Report on the investigation by SafeWork SA into the death of Gayle Woodford and related matters

15 July 2022

By John Mansfield AM QC

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LETTER OF TRANSMITTAL

15 July 2022

The Honourable Kyam Maher MLC
Attorney-General
Minister for Aboriginal Affairs
Minister for Industrial Relations and Public Sector
GPO Box 464
ADELAIDE SA 5001

Dear Attorney-General,

On 13 May 2022, you requested me to undertake an inquiry into matters arising from the death of Gayle Woodford on the night of 23/24 March 2016, and in particular concerning the investigation conducted by SafeWork SA and its communications with her husband Keith Woodford and her family.

I have now completed the inquiry in accordance with the Terms of Reference.

I enclose my Report.

Yours faithfully,

John Mansfield AM QC

INTRODUCTION

In May 2022 the Attorney-General for the State of South Australia requested me to conduct an inquiry into, and report on, certain matters arising from the death of Gayle Woodford on the night of 23/24 March 2016 in or near the town of Fregon in the Anangu Pitjantjatjara Yankunytjatjara Lands (APY Lands) in the north western section of South Australia.

Fregon at the time had a fluctuating population of between 200 and 300 people, mainly Indigenous people.

Gayle Woodford was, at the time of her death, employed by the Nganampa Health Council Incorporated (NHC) as a community health nurse. She, and her husband Keith Woodford were living in the town of Fregon, in premises provided by NHC. NHC is a non-government entity which provides medical services to the Fregon community, and to some other communities in the APY Lands. She was at the time under a contract for two years, between 12 March 2015 and 11 March 2017, although she had worked as a locum nurse for NHC from 2011 at Ernabella and elsewhere in the APY Lands. At the request of Keith Woodford, I will refer to him in this Report as Keith and to Gayle Woodford as Gayle. Otherwise I will refer to a named person first by their name and thereafter as Mr or Ms with their surname.

On the night of 23/24 March 2016, Gayle was the on-call nurse for providing medical assistance after hours to the Fregon community. Those duties were, in essence, provided at her home. There was a locked caged area in the front of the home to protect her (and other nurses performing on-call duties) from violence while performing those duties. Somehow, she was able to be seized by one Dudley Davey despite that security protection, and he abducted her, took her in the ambulance from her home and then raped and murdered her.

The NHC reported her death to SafeWork SA (as noted below, that is the relevant departmental section responsible for administering the *Work Health and Safety Act 2012* (SA) (WHS Act)) on 29 March 2016. It investigated the circumstances of Gayle's death. It concluded that the evidence did not support the view that her death was work related. It notified her husband Keith of that by letter of 25 November 2016. The letter said that: 'It has been determined that the death of your late wife was not work related.' and that a copy of the findings would be sent to the Coroner.

There was nothing in that letter which suggested that SafeWork SA had kept its file open in case there was additional information forthcoming.

Martyn Campbell was appointed as the Executive Director of SafeWork SA in August 2017. In the early period of 2018, there was a strong media focus into the circumstance of Gayle's death and the security of nurses working in remote communities. It was critical of the decision of SafeWork SA to decide not to accept her death as work related and of the decision not to investigate in detail whether NHC had taken all appropriate care to protect her. Its concerns extended to the safety of nurses working in remote communities. Martyn Campbell, no doubt prompted by that public interest, caused a review of the earlier decision of SafeWork SA to be conducted in 2018.

Mr Campbell also telephoned Keith to arrange to see him at that time, he and SafeWork SA's Director of Compliance and Enforcement, Glenn Farrell, went to a meeting with Keith and other members of his family to inform them of the further review. That meeting took place on 23 March 2018 at Stansbury. By that time, the period of 2 years within which any prosecution

against NHC or its directors for a contravention of any provision of the WHS Act had expired. There is no real issue about the nature of what was said at that meeting. Mr Campbell telephoned Keith within a few days. The terms of that telephone conversation are somewhat contentious. From the point of view of Keith, what was then said, and the subsequent investigation in 2018 and its outcome are an ongoing cause of distress and concern. That aspect is discussed when addressing the adequacy of the engagement of SafeWork SA with Keith and his family.

The further review was duly conducted. It was a substantive investigation. It included the review of the previous material, the obtaining of additional information from the South Australian Police (SAPOL), the interviewing of certain nurses at some length, and of the general practitioner who was working at Fregon at the relevant period, and the pursuit of information through the process of compulsory notices from NHC. NHC, through its lawyers, refused to provide the additional information requested on the ground that the limitation period had expired and so the compulsory powers were no longer available. It was accepted by SafeWork SA through Mr Campbell that the death of Gayle occurred while she was performing work as an on-call nurse for NHC. However, despite the additional information, it was concluded that no breach of the WHS Act was able to be established against NHC.

The notification of that outcome was given to Keith by letter of 28 September 2018.

The Coroner (through the Deputy State Coroner) then conducted an inquiry into matters arising from the death of Gayle. The hearing commenced on 6 November 2019, although it is clear that the Coroner had caused significant inquiries to be carried out before the hearing commenced. The hearing was completed on 29 July 2020 and the Report of the Coroner was given on 15 April 2021.

The Coroner concluded that, on the balance of probabilities, Gayle opened the cage door in her capacity as the on-call nurse for reasons connected with the purported medical treatment of Mr Davey, and was then physically overpowered by Davey and taken away in the ambulance [para 3.17 of the Coroner's Finding of Inquest] and then concluded later in the Report that the measures adopted by NHC for the protection of nursing staff working alone at night and on call were not adequate [para 9.9 of the Coroner's Finding of Inquest]. He observed 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 [para 9.11 of the Coroner's Finding of Inquest].

As noted below, the effect of the Coroner's Report was to create a further window of 12 months within which SafeWork SA through its Executive Director could bring a prosecution against NHC if it considered that such a prosecution was appropriate, that is a period expiring on 15 April 2022.

In the light of the Coroner's Report, SafeWork SA commenced a further investigation into the circumstances surrounding the abduction, rape and murder of Gayle. That investigation was completed, or largely completed by 24 January 2022. As required by the relevant protocol, the results of the investigation were reported in a Prosecution Minute which accompanied the Brief of Evidence. This was provided to the Crown Solicitor's Office for advice. The matter was then referred to external counsel for advice. Ultimately that advice was given orally on 8 April 2022. It was to the effect that the available evidence was not sufficient to prosecute NHC and its

directors for contraventions of the WHS Act, relevantly sections 32 and/or 33, as there was no reasonable prospect of securing a conviction for any such contravention.

The Executive Director of SafeWork SA acted on that advice and did not institute any prosecution.

That was conveyed to Keith by Mr Campbell orally on 11 April 2022 after the written legal advice had been provided to SafeWork SA. This was only days before the additional limitation period expired.

In the general circumstances outlined, I have been requested to report to the Attorney-General on:

1. The adequacy of SafeWork SA's engagement with Gayle's family during its investigation into a possible offence under the WHS Act;
2. The adequacy of SafeWork SA's investigation into whether Gayle's death gave rise to a reasonable prospect of conviction for an offence contrary to the WHS Act; and
3. Recommendations as to any other matters that may arise during the course of the inquiry.

The context is also an intended broader review into the practices and procedures of SafeWork SA's investigative and prosecutorial functions, which is to commence in due course.

DETAILED BACKGROUND

There is a clear general picture which has emerged about the working conditions and risks applicable to nurses engaged at Fregon by NHC at the time in 2016 who were performing on-call duties from their homes.

The normal working hours at the Fregon Clinic were 9.00am to 5.00 pm. However, Gayle's duties included providing after hours on-call medical services to the Fregon community in rotation with the other two nurses employed by NHC in Fregon at the time. To fulfil that role, she was required to take to her home the ambulance used by NHC for fulfilling its functions. She also was expected to leave a light on at the front of her home, so that those seeking after hours help could know where to go if medical help was needed. The front of her home (and of premises occupied by the other nurses employed by NHC) was then fitted with a buzzer system to attract the attention of the nurse on call if necessary.

