transcript, page 368

around the time he first met Ms Weetra, or possibly a year prior to that, which would have meant Mr Weetra was between six and eight years old at that time.

100 On Thursday, 12 September 2019, Mr Willis had stayed overnight at Ms Weetra's house. He was there the following day when Ms Weetra had called out and drawn his attention to her brother standing in the backyard with some rope. He remembered feeling nervous as he 'didn't want him to harm himself' and 'just wanted to get it away from him'.⁹⁰ He presumed this incident took place at around 4pm as he had returned home from a course he attended that day for gaining employment.

101 At the Inquest he initially could not recall whether Mr Weetra was holding the rope in his hands or if it was on the tree when he first noticed him.⁹¹ In later evidence he remembered 'ripping it off the tree'. He then hid the rope in a 'cupboard in the back' to prevent Mr Weetra from finding it. This was the first of two occasions that same afternoon.⁹²

102 The second occasion took place about an hour after the first. Mr Willis at this time was with his brother-in-law, Charlie Burnell, who had approached Mr Weetra and grabbed the rope off him. Following this incident the family gathered around to chat with Mr Weetra in the lounge room, assuring him they loved him. Mr Willis believed it was a matter for family to discuss. That is why he was not so inclined to call someone external to the family, such as DCS or an ambulance or a doctor for assistance for Mr Weetra.

103 Mr Willis described Mr Weetra's mood that afternoon as 'really quiet', 'didn't even talk a lot, didn't even say nothing', which was significantly out of character. Before going to prison he was energetic, happy, and would 'talk a lot'. This changed after coming out of prison as they 'couldn't even get a word out of him'.⁹³ Mr Willis did not hear Mr Weetra say anything about wanting to hurt anyone else or act in any way like that.

104 Mr Willis at best had a fair recollection of certain events but was very poor on other related events. For example, he could not recall whether, prior to leaving for his afternoon course that Thursday, DCS officers had attended at Ms Weetra's home following Mr Weetra breaching his HD conditions by leaving the premises. His evidence was he could not recall any of this occurring likely because he 'might have been asleep'.⁹⁴ Mr Willis said that back then he would 'sleep in a lot'.⁹⁵ Although he remembered a doctor visiting Mr Weetra that Friday night, he could not remember whether he contributed to the overall conversation at all. He did have a few drinks that night and thought maybe he was occupied in either the laundry or the kitchen. He left Ms Weetra to deal with the doctor to help her brother. He trusted that she would do 'what she's got to do to look after her brother'.⁹⁶

Dr Lynette Rose

105 Dr Rose is an expert consultant psychiatrist of over 30 years working experience. In her career she has always worked in the public mental health system, together with working in the private mental health system. In 2019, she became the inaugural Head of the

⁹⁰ Transcript, page 377

⁹¹ Transcript, page 369

⁹² Transcript, pages 370-371

⁹³ Transcript, page 372

⁹⁴ Transcript, page 379

⁹⁵ Transcript, page 378

⁹⁶ Transcript, pages 373 and 379

Marion Psychosis Unit which specialised in the treatment of schizophrenia and other psychotic disorders in the southern community.

106 A psychosis is defined at its core as a situation:

‘... when people lose some contact with reality. This might involve seeing or hearing things that other people cannot see or hear (hallucinations) and believing things that are not actually true (delusions). It may also involve confused (disordered) thinking and speaking.’⁹⁷

107 On 30 July 2022 Dr Rose provided a written report to the State Coroner after conducting an expert review of Mr Weetra’s mental health history, care and treatment. This report was part of her evidence at the Inquest.⁹⁸ Her curriculum vitae provided evidence of her extensive clinical and academic career in psychiatry. She was eminently qualified to provide her opinion to this Inquest about both Mr Weetra’s long-term mental health as well as for the last weeks of his life.

108 Dr Rose was provided with all the relevant statements and exhibits from the Inquest, including Mr Weetra’s health records. She noted that he identified as an Anunga man and was ‘largely raised by his older siblings’. He had a long history of juvenile offending from 2013 and had spent time in detention from 2016 onwards. Unfortunately, his education was ‘very limited’, and he had experienced a traumatic childhood involving domestic violence, an alcoholic mother and his brother being stabbed.

109 Despite some positive influences and support from his wider family, he fell into bad ways including crime and substance abuse such as glue sniffing, cannabis and alcohol from a ‘very young age’.

110 Further, he had poor impulse control and struggled with anger issues. This was coupled with self-harm episodes, including applying ligatures to his neck in 2016 whilst in youth detention.

111 On the background of all the problems described above, in 2018 he started to express that he was under a culturally bad spirit. Despite some determinations to the contrary by cultural consultants, he continued to make these claims into 2019.