Because there was considerable violence in the community, the front verandah of each home was fitted with an enclosed wire cage face so that direct access to the home was not available. The nurse on call was intended to be protected from direct violence by that caged area. The lock to the caged area could be opened from the inside manually, but from the outside it required a key to be opened. There was a panel around the lock so that manual opening from the outside could not be achieved. The inquiries made by SAPOL immediately after the death of Gayle did not indicate that the lock on the cage was not operating properly or had been forced on 23/24 March 2016.

The cage facing was sufficiently small that, apart from passing through the cage face a small package of tablets or the like, it was necessary to open the cage to allow access to any patient if a minor medical procedure was needed. The cage openings were not large enough to pass a cup of water through them.

There were, it is clear, circumstances in which the nurse on call could, and did, open the caged section either to take a patient to the principal clinic of NHC in the township sometimes in the ambulance, or to go by ambulance to a location in the township where medical help was needed, or in providing minor medical assistance as the on-call nurse. Clearly, if going to the clinic was necessary, the cage would have to be opened. Also, on occasions, a patient would telephone the on-call nurse rather than go to the nurses' home, and the nurse then might collect the patient to go to the clinic. It will be necessary to refer to the details of the NHC security systems provided for on-call nurses in more detail.

On the night of 23/24 March 2016, Gayle was on call. On that night, she was abducted, raped and then murdered by Mr Davey. It is clear that, somehow, he was able to take Gayle from her home, apparently after she had opened the caged area, and take her in the ambulance some distance from her home where he committed the offences of rape and murder.

The precise circumstances in which Gayle came to leave the caged area are not known. For the purposes of this inquiry, it will be necessary to refer to the relevant material in more detail.

SAPOL investigated the circumstances of Gayle's death. Mr Davey was found in Cooper Pedy, after the ambulance movements were traced to there, and was arrested and charged with her rape and murder. When first arrested, he acknowledged stealing the ambulance, but denied any contact with Gayle. Ultimately, he pleaded guilty to those offences on 23 February 2017. On 8 June 2017, he was sentenced to a mandatory term of life imprisonment. A non-parole period of 32 years was imposed. During his Court sentencing process, he explained through his counsel that he had tricked Gayle into opening the cage by saying that he needed Panadol for his grandmother, and that Gayle had offered to deliver it personally. She had then gone and collected the ambulance keys from inside her home. He said he overpowered her as she was walking to the ambulance to drive to his grandmother's house. The sentencing judge described that version of events as not credible.

An appeal to the Full Court of the Supreme Court against the sentence was unanimously dismissed in November 2017.

As noted, the death of Gayle was reported by NHC to SafeWork SA on 29 March 2015. SafeWork SA promptly made inquiries into the circumstances of her death. The focus in my Terms of Reference is upon the investigation conducted by SafeWork SA after the publication of the Coroner's Report, it is therefore not necessary to set out in too much detail the process undertaken before then.

The records of the investigation show inquiries were made by SafeWork SA of the Health Services Manager of NHC David Busuttil and then of SAPOL through the principal investigating officer. The inquiries included ascertaining and inspecting the 'Incident Reports' of NHC from April 2015 to 23 March 2016. They included checking the NHC Clinical Staff Safety Policies and Guidelines, and speaking to certain nursing staff who were working at Fregon at the time.

At a certain point, on 29 April 2016, the inquiries were formally designated as an investigation. The investigator continued the inquiries, including identifying that there had been a change implemented by NHC shortly after 24 March 2016 in procedures to protect on-call nursing staff by requiring the provision of a support person whenever the security cage was to be opened. NHC had itself commissioned an independent safety assessment, provided in June 2016, the 'Security Risk Assessment Report', which was provided to the investigator. Keith had been

interviewed by SAPOL and his statement was obtained by the investigator. A formal notice was given to SAPOL to procure certain documents. SAPOL provided information informally as to the progress of their investigation.

It became a matter of concern to SafeWork SA as to whether Gayle was actually engaged in nursing duties at the time she was abducted by Mr Davey.

On 14 October 2016, SafeWork SA wrote to the Coroner's Office indicating its concerns about the events which befell Gayle and suggested that there might be an inquest into her death and matters arising from it.

Ultimately, the inspector reported that the information did not appear to confirm that Gayle was engaged in nursing duties at that time.

The then Executive Director decided that the information available to SafeWork SA did not justify a conclusion that Gayle's death arose in the course of her employment. SafeWork SA notified Keith of that decision by a short letter of 25 November 2016. A further letter of the same date was sent to NHC, notifying it of the decision. I have noted the terms of that letter above. Although Keith, in his interviews with me, said that he expected to be kept informed by SafeWork SA of additional information as it came to hand during 2017 and thereafter, the letter itself did not suggest that.

As the Terms of Reference require a focus on the engagement with Keith and his family after the Coroner's Report, it is not necessary to pursue that aspect further. It is nevertheless understandable that Keith may have had that expectation. On the other hand, it is also understandable that SafeWork SA, during that period, was not conscious of any expectation of Keith to that effect.

In the course of the investigation, SafeWork SA had prepared papers which addressed 'Industry Engagement to Address Issues Concerning Nurses in Remote Areas' and 'Nursing in Remote Areas'.

No further action was taken by SafeWork SA in relation to the death of Gayle for some time.

In the meantime, understandably, Keith had applied to Return to Work SA (established under the *Return to Work Corporation Act 1994* (SA)) for the entitlement to which he claimed to be entitled arising from Gayle's death under the *Return to Work Act 2014* (SA). The file indicated that the claim was accepted on the basis that Gayle's death arose from her employment, as that term is defined in section 7 of that Act. I have had access to the Return to Work SA file. It appears that its decision was based upon information then available from SAPOL. There was little separate and additional investigation carried out by Return to Work SA. It did not have any dealings with SafeWork SA about Gayle's death around that time.

Its decision was made on 16 March 2017.

Keith duly received the prescribed benefits.

As noted, also during 2017, Mr Davey pleaded guilty to the charges of rape and murder of Gayle, and he was later sentenced for those crimes. An appeal from the sentence was dismissed.

In October 2017 the *Health Regulation National Law (South Australia) (Remote Area Attendance) Amendment Act 2017* (SA) was passed. It was in response to what had happened

to Gayle. It is plain from the Parliamentary Debate [Hansard, House of Assembly, 18 October 2017, p 11518] that Keith and his family had played a significant part in promoting those changes to that Act. All Members of the House of Assembly who spoke to the motion that the relevant Bill be read a second time clearly proceeded on the basis that Gayle was engaged in nursing duties as an on-call nurse at the time of her abduction and murder.

The amending Act is commonly called 'Gayle's Law'. It came into effect on 12 December 2017.

As noted below, the statutory head of SafeWork SA is the Executive Director. In August 2017, Mr Campbell was appointed as the Executive Director of SafeWork SA.

Soon after his appointment, in February 2018, the Australian Broadcasting Corporation (ABC) put to air two 'Australian Story' presentations focussing on the circumstances of Gayle's death, and the risks to nurses working in remote communities. There was also other media interest in the circumstances surrounding Gayle's death at about the same time, probably prompted by the ABC stories.

As appears below, in the more detailed reference to the provisions of the WHS Act, NHC had a duty under section 19(1) of the WHS Act to ensure, so far as reasonably practicable, the health and safety of its workers while they are at work. There is also a duty to report significant incidents to SafeWork SA. There is no definition of 'while they are at work' in the WHS Act.

As a consequence of his attention being brought to the circumstances of Gayle's death, Mr Campbell initially on 6 March 2018 announced that there would be a review of the initial investigation file of SafeWork SA. He shortly after formed the view that the initial investigation was insufficient, and that he did not necessarily agree that the death of Gayle was not in the course of her work. He considered that it was appropriate that he should make contact with Keith to explain his position, and in effect the position of SafeWork SA, and to conduct a more detailed investigation into the circumstances of and surrounding her death.

At the time, the 2 year limitation period specified for bringing any prosecution against NHC or its directors was about to expire. It is specified in section 232(1) of the WHS Act. Mr Campbell was aware of that. He understood, that, as a result of the time limitation period expiring, the compulsory investigatory powers available to SafeWork SA to require the provision of information and documents would also lapse. I accept that at about or shortly after that time he also became aware that, in the event of a Coroner's Inquest into the death of Gayle, the Report of the Coroner could open up a further 'window' - a one year period to institute such proceedings from the date of the Coroner's Report. That is the effect of section 232(1)(b) of the WHS Act. He also became aware that the compulsory investigatory powers would be revived and be exercisable during that period of 12 months.

On 27 March 2018 the Executive Director formally announced that SafeWork SA would review the initial investigation.

On about 6 March 2018, that is shortly before the expiration of the 2 year limitation period prescribed by section 232(1)(a) of the WHS Act, Mr Campbell rang Keith to tell him of the action he was taking and to arrange a meeting with Keith and his family.

The meeting took place at Stansbury on 23 March 2018. Mr Campbell was accompanied by Mr Farrell. There was a short telephone conversation between Mr Campbell and Keith a few days later. My Terms of Reference concern the adequacy of the engagement with Keith and his family by SafeWork SA after the Coroner's Report on 15 April 2021. I consider that those

two communications between SafeWork SA and Keith are relevant, noting that their effect was twofold. Firstly, they elevated Keith's hopes that NHC would be prosecuted for its failure to properly protect Gayle from what happened to her, and secondly they caused Keith to have a mistrust of SafeWork SA. In my view, that unfortunate state of affairs has made Keith and his family critical of the engagement of SafeWork SA with him and his family in the period of time after the Coroner's Report.

At the meeting of 23 March 2018, Mr Campbell apologised for the earlier decision of SafeWork SA notified to Keith by letter of 25 November 2016. He said he had a different view, namely that Gayle was probably engaged in nursing duties when she was somehow induced to open the cage door and then Mr Davey was able to abduct her and murder her. He made some comments about the quality of the initial investigation. So much is common ground. So too is the fact that Mr Campbell said that he would review the investigation, but that there would be restrictions on it because the time limitation was about to expire and the compulsory investigative powers could not be exercised. It is also common ground that Mr Campbell said he would nevertheless see what 'they' – meaning SafeWork SA – could do to clarify that Gayle was engaged in nursing duties on that night and determine avenues for the prosecution of NHC. It was not an unpleasant or aggressive meeting.

In describing briefly that meeting, which took something over an hour, I have had the benefit of hearing what Keith and members of his family who were present said about it, as well as hearing what Mr Campbell and Mr Farrell said about it. I also have had the benefit of brief contemporaneous notes made on her telephone by Andrea Hannemann, one of Gayle's sisters who was present at the time. I am not aware of any other contemporaneous record of the meeting.

That meeting was followed by a brief telephone conversation between Keith and Mr Campbell a few days later. Mr Campbell said he told Keith that the review/fresh investigation had started, and that what additional material it obtained could be sent to the Coroner. He arranged to be available for Keith to ring him about the progress of the fresh investigation. He said that they had a few brief conversations about its progress over the following months. He also agreed that he may have pointed out to Keith that there was an opportunity (or 'loophole' as Keith described it) which might have enabled a prosecution to be brought despite the elapse of the 2 year limitation period. Mr Campbell says he was referring to the additional 12 month period that may have followed the Coroner's Report, and that he invited Keith to actively support a Coroner's Inquest. Keith says that he was not told that that was the loophole, and that a Coroner's Inquest was not mentioned. He and his family had already been pressing for an Inquest. He says he understood that it was a loophole which existed in any event, available to SafeWork SA. He did not ask what it was. He did not have any understanding of what it might have been. He came to learn that there was no such loophole, independent of the consequence of the Coroner's Report, and he then (and now) thinks he was misled by what he was told. His optimism following that telephone conversation was later destroyed when he was told by letter of 28 September 2018 that the additional review/investigation would not lead to any prosecution by SafeWork SA against NHC.

That experience, which he of course shared with his family, meant that Keith and his family then had little or no confidence in what they were informed by SafeWork SA from 28 September 2018 and thereafter.

That is an important context for assessing the adequacy of the engagement by SafeWork SA with Keith and his family from the time of the Coroner's Report on 15 April 2021.

I should record my view that the 'loophole' that Mr Campbell was referring to was the window of 12 months to prosecute NHC which might have become available following, and by reason of, the Coroner's Report. There is no other 'loophole' that it might have been. I do not think Mr Campbell deliberately misled Keith by suggesting another 'loophole' which did not in fact exist. I also have no doubt as to the honesty of Keith, in what he thought came from that conversation. It is most likely that the different understandings came from the different comprehension of what was legally possible at the time, and the obviously different positions of Mr Campbell and of Keith.

There is a further observation which should be made at this point. Keith, in his interviews, was critical of the fact that Mr Farrell had attended that meeting as it was thought Mr Farrell had 'signed off' on the closure of the investigation in 2016. I have rechecked the file of SafeWork SA relating to that investigation. Mr Farrell did not 'sign off' on that outcome. It was done by the then Executive Director of SafeWork SA. The letter to Keith of 25 November 2016 was signed by the Acting Investigation Team Manager, who was David Osborne. Mr Osborne subsequently in March 2018 was an officer who recommended reviewing the earlier decision. Mr Farrell was not involved in the investigation in 2016 or in the decision making about whether to bring it to an end. Keith's no doubt genuine suspicion about him for the reason Keith expressed is not warranted. I think it is a further indication of the mistrust of SafeWork SA which had developed by this time on the part of Keith and his family.

As I have noted, the mistrust which Keith and his family then had of SafeWork SA and its officers no doubt influenced their suspicions of the quality of the final investigation which is the subject of the Terms of Reference, and of the motives of SafeWork SA in its communications with them, and even in the timing of the notification it gave to them ultimately that it would not be prosecuting NHC or its directors for any breach of the WHS Act arising from the circumstances of Gayle's death.

That mistrust was added to, in my view, because Keith and his family, understandably, had a strong belief that it must have been a flaw in the safety systems adopted by NHC in relation to the work of its on-call nurses which enabled Mr Dudley to abduct and murder Gayle. That strong belief persists. I refer to it again later in this Report.

That mistrust arising from the belief that SafeWork SA had not done enough to secure a prosecution became apparent in late 2018. On 28 November 2018, Keith and his family engaged a firm of lawyers, Oak Law, to act for them and to give advice about what could still be done to secure the prosecution of NHC for the circumstances surrounding Gayle's death. The action which was undertaken included Keith and his family in any event trying to convince the Coroner to undertake an inquest. It is also appropriate to note that the advice of the lawyer for Keith and his family was then, and remained, that there were good grounds for a successful prosecution of NHC in relation to the death of Gayle.

In the meantime, in March 2018 SafeWork SA designated a senior officer to carry out the review/renewed investigation. That officer sought some additional information from two nurses who had earlier provided a detailed statement, and in July 2018 the file recorded two detailed statements from them as well as a detailed statement from the general practitioner who was working at Fregon at the time. That officer reviewed the NHC Safety Policies and Guidelines.

She checked the information that, on the night of the abduction and murder, the cage lock had apparently been working properly. She sought from NHC (through a notice under section 155 of the WHS Act) additional information as to the awareness of its senior officers about the practice of on-call nursing staff opening the cage gates for the purpose of providing medical assistance in the period leading up to the critical night. She sought additional information from SAPOL. The NHC declined to respond to the notice under section 155 by the provision of information as (it claimed through its solicitors) the notice was not valid as the limitation period had expired and that they had already provided this information before.