112 In August 2018 Dr Daphne, a psychiatrist, assessed Mr Weetra in youth detention and concluded that he had ‘an antisocial personality disorder and a background of trauma with impulsive aggression, at chronic risk to himself and others’. During this assessment he told her of hearing voices and seeing spirit members of his family that had died. Unsurprisingly, she found these hallucinations were ‘culturally bound’.

113 She saw him again in January 2016 in youth detention with a cultural consultant after he had complained of feeling threatened by others and believing he was under spells by African residents. She concluded he was unlikely to be psychotic, but did recommend ongoing review.

114 Her final contact with him was on 1 February 2019. This was after two reports that he was threatening to stab other juveniles and, later in January, he was hearing voices and

⁹⁷ NHS Website (UK)

⁹⁸ Exhibit C30

‘casting spells’. She concluded the issues ‘related to personality, vulnerability, complex trauma, cognitive delays and a family with an atypical stance towards cultural interpretation, with little to suggest psychosis’.⁹⁹

- 115 This is the last documented contact with a mental health service provider until Yatala under the care of Mr Williams at the HDU where, by 10 September 2019, he was believed to be psychotic.
- 116 As we know, he was granted bail the next day without this belief as to his mental state being known to his solicitor or the EMC. As Dr Rose summarised, ‘he went from a high level of concern, on camera observation and canvas due to acute risk concerns, to living with his sister and her young family with no special precautions or supports in place’.¹⁰⁰
- 117 Dr Rose was aware of the DCS contact with him on HD bail. She was asked to comment on the events in the 14 days from his arrest to his death concerning any features that were of importance and how they were handled.
- 118 She identified events in her report as being missed opportunities to obtain urgent psychiatric assessment and treatment. These involved DCS, predominantly from his last day and night at YLP in HDU on 10 September 2019, through to the locum GP visit in the early hours of 13 September 2019. It is true that any variation of the events and responses could have caused a vastly different outcome. I have to be mindful of the general background that DCS and Mr Weetra’s family, in particular his sister, were acting in good faith to help him. Mr Williams was caring for him in ignorance of his bid to gain bail.
- 119 Mr Weetra’s family have advocated strongly that DCS did not do enough to get him the acute mental health care he needed. I have carefully considered their thorough oral and written submissions. I have already set out in detail each DCS officer’s contact with him. The general response of DCS to this allegation is that great caution ought to be applied to the criticism, although it was ‘acknowledged that there are certain factors that, cumulatively, resulted in a lack of mental health support being provided to Mr Weetra upon his release from Yatala’.¹⁰¹
- 120 This concession is a proper one. It would be obvious to anyone that his monitoring in HDU as described made the chance for him to die by suicide negligible. He then moved to a busy and small house carrying the burden of mental health issues. His sister did all she could for him in regard to love and support. He died when she was asleep.
- 121 The comprehensive HRAT assessment with Mr Weetra on the afternoon of 10 September 2019 could not be completed ‘due to his psychotic features, poor engagement and rapport’.¹⁰² Dr Rose believed at that point he should have been referred to a psychiatrist.¹⁰³ I am confident that if his stay extended in HDU, and he did not improve, Mr Williams would have referred him to SAPHS, and that level of care would have been strongly

⁹⁹ Exhibit C30, page 5

¹⁰⁰ Exhibit C30, page 11

¹⁰¹ Written submissions of DCS at [124]

¹⁰² Transcript, page 410

¹⁰³ Transcript, page 449

considered and probably actioned. Mr Williams' actions in caring for Mr Weetra showed a professional and risk-adverse approach.

- 122 The breakdown of intense monitoring for Mr Weetra concerning mental health care manifested in a gap in referral about him to CMH which lasted until Ms Beagley's actions on 12 September 2019 when she notified NCMHS. One of the most unfortunate features of this crucial time period was the inability of NCMHS to see Mr Weetra on Friday 13 September 2019 for the reasons explained in evidence, particularly by Ms Bolt.
- 123 Ms Bolt was falsely comforted about the problems of finding him and seeing him that day by the non-urgent referral given for his visit. The reason for that classification was due to Mr Fort's application of the triage chart used by the MHS for assessment of what future action is required for any referral.¹⁰⁴
- 124 The chart and its application by Mr Fort in this call was a key area of evidence and submissions in the Inquest. It must be remembered that this call was the only opportunity Mr Fort had to make the assessment of the non-urgent referral. This is where I must remind myself of the important principles of hindsight bias and outcome bias as discussed above.
- 125 I have heard this call¹⁰⁵ many times and confirm that Ms Beagley conveyed the following information:
1. His address.
 2. He was released yesterday.
 3. Presented to Ms Beagley today with a blunt appearance.
 4. 18-year-old Aboriginal male.
 5. He claimed to be possessed by the devil 'which is the same presentation of when he was in Yatala, he was transferred to the high dependency unit, because of his presentation. They weren't able to complete an assessment due to his irritability and sarcasm'.
 6. The ALO from Yatala was following up on a cultural healer.
 7. He does not want to be Aboriginal anymore, nor live in New York¹⁰⁶ anymore and feels like he is burning.
 8. Ms Beagley described him being 'quite disengaged in anything I try to talk to him about'.
 9. He was responding to voices and had a history of voices telling him to hurt himself.
 10. She had never seen him before and was 'a bit concerned about him'.
- 126 Mr Fort assessed the situation as she was 'describing a lot of things that haven't changed' but noted the change of having thoughts of hurting other people. As he put it, when such a thought is reported, 'we generally harvest the person who is telling you about that, who knows most about it, to ring the police' with the aim of an attendance at the house. This