Upon its review, and in the face of the refusal of NHC to provide further information, the investigator determined that, apart from accepting that Gayle was in the course of working as an on-call nurse at the time she was abducted by Mr Davey, there was nothing more which could usefully be pursued. Unless there were to be a Coroner's Inquest, the time limitation for bringing any prosecution had expired.

As a result of that review/investigation, SafeWork SA had accepted that Gayle was engaged in duties as an on-call nurse at the time of her abduction and murder. It could not take the possible prosecution of NHC or its directors further due to the expiry of the time limitation. It was also not satisfied that NHC could be shown to have breached its duty to Gayle and other on-call nurses having regard to what had been put in place by NHC for the safety of the on-call nurses. On 28 August 2018, it again closed its file relating to the investigation.

As noted, on 28 September 2018, Mr Campbell informed Keith of the outcome of the additional investigation in a lengthy letter. He informed Keith that the best course to follow to pursue any prosecution of NHC and its directors was to secure a Coroner's Inquest, and invited Keith and the Woodford family to make representations to the Coroner to conduct an Inquest. He confirmed that SafeWork SA would forward to the Coroner's Office the additional information it had obtained to support any Inquest.

SafeWork SA had, as noted earlier, written to the Coroner on 14 October 2016 following its first investigation, and provided details of that investigation. It had also written to the Coroner on 5 March 2018, when it commenced reviewing its earlier decision, to inquire whether the Coroner intended to conduct an Inquest. On 6 March 2019, SafeWork SA, aware of the proposed Coronial Inquest, forwarded to the Coroner its records relating to both the initial investigation in 2016 and the investigation conducted in 2018.

On 6 November 2019, the Deputy State Coroner commenced an Inquest into the death of Gayle. It was a lengthy Inquest culminating in findings published on 15 April 2021. By reason of section 232(1)(b) of the WHS Act, the time restriction on bringing any proceedings for an offence against the WHS Act was extended to a period of 1 year after the Coroner's Report (having regard to the terms of the Coroner's Report).

Following the Coroner's Report, SafeWork SA commenced a further investigation into the circumstances surrounding the death of Gayle. A detailed investigation was conducted, resulting in the preparation of a Prosecution Minute and a Brief of Evidence as a result of that investigation. Following that investigation, the Minute and Brief of Evidence was submitted to the Crown Solicitor's Office, as the relevant protocol required SafeWork SA to seek advice from the Crown Solicitor's Office as to whether the results of the investigation should lead to the laying of any charges against NHC for contravention of its duty towards Gayle in the circumstances. The Crown Solicitor's Office engaged external senior and junior counsel to

provide such advice. The advice was that it was not appropriate to institute any prosecution against NHC. That advice was given orally to SafeWork SA on 8 April 2022, so only a few days before 15 April 2022, that is only a few days before the expiration of the further period of 1 year referred to above.

Mr Campbell as the regulator under the WHS Act acted on that advice and decided not to institute any prosecution.

Mr Campbell then promptly arranged to inform Keith of that decision.

Not surprisingly, Keith and other members of his family were distressed that no prosecution was to be brought against NHC. They were also distressed that they had been notified of the decision so late in relation to the expiration of the limitation period. It provided them with no opportunity to consider whether any further avenue to take steps against NHC was available, or to make representations to any other person about further action against NHC.

Keith has also expressed concern about whether SafeWork SA, during the period since the Coroner's Report and up to the final notification of the decision conveyed to him by Mr Campbell, properly communicated with him about the progress of the investigation. He maintains that criticism, although he is aware that section 271 of the WHS Act proscribes any person, relevantly the officers of SafeWork SA and including Mr Campbell, from disclosing information or the contents of any documents that that person has obtained in the exercise of any power or function under that WHS Act.

THE LEGISLATION

It is helpful at this point to identify the important provisions of the WHS Act.

On 1 January 2013, the WHS Act came into operation. The first stage of the *Work Health and Safety Regulations 2012* (SA) (the Regulations) also commenced on this date. The WHS Act and the Regulations were based on a national model. The national model is a result of the Intergovernmental Agreement and Operational Reform in Occupational Health and Safety, in which the commonwealth and states and territories agreed to harmonise their approach to occupational health and safety to provide consistent workplace protections for Australian workers.

The main object of the WHS Act, as specified in sections 3(1)(a) is to facilitate a nationally consistent framework to secure the health and safety of workers and workplaces by protecting workers and other persons against harm to their health, safety and welfare by the elimination or minimisation of risks arising from work.

The primary obligations on employees are under Part 2 Divisions 2, 3 and 4 of the WHS Act. The WHS Act establishes health and safety duties on persons conducting businesses or undertakings (PCBUs), officers of PCBUs, workers and other persons at the workplace.

Of particular relevance is, section 19 of the WHS Act. It imposes a primary duty of care which requires an employer (in this instance NHC), to ensure, so far as is reasonably practicable, the health and safety of workers engaged by that person or of workers whose activities in carrying out work are influenced or directed by that person while the workers are at work in the business or undertaking. Section 18 of the WHS Act defines reasonably practicable in relation to a duty to ensure health and safety, as that which is, or was at a particular time,

reasonably able to be done in relation to ensuring health and safety. In determining this, various relevant factors are considered.

These provisions were properly the focus of the SafeWork SA investigation.

The WHS Act specifies in section 4 that the Executive Director of the business unit with a government department that is responsible for the administration of the WHS Act is the regulator. The business unit responsible for the administration of the WHS Act is SafeWork SA. As a consequence of Machinery of Government changes in 2014, SafeWork SA became a part of the Attorney-General's Department; then in 2018, the business unit moved to the Department of Treasury and Finance. SafeWork SA transitioned back to the Attorney-General's Department, effective from 1 July 2022.

Martyn Campbell became the Executive Director of SafeWork SA in August 2017.

SafeWork SA is partly comprised of a regulatory arm that focuses on enforcing compliance with the WHS Act. This arm has an investigations team that consists of employees who are appointed as inspectors, their primary duty being to investigate incidents arising under the WHS Act (see section 156). As the regulator under the WHS Act, the investigations team reports to the Executive Director of SafeWork SA. During the course of an investigation, the regulator has the power to do all things necessary or convenient in connection with the performance of its functions (see section 153). The functions of the regulator are outlined in section 152 of the WHS Act. Pursuant to section 154 of the WHS Act, the regulator may delegate a power or function under the WHS Act to another body or person.

Section 230 of the WHS Act specifies that the regulator may bring a prosecution for an offence against the WHS Act.

There are three categories under the WHS Act for offences for a breach of a health and safety duty under the WHS Act (see sections 31–33). A Category 1 offence constitutes conduct that exposes an individual, to whom a health and safety duty is owed, to a risk of death or serious injury or illness and the person is reckless as to that risk. A Category 2 offence relates to a failure to comply with a health and safety duty when that failure exposes a person to a risk of death or serious injury or illness. A Category 3 offence may be viewed as the basic offence of breaching either one of the duties imposed by section 19 of the WHS Act. It is committed when a PCBU breaches a duty owed to workers by failing to eliminate or minimise risks to them.

As it is of particular relevance to the matters to which the Terms of Reference relate, it is important to note the relevant time limitations for the purposes of any prosecution under section 230 of the WHS Act.

The WHS Act specifies two limitation periods within which the regulator may bring prosecutorial proceedings. The first limitation period is set at 2 years after the offence first comes to the notice of the regulator (see section 232(1)(a)). As set out above, at the expiration of two years from Gayle's death and the report by NHC of 29 March 2016, that is by 29 March 2018, SafeWork SA had not commenced any prosecution against NHC and had indicated that its file was closed.

There is a further period of 12 months within which to prosecute permitted by section 232(1)(b). This provision applies if there is a coronial report made or a coronial inquest ended, from which it appears that an offence had been committed against the WHS Act. The

Coroner's Report of 15 April 2021 clearly fell within that description, so a further period of 12 months until 15 April 2022 within which to prosecute NHC became available to SafeWork SA.

As previously mentioned, the regulator possesses powers under the WHS Act to carry out its functions. During the course of investigating incidents, the regulator has the ability to obtain information after giving persons written notice (see section 155). When investigating incidents, inspectors within the regulatory arm of SafeWork SA can also require production of documents and answers to questions upon their entry into a workplace (see section 171). These investigatory powers may be commonly referred to as compulsory powers under the WHS Act.

The WHS Act does provide, in limited circumstances, for any person (no doubt generally the victim or the family of a victim of an employment occurrence which is thought to warrant prosecution) to 'prompt' action on the part of SafeWork SA. Section 231 of the WHS Act enables a person to make a written request to the regulator that a prosecution be brought, where a person reasonably considers that a particular act, matter or thing constitutes an offence under either Category 1 or 2 and no prosecution has been brought within six months of the occurrence of that act, matter or thing, but no later than 12 months after that occurrence. In short, that request must be made in the period of 6-12 months. When this request is received, the regulator must advise the person in writing within 3 months as to whether the investigation is complete, and whether a prosecution has been or will be brought. If no prosecution is to be brought, then the regulator must outline the reasons for this decision (see section 231(2)). The regulator must also advise the person who the applicant believes committed the offence of this application (see section 231(2)(b)).

Where the regulator advises the person that no prosecution is to be brought, the regulator must also advise the person that a request can be made to the Director of Public Prosecutions (DPP) to consider the matter. If the person then makes a written request to the regulator, the decision must be referred to the DPP within one month of the request (see section 231(3)). The DPP is required to consider the matter and respond to the regulator in writing within one month, indicating whether proceedings should be brought (see section 231(4)). The regulator must provide a copy of the DPP's written response to the applicant and also the person who the applicant believes committed the offence (see section 231(5)). If the regulator declines to follow the advice of the DPP, the regulator must provide written reasons for their decision to the applicant and the person whom the applicant believes committed the offence (see section 231(6)).

I comment about this provision in response to paragraph 3 of the Terms of Reference. It was not used by Keith or his family as they were not aware of it. Finally, it is necessary to note in some detail section 271 of the WHS Act. It is quite extensive in its terms and in its application. As appears in my consideration of the Terms of Reference concerning the adequacy of the engagement of SafeWork SA with Keith and his family, it has played a not insignificant role in the nature of communications.

Pursuant to section 271 of the WHS Act, persons must not disclose information or provide access to documents if they have obtained such information or document when exercising any power or function under the WHS Act. This provision, stipulating confidentiality of information, applies to the regulator of SafeWork SA and its employees when carrying out powers or functions under the WHS Act.

The prohibition in section 271(2) is from disclosing to ‘’anyone else” information acquired, or the contents of any document obtained, or from giving any document to “anyone else”, or from using the information or document “for any purpose”. Obviously, the section needed to permit the disclosure of information or giving of access to documents in some circumstances which are specified in s 271(3). These include disclosure of information about a person with that person’s consent; as necessary for exercising a power or function under the WHS Act; or used as authorised by the regulator if the regulator reasonably believes the disclosure, access or use is necessary for “administering or monitoring or compliance with” the WHS Act or another Act or law. There are also exemptions for disclosure to courts or tribunals, as authorised by another law, or to a Minister. For the purposes of this inquiry on behalf of the Minister, that qualification applies.

There is presently no specific reference for disclosure to victims of crime. I note that, in circumstances where section 231 is available to be utilised, the person would have access to little or no information about the detail of any investigation, except as exposed to by the reasons for a decision by the regulator or the DPP.

THE PROCESS OF THIS INQUIRY

The process of the inquiry involved first identifying those persons from SafeWork SA who were involved in any aspect of the critical decision making on its behalf, notably of course Mr Campbell as the Executive Director, in the decision to conduct the further investigation following the Coroner’s Report including the selection of the investigating persons, the investigators themselves. That was done by inquiries through SafeWork SA. I am satisfied that the relevant persons have all been identified.

Second, it was necessary to determine how the investigation was conducted, including sources and the extent of the assembly of information, and the focus or focuses of the investigation. That process was again pursued through SafeWork SA. Again, it is apparent that the material provided in response to that request was properly met. The detail is set out in the section referring to the adequacy of the investigation.

As noted in the Introduction, the investigation culminated in the Prosecution Minute dated 24 January 2022, which was at the commencement of the 24 folders of material provided initially to me constituting the Brief of Evidence. The Minute was the document (with the supporting materials in the 24 folders) that was sent to the Crown Solicitor’s Office and then considered by senior and junior counsel. It is described in more detail in the section of this Report dealing with the adequacy of the investigation. In the course of the investigation, I was given access to the internal electronic records of SafeWork SA as I required. In addition, at my request, I was given copies of all the written records of communications between SafeWork SA and Keith and his family held by SafeWork SA (some of which were included in the material provided by Keith through his lawyer through the firm Oak Law). Finally, I was also given access to the closed files held by SafeWork SA relating to the investigations carried out in 2016 and 2018.

I progressively interviewed all the persons identified by SafeWork SA as relevant to understand the decision-making process, and the investigation process, and to respond to matters which had emerged as possibly significant in my perusal of the very extensive documentary material which had been provided to me, and in the documents produced by the lawyer for Keith and his family.

Third, obviously, it was necessary to speak with Keith and the members of his family to ensure that their concerns about the quality and adequacy (or inadequacy) of the SafeWork SA engagement with them was properly understood. That was done by the lawyer for Keith and his firm providing a written commentary about those matters, supported by the production of relevant documents, and then by a lengthy meeting with Keith and some members of his family to give him the opportunity to express his and the family's concerns fully. The family group included Alison Woodford, the daughter of Gayle and Keith, and Gayle's sisters Ms Hannemann and Wendy McDonald and her husband Harry. Their lawyer elected not to attend that meeting, understandably, so as to allow Keith and his family to speak in an unrestricted way and on any topics they felt it desirable to speak. I conducted a separate interview with his lawyer to ensure that Keith and the family's concerns had been comprehensively expressed and understood by me, and to invite attention to any particular areas of focus. At the later meeting referred to below, Alison was not able to attend, and Andrea's husband Mark attended. Gayle's brother Darren Thomson provided a written statement supporting the concerns of Keith and the family generally.

Where it was desirable, I conducted further interviews with some of the SafeWork SA persons to ensure that particular matters of interest, or which required to be cleared up, were properly addressed.

I also conducted an interview with Ms Bronwyn Killmier, the South Australian Commissioner for Victims' Rights, who had become involved directly in certain of the communications between Keith and SafeWork SA from about October 2021, and of course to better understand the community expectations for communications between authorities such as SafeWork SA and the victims of crimes.

As it remains a significant concern of Keith and his family that none of NHC or its directors have been prosecuted for any contravention of the WHS Act, and now cannot be so prosecuted by reason of the applicable time limits, I also considered it appropriate to interview the senior counsel who provided the oral advice to SafeWork SA on 8 April 2022 (and a subsequent written advice dated 14 April 2022) to confirm the general terms of the advice then given. I wished to confirm that the SafeWork SA persons present at the meeting, and in particular Mr Campbell as the decision maker, had properly understood that advice. Obviously, it is relevant to the adequacy of the investigation itself. As Keith and his family had strong expectations that a prosecution would follow from the investigation, especially in the light of the Coroner's Report, it is also relevant to the adequacy of the communications with Keith and his family.

Finally, in the light of the investigations conducted and provisional views which had been formed as a result, I had a further lengthy meeting with Keith and the members of his family to ensure that my Report properly addressed his concerns about the adequacy of the investigation and that it properly reflected his concerns about the adequacy of the communications with him and his family. His lawyer was invited to attend that meeting, but did not do so. I also spoke again to his lawyer, with their approval, to clarify any concerns and to ensure as best I could that I had properly understood their concerns. I also discussed with Keith and his family, and with their lawyer, the few suggestions that I was contemplating to include in my Report in response to the third Term of Reference.