¹⁰⁴ Triage chart or the chart

¹⁰⁵ Exhibits C14b and C37 (transcript)

¹⁰⁶ Transcript, pages 183 and 579

is what Ms Beagley did, believing that SAPOL had the chance to consider exercising their powers, including detention, under the Mental Health Act.¹⁰⁷ SAPOL did not honour the request.¹⁰⁸

- 127 Sergeant Twiggs, placed at the Elizabeth Police Station, made an assessment of the tasking at 5:53pm on 12 September 2019. She noted that Mr Weetra had made ‘generalised’ comments about wanting to harm others as well as reports of being deluded. Further, she found it important that ACIS had not contacted SAPOL directly to conduct a mental health assessment. She was aware Mr Weetra was under DCS supervision. In all the circumstances, including no behaviours having escalated, there was no need for attendance in her opinion.¹⁰⁹
- 128 Her position was supported by Inspector Cornell based on the same information and reasoning.
- 129 So, in the end, nothing happened as an extra precaution on behalf of ACIS after they made a non-urgent assessment. It seems that either Ms Beagley or ACIS should have been notified of this decision which, at the very least, would allow further discussion to have taken place between the agencies.

Mr John Strachan

- 130 As at April 2023 Mr Strachan was Acting Regional Director of Community Corrections South. Prior to obtaining this position he was Principal Advisor for the Offender Service for five years.
- 131 His role included oversight of the Intensive Compliance Unit at Edwardstown which monitors people on HD bail. He outlined that whilst there are ‘no base requirements’¹¹⁰ to become an ICO, there are mandatory training and induction requirements.
- 132 DCS also conducts training in Aboriginal Culture Awareness for all its officers. Further, in 2020, a system was developed to allow authorised officers to convey a prisoner to an approved treatment centre as defined in the Mental Health Act 2009 for care under section 56 of that Act.
- 133 Mr Strachan cautioned against introducing a NOC system for prisoners or bailees under HD conditions, or otherwise in the community, due to ICOs’ work being ‘rapidly overrun’ by such a system.
- 134 I have considered Mr Weetra’s family’s position in response to these developments. They correctly refer me to the Royal Commission into Aboriginal Deaths in Custody in 1991¹¹¹ and, in particular, Recommendations 156 and 157. Recommendations 156 and 157 emphasise the importance for prisoners to undergo a thorough medical assessment upon their admission and that a prisoner’s medical file should accompany them on their transfer to other institutions and upon their readmission.

¹⁰⁷ Transcript, page 98

¹⁰⁸ Transcript, page 648

¹⁰⁹ See exhibit C15, Statement of Sgt Twiggs

¹¹⁰ Exhibit C46 at [7]

¹¹¹ ‘The Royal Commission’

135 In modern times, this translates to a complete file sharing protocol such as juvenile detention medical records and information being available to those who need it in the adult DCS institution.

Mr Andrew Wiley

136 Mr Wiley in 2023 was Director of SAPHS as part of the Central Adelaide Local Health Network¹¹².

137 He described the release of Mr Weetra on bail from HDU on 11 September 2019 in the following manner:

‘It appears there was a communication break-down on 11 September 2019 in that Mr Weetra was released from the High Dependency Unit (**HDU**) of Yatala Labour Prison (**YLP**) (where he had been under observation for a day after displaying some psychotic behaviour) to home detention bail without Community Mental Health Services (**CMHS**) being made aware of the need for his further assessment until about 24 hours later.’¹¹³