I note below one contemporaneous record of the discussion held between Keith and SafeWork SA related to a meeting which took place at Stansbury on 23 March 2018. Ms Hannemann

had a brief record of that meeting made at the time and held on her phone. I asked Keith and his family if there were any other more or less contemporaneous records of their oral communications, but as they expected there were no other such records produced.

THE ADEQUACY OF THE INVESTIGATION

It is clear that the Coroner's Report of 15 March 2021 was sufficient to enliven the possibility of a prosecution of NHC for breach of sections 32 or 33 of the WHS Act. It brought into life the extended period of 12 months from its publication within which such a prosecution might be brought: section 232(1)(b) of the WHS Act.

Mr Campbell, who was about to go on leave, arranged for SafeWork SA to promptly put in place a fresh investigation team to further investigate the possibility of a prosecution against NHC and its directors, as the Coroner's Report required action during his leave.

SafeWork SA was well aware of the fresh time limit.

As that window of opportunity had by then been discussed with Keith through his lawyer, both he and his lawyer were also aware of it.

The material indicates that the three investigators were specifically selected for their experience, and expertise and commitment. I have no reason to doubt that. Having interviewed each of the three investigators, I am confident that they had the necessary training and experience and commitment to conduct the investigation. I interviewed each of the Manager – Investigations and the Investigations Team Leader who were involved in the selection decision of the investigators, with Mr Farrell to confirm that basis of the selection of the team of investigators. The Lead Investigator resigned from his position with SafeWork SA after the Brief of Evidence had been signed off on 24 January 2022, and was replaced by another investigator. I interviewed that person as well, to ensure that he did not propose any additional investigations and that he did not have any concerns of the quality of the investigation to that date. He did not.

The Adelaide based investigators were removed from their usual work areas to work in a dedicated area exclusively on the investigation. The third investigator, who was based in the Riverland of South Australia, participated in the regular and frequent discussions and planning sessions of the group, sometimes by electronic communication and sometimes in person. They were at all times aware of the particular investigative steps being taken by each of them. The 'team leader' or the Lead Investigator maintained the oversight and focus of the group.

In the balance of this Report I shall call the three investigators 'the investigation team'.

They, too, were aware of the relevant time limitation and had an internal time frame of up to 9 months to complete their report.

Their clear focus was to conduct such investigations as necessary, and as were available to them, to prepare a Minute and Brief of Evidence, recording the evidence available to determine whether NHC had breached any of its health and safety duties owed to Gayle imposed under section 19 of the WHS Act. It is set out above. Their particular focus was upon possible breaches of section 19(1), section 19(3)(a), section 19(3)(c) and section 19(3)(f).

Inevitably, their initial focus was on the Coroner's Report. It contained 17 headed sections, commencing with the 'Introduction' and concluding with the 'Recommendations'. There are

sections of direct and immediate relevance to the SafeWork SA investigation: Section 3 'The circumstances of Mrs Woodford's abduction'; Section 4 'The level of violence in the Fregon community'; Section 5 'The incident at Watarru' and section 6 'Police intervention following the Watarru incident'; Section 7 'NHC Policies and guidelines relating to on-call nursing practices'; Section 8 'Relevant on-call nursing practices in Fregon'; and Section 9 'Conclusions in relation to nursing practices'. Section 16 'Gayle's Law' also falls into the sections of the Coroner's Report of direct relevance to the current Terms of Reference.

It may be noted that the 'Recommendations' in Section 17 of the Coroner's Report did not include any specific recommendations for considering the potential prosecution of NHC or its directors, for further investigation by SafeWork SA of the conduct of NHC with a view to determining whether NHC should be prosecuted for any contravention of the WHS Act.

The other sections of the Coroner's Report related to important matters, but not of such direct relevance to the question of whether NHC or its directors should be prosecuted for any such contravention. Section 2 'Dudley Davey's criminal history'; Section 10 'The section 23 issue' relating to whether Mr Davey could have been kept in prison beyond the expiration of a sentence passed in 2015; Section 11 'Dudley Davey's rehabilitation in prison'; Section 12 'Child Sex Offender Registration'; Section 13 'The warrant for Davey's arrest' relating to the circumstance that a warrant was issued on 10 February 2016 for his arrest for failing to appear at the Mimili Magistrates Court in breach of a bail condition, but which was never executed; Section 14 'Police presence in Fregon'; and Section 15 'Information to be provided to persons living in remote communities regarding the criminality of a person in that community'.

The investigation team regarded the Coroner's Report as especially useful to their investigation, including the primary materials which the Coroner had assembled (largely through SAPOL officers) and the information which many persons had provided to the Coroner by way of written statements and during oral evidence as recorded in transcript.

It is also important to note, as each member of the investigation team pointed out, that the Coroner's Report was able to be based on materials which, in the event of a prosecution by SafeWork SA, would not routinely be admissible in a Court prosecution and that any oral evidence to be adduced in support of a prosecution would have to be in an admissible form. The Coroner was not necessarily bound by the same rules of evidence or of strict proof.

Consequently, they approached the investigation in a way which ensured that the evidence they assembled was in an admissible form for the purposes of a criminal prosecution. They could not simply adopt the records of the Coroner for that purpose. Those records did provide a very useful starting point for a number of the statements obtained in the course of their investigation.

There was an additional reason why the investigation team could not simply adopt the Coroner's Findings, and more specifically the evidence underlying them, to present a prompt Brief of Evidence recommending prosecution of NHC and its directors. The Coroner made the point in Section 3 at [3.3] of his Report. He recognised that his findings were to be made on the balance of probabilities, and that he did not need to make his findings beyond reasonable doubt, that is to the criminal standard of proof. Consequently, he said there that he did not need to conclude that all other reasonable hypotheses consistent with Gayle having left the premises for reasons other than medical had been excluded. That is an important distinction.

I draw those remarks of the Coroner to attention, because the concluding section of this part of my Report refers to the reasons given by senior counsel for advising SafeWork SA not to institute any criminal prosecution against NHC or its directors. It is apparent that the different standard of proof applicable in such a prosecution is the principal reason for the advice given to SafeWork SA.

The investigation team, having considered the Coroner's Report, proceeded to consider what needed to be further investigated to be able to provide a Brief of Evidence to the Crown Solicitor's Office. Ultimately, the prescribed procedure was for such a brief to be submitted to the Crown Solicitor's Office to advise whether a prosecution should brought against NHC and /or its directors.

The Prosecution Minute to the Brief of Evidence of the investigation team is a sound basis for reviewing the adequacy of their investigation.

It commences with Section A - Summary statement of the alleged offending. It identifies there the relevant health and safety statutory obligations imposed on NHC by section 19(1), section 19(3)(a), section 19(3)(c) and section 19(3)(f) of the WHS Act. They are referred to above. It then clearly identifies the potential breaches, and offences. It is quite clear:

SafeWork SA allege that the following breaches were committed by NHCI:

- Section 32 – Failure to comply with health and safety duty – Category 2
- Section 33 – Failure to comply with health and safety duty – Category 3
- Regulation 34 – Duty to identify hazards
- Regulation 39(2) – Provision of information, training and instruction.

That is followed by a detailed background description of the circumstances and the setting out in detail of the relevant provisions.

Section B is brief. It notes the time limitation, then expiring on 15 April 2022.

Section C – Statements of Each Fact then refers to 10 facts, identified in detail with supporting references to the material enclosed with the Brief of Evidence which is to prove the relevant fact. The material is referred to by the relevant statement and where it can be seen in the Brief of Evidence material and the relevant document and where it can be found in the material. This is the principal section of the Prosecution Minute which indicates the extent of the investigation.

I will list each 'fact' to be proved. Some need be noted only in passing.

Fact 1 is the incorporated status of NHC. It does not require comment.

Fact 2 is that Gayle was a worker employed by NHC at the time of her death. It too does not require comment, save to note that the documentary material referred to includes her contract of employment. I note that to indicate the thoroughness of the investigation.

Fact 3 is that on the night of 23 March 2016, Gayle's Fregon residence was a workplace as defined in the WHS Act. The material referred to includes the statement of Keith, and the documentary material provided by Mr Busuttil. Again that does not require further comment.

Fact 5 is that Gayle sustained fatal injuries while conducting her duties as the on-call nurse on the night of 23 March 2016. This fact focusses on the cause of death, rather than the

circumstances in which Gayle came to be abducted by Mr Davey. Reference is made to the evidence to the Coroner. This fact, as explained, does also not require further comment.

Fact 6 is that the activities of Gayle and other NHC nurses in carrying out on-call work were influenced or directed by NHC policy and procedures. In turn, Fact 6 is broken into 15 subsections which break up the facts to be proved into greater detail each subsection has its own references.

Subsection 6.1 says that, as per NHC's policies and guidelines, Gayle and other NHC nurses were required to take the ambulance home with them, park it in view outside of their house and leave the porch light on to indicate to the community that they were the on-call nurse for the night. The supporting references include 17 statements provided to the investigation team from nurses who have worked at Fregon or in the APY lands, and the general practitioner who was working at Fregon at the relevant time, and it refers to documentary materials from NHC, and to certain material presented to the Coroner.

There are equally extensive evidence references to support the further subsections of Fact 6. I will set out the subsection facts, but not repeat that the evidence references are extensive and of the same character.

Subsection 6.2 says that, as per NHC's policies and guidelines, community members requiring medical assistance after hours were able to present directly to the private residence of Gayle and other NHC nurses.

Subsection 6.3 says that, as per NHC's policies and guidelines, Gayle and other NHC nurses were required to conduct a survey of the airway, breathing, circulation and disability of all patients presenting to their houses to determine if a more complete assessment was required. It says also that nurses spoken to by SafeWork SA made it clear that a full assessment could not be achieved without opening their security cages.

Subsection 6.4 says that, as per NHC's policies and guidelines, if a patient presented to the house of the on-call nurse and required further assessment and treatment, Gayle and other NHC nurses were required to take them to the clinic.

Subsection 6.5 says that, as per NHC's policies and guidelines, if a patient presented to the house of the on-call nurse and required the provision of simple analgesia or needed a simple dressing done, Gayle and other NHC nurses were able to do this at their house. For many of these minor treatments, it was necessary to open the security cage.

Subsection 6.6 says that, as per NHC's policies and guidelines, an on-call medication box was provided by NHC for Gayle and other NHC nurses to utilise for minor presentations at their houses. This, it is said, indicates that providing some level of treatment at the nurses' residences was permitted.

Subsection 6.7 says that as per NHC's policies and guidelines, provided that a patient was not abusive, drunk or psychotic, and as long as Gayle and the other NHC nurses felt comfortable with the patients, they were able to open their security cage to the patients.

Subsection 6.8 says that as per NHC's policies and guidelines, if a person was sick and unable to come to the house of the on-call nurse, then the on-call nurse was allowed to visit the patient at their home and, if required, to take them to the clinic.

Subsection 6.9 says that NHC was advised/aware that nurses were treating patients alone at their residence, another residence and/or at the clinic.

Subsection 6.10 says that the APY lands, and in particular Fregon, was prone to levels of violence amongst the community. The evidentiary material referred to also included the Occurrence Reports provided to SAPOL.

Subsection 6.11 says that NHC had previously ceased providing health service to a remote clinic (Watarru) in the APY lands. NHC had raised concerns about the safety of nurses who travelled to the clinic and worked alone. The evidentiary material referred to in this instance is obviously different from that for the other subsections, and it includes records relating to Watarru, and the response of NHC to a notice under section 155 of the WHS Act dated 21 September 2021 issued to NHC by SafeWork SA.

Subsection 6.12 says that the NHC nurses in the APY lands, and in particular in Fregon, were victims of acts of violence/sexual assault by members of the community prior to and post Gayle's death.

Subsection 6.13 says that the risk of Gayle experiencing workplace violence was foreseeable, and that Gayle herself had been the victim of crime during her employment with NHC prior to her death. The evidence referred to included the statement of Keith, and records of NHC, namely incident reports, and the Incident Report Register 2013-2019 of NHC and some information provided by Mr Busuttil.

Subsection 6.14 says that NHC was aware of, and failed to act on the inherent risks that were associated with working alone and/or patients attending nurses' residences in a remote area. It notes that such risks were re-iterated to NHC by staff and by SAPOL. As well as the statement, certain documents produced by NHC by its responses to notices under section 155 of the WHS Act, records earlier obtained through the Coroner and SAPOL including the Incident Report Register referred to, and certain Risk Management Guidelines of NHC, and the record of an interview with a further nurse of 17 November 2021.

Subsection 6.15 says that, prior to Gayle's death, NHC failed to carry out an organisation-wide hazard identification or risk assessment to identify all risks associated with the nurses' line of work and the environment they worked in. A risk assessment was not completed until after Gayle's death and was conducted by an external provider. The documents relied on are identified, and include a specified response of NHC to a notice under section 155 of the WHS.

That is the completion of the detailed breakup of Fact 6 and the evidence relied on to establish the facts.

Fact 7 says that NHC failed to provide information, training and instruction to Gayle and other NHC nurses in order to conduct a 'personal situational (threat) risk assessment' before deciding whether or not to open their security cage or see a patient alone. The evidentiary material referred to included the same statements as supported Fact 6 and records of NHC including the Training Certificates of Gayle and the NHC Training Register and the transcript of the interview with the nurse referred to above.

Fact 8 states that on 23 March 2016 NHC failed to comply with their duty under section 19(3)(c) of the WHS Act. It is then broken into 5 subsections, with evidence references.

Subsection 8.1 states that NHC failed to implement a two-up or buddy system and allowed the on-call nurse to work alone with patients. Reference is made to the 17 statements and to relevant records of NHC, and to the transcript of interviews with the nurse referred to and with a further nurse also made on 21 November 2021.

Subsection 8.2 states that NHC implemented an on-call system that put NHC nurses at risk by directing patients to their residences, and instructing the ambulance to be parked at their residence for visibility to patients who wished to see the on-call nurse. The references to evidence are the same.

Subsection 8.3 states that, at the time of Gayle's death, an electronic patient record system called Communicare was in place and contained pop up alerts for high risk patients. These alerts could include that the patient must be seen with a family member, that a patient must only be see with two staff present, or that a patient must be seen with police presence only. The same evidentiary material in support is identified (less a few of the nurses statements) together with NHC documents and the two interviews of nurses.

Subsection 8.4 says that the NHC on-call system relied on NHC nurses conducting a personal (threat) risk assessment to assess if it was safe to provide treatment/tend to patients, and it was a system that NHC nurses were not equipped with the tools/aids to make such assessments. The same statements and transcripts were relied on together with the NHC Clinic/Community Orientation – Overview document and the August 2015 version of it.

Subsection 8.5 states that NHC failed to implement an on-call system that incorporated personal safety items common with remote and isolated work such as personal duress alarms/emergency distress beacons to alert if NHC nurses were at risk. The item of evidence relied on is that NHC response to a notice under section 155 of the WHS Act.

Fact 9 states that, after Gayle's death, NHC transferred the initial risks that Gayle and other NHC nurses previously encountered with patients attending their residences to the On-Call Support Workers. The statements and interviews relied on are referred to, including a transcript of interview of Heidi Chard and the March 2016 and October 2016 Safety Security Protocols for Clinic Out Of Hours and Unscheduled Call Outs of NHC.