138 Mr Wiley listed the extensive changes since 2019 to:

‘... strengthen the discharge planning process to ensure that appropriate referrals are made to community services, including CMHS. Three staff are allocated to deal with any discharges each shift and ensure that any ongoing health issues, such as treatment, medication, referrals, etc are addressed and discharge summaries are completed. Discharge of HRAT prisoners prompts an email to all staff including those managing discharges.’¹¹⁴

139 The changes include:

1. Creating positions at major prisons including Yatala and Mobilong Prison for an Aboriginal Health Practitioner.¹¹⁵ An AHP exists at Port Augusta Prison.
2. Allowing SAPHS to provide cultural/traditional healers¹¹⁶ at metropolitan prisons, especially for situations of Aboriginal prisoners being released from immediate custody.
3. Consultations for prisoners leaving immediate custody at Yatala, specifically focused on continuing management of health issues.
4. The appointment of a full-time mental health clinical nurse to manage patients on HRAT.
5. A system of care involving Forensic Mental Health Services providing a psychiatric service for prisoners going into a community setting.
6. A desire to move from a paper-based SAPHS health record system to an electronic system to allow public health clinicians to see a prisoner’s patient history.

¹¹² CALHN

¹¹³ Exhibit C19 at [5]

¹¹⁴ Exhibit C19 at [10]

¹¹⁵ AHP

¹¹⁶ Ngankaris

Summary

- 140 It pains me to say that, from what we know now and his observed behaviours and words, Mr Weetra would have been better placed had he not received bail and remained at Yatala in HDU at that time in September 2019. This goes against every principle concerning the detriment to Aboriginal people of being in custody awaiting their outcome of criminal charges against them. It would have been best for him to have his psychotic state treated and controlled before releasing him on bail. As I have already stated, I believe Mr Williams was controlling the situation in HDU very well before Mr Weetra's release.
- 141 There is no criticism of the decision to grant HD bail in the terms that were done. The Court granted bail with the balancing aim of ensuring that other citizens would not be subject to unsafe behaviour towards them by Mr Weetra, as well as his own considerations demanding controlled liberty rather than immediate custody.
- 142 I believe Mr Weetra's care at Yatala was of reasonable to high standard at the time of his admission until his discharge. I accept that whilst living under conditions imposed by HDU he was physically safe from taking his own life.
- 143 Mr Williams' evidence convinced me that Mr Weetra's mental health care was going to be elevated to the appropriate levels until it was able to be managed by less strict conditions of living.
- 144 As I have previously expressed, Mr Weetra was a very troubled and disadvantaged young Aboriginal man. Upon release on HD bail errors were made, as conceded. He did not receive the benefit of trained mental health workers assisting him by a timely assessment as to how his mental health would be managed in the community setting, albeit on a limited basis of HD bail.
- 145 These errors were compounded by the decision of SAPOL not to assist as requested.
- 146 The ultimate issue is, was this assessment as a non-urgent follow up by NCMHS proper, or at least reasonable in the circumstances based on the criteria in the triage chart?
- 147 In the end, I cannot find that Mr Fort's decision was wholly unreasonable or lacking in care when it was made. This finding was made based on his experience and from the calm manner in which he conducted the call with Ms Beagley. He also analysed the situation of the new threat to hurt others and sought to involve SAPOL. He also provided the reporting person, namely Ms Beagley, details for SAPOL to deal with as she was the most informed. I find that in hindsight, the assessment should have led to a more urgent response and assessment of him that day. I refer again to hindsight not being the focus of an assessment of a witness compared with analysing the reasonableness of actions and behaviour at the time the relevant decision was made.

Recommendations

- 148 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.
- 149 There was a series of unfortunate events as I have set out.
- 150 These have been somewhat addressed by DCS to prevent them being able to be repeated in the future. The Court received comprehensive affidavits from Mr Andrew Wiley¹¹⁷ and Mr John Strachan,¹¹⁸ in this regard. All the initiatives mentioned in these affidavits must be maintained and developed where necessary. To remove any doubt, I view these initiatives as essential for the future care of Aboriginal people under the care of DCS.
- 151 I recommend the following:
1. That the Minister for Correctional Services review the protocol of file sharing between the Youth Detention Centre and adult prisons concerning youths in detention, who later spend time in immediate custody as adults; and
 2. That the Minister for Health and Wellbeing upgrade the SAPHS records to electronic format to allow public health clinicians treating and providing care for prisoners to access information and medical history promptly if necessary.
 3. That the Minister for Health and Wellbeing make the procedures and protocols outlined in paragraph 139 of this Finding permanent and subject to ongoing improvements as warranted in the opinion of the Minister at the relevant time.

Keywords: Death in Custody; Home Detention Bail; Mental Health; Hanging

¹¹⁷ Exhibit C19

¹¹⁸ Exhibit C46