Fact 9 then has a subsection which states that On-Call Support Workers are not awarded the same protection as nurses in relation to the protection of a security cage at their residence and the ambulance is still parked at the nurse's residence indicating who is the on-call nurse. Similar material is identified to support that.

Fact 10 states that, on 23 March 2016, NHC failed to provide and maintain, so far as was reasonably practicable, a safe system of work for Gayle and other NHC nurses that enable a two-up system and prevented working alone whilst on-call. At the time, NHC had the resources/capability to implement a two-up system/prevention of working alone. There is extensive evidentiary material referred to: the statement of nurses, documents describing job positions including a number relating to the period after March 2016, Safety and Security Protocols of NHC and like documents, and the interviews and transcripts of the three persons mentioned above.

It's subsection states that NHC failed to provide and maintain, so far as was reasonably practicable, a workplace that implemented practicable control measures for NHC nurses

working in a remote and isolated environment. A number of documentary resources are referred to in support.

Section D of the Prosecution Minute contains a list of the Regulations, Guides and Codes both from South Australia, nationally and from interstate which are relied on.

Section E is headed: Weaknesses in the evidence/difficulties in the Brief of Evidence.

Apart from noting the SafeWork SA investigation history, it noted that the 2018 investigation could not utilise the compulsory investigative powers during the 2018 investigation, and that statements had been taken only during that investigation and the current one. It noted that managerial staff employed by NHC had declined to provide voluntary interviews, and that because those persons were generally interstate that could not be compulsorily examined under section 171 of the WHS. Reliance was heavily placed on notices under section 155 of the WHS.

Finally, it noted that the only eyewitness to what happened to Gayle was Mr Dudley and at the time of the Prosecution Minute he had not been available to the investigation team, partly through COVID-19 related access restrictions.

Section F is headed: Matters relevant to sentencing including the impact of the offending. The matters set out under that heading are more diffuse.

Relevantly to the present Terms of Reference is the comment that it is in the interest of the public that the matter should proceed to prosecution, having regard to the seriousness of the offence, the consequence to Gayle and the ripple effect a conviction would have on the safety of those working remotely and in isolated area in providing medical services.

It noted that NHC had claimed that prior to March 2016 it could not afford a two-person on-call system, and that it could only do so after that date by the provision of extra funding. However, it also noted that NHC had not earlier sought further funding for the purpose of reason, and that its focus was on securing a greater police presence. It also noted some evidence during the Coronial Inquest that NHC many years before had in fact operated such a system.

Section G headed: Other matters, does not contain anything of particular significance to the Terms of Reference. It records a number of Improvement Notices issued by a SafeWork SA Inspector in late 2021 which have not fully been rectified by the date of the Brief of Evidence.

I move to my views about the adequacy of the investigation, and to comment on some matters raised by Keith and his family.

It is a matter addressed in detail in the next section of this Report, but it should be noted that the communications of SafeWork SA to Keith and his family about the progress of the investigation, were not sufficient to satisfy him that all that could have been done was at the time being done. The explanation for that is found in section 271 of the WHS Act, also discussed later in this Report. If one starts with the level of suspicion and distrust for SafeWork SA that Keith and his family held, that relative paucity of that information may well have fuelled his concerns. I suspect that Keith did not know that the Prosecution Minute and the Brief of Evidence in its terms was supportive of a prosecution in the terms I have set out above. I note also that Keith and his family were not aware that the investigation team had travelled to Fregon in November 2021 for the purposes of their investigation, and in my first interview with them they were concerned that that had not been done.

In short, in my view, the investigation was adequate, and was as thorough as it could reasonably have been. Given the past history, it is understandable that Keith and his family might have thought that it was not good enough. However, there are no signs of inadequacy. Keith and his family referred to several persons who they thought should have been questioned for the Brief of Evidence. I checked the names and there are statements from all of them. They referred to the obtaining of information from NHC and its officers under section 155 of the WHS Act. That was done as much as possible.

It is worth recording that, after the 2018 investigation, when NHC declined to respond to such notices, such notices were used extensively.

Section 155 of the WHS Act provides:

> *(1) This section applies if the regulator has reasonable grounds to believe that a person is capable of giving information, providing documents or giving evidence in relation to a possible contravention of this Act or that will assist the regulator to monitor or enforce compliance with this Act.*
>
> *(2) The regulator may, by written notice served on the person, require the person to do one or more of the following:*
>
> > *(a) to give the regulator, in writing signed by the person (or in the case of a body corporate, by a competent officer of the body corporate) and within the time and in the manner specified in the notice, that information of which the person has knowledge;*
> >
> > *(b) to produce to the regulator, in accordance with the notice, those documents;*
> >
> > *(c) to appear before a person appointed by the regulator on a day, and at a time and place, specified in the notice (being a day, time and place that are reasonable in the circumstances) and give either orally or in writing that evidence and produce those documents.*

A failure to comply with a requirement set out in the notice issued under section 155 of the WHS Act (section 155 notice) is an offence. The person upon whom the notice is issued may find recourse in sections 172 and 269 of the WHS Act, which state that the person is excused from providing information if that response may incriminate that individual, or if the response would disclose or provide information that is subject to legal professional privilege, respectively. Consequently, they are a powerful investigative tool.

On 3 August 2021, Mr Farrell, holding a delegation from the regulator pursuant to section 154 of the WHS Act, issued a section 155 notice to the following person at the request of the investigation team, on the basis that there existed reasonable grounds to believe that they could give information and provide documents in relation to a possible contravention of the WHS Act, namely regarding the investigation into NHC after the death of Gayle.

- → Commissioner of SAPOL
- → NHC

On 3 September 2021, another section 155 notice was sent to the Commissioner of SAPOL to seek clarification and further inquire after a response was received to the initial section 155 notice. A response to this was received by SafeWork SA on 24 September 2021.

On 27 October 2021, another section 155 notice was sent to NHC to seek further information. This consisted of 30 detailed queries for information mainly related to the nature and circumstances of employment for an on-call nurse at NHC prior to the death of Gayle. It was refined in response to NHC's initial provision of information.

On 21 December 2021 and 22 December 2021, Glenn Farrell issued a section 155 notice to the following persons, on the basis that there existed reasonable grounds to believe that they could give information and provide documents in relation to a possible contravention of the WHS Act, namely regarding the investigation into NHC after the death of Gayle.

→ John Singer, Executive Director of NHC
→ Mr Busuttil
→ Vivien Hammond, Clinical Services Manager of NHC

On 21 January 2022, Ms Hammond and Mr Busuttil separately declined to answer a majority of the queries included in the section 155 notice issued to them individually, claiming that a response providing information and documents to the questions may incriminate or expose them to penalty (see section 172). On 25 January 2022, Mr Singer provided the same response to the majority of the queries contained in the section 155 notice issued to him.

An evaluation of each section 155 notice issued during the SafeWork SA investigation indicates a thoughtful and thorough inquiry to gather information and documents. The requests and queries put to the persons in receipt of the section 155 notices were detailed and of a nature that would provide information that would be relevant to establishing a breach under the relevant sections of the WHS Act.

Keith and his family also raised the question whether Mr Dudley was further questioned, as a pathway to proving that Gayle was engaged in nursing duties when he somehow took the opportunity to abduct her as she had opened the cage. The Prosecution Minute records that, at the time it was submitted, he had not been further interviewed. The efforts to interview him were ongoing. In fact, that interview took place shortly afterwards. There is a recording of it available. He adhered to what he had said through his counsel in the sentencing submissions. That is a version which the sentencing judge said was simply not credible. It did not accord with Gayle's invariable practice, when responding to a buzzer for some medical services, and as described by Keith.

Ultimately, their Prosecution Minute raised for consideration whether, in respect of any of the duties imposed under the WHS Act, NHC or its directors had breached any provisions of section 32 (Category 2) or section 33 (Category 3) of the WHS Act. As noted in the 'Legislation' section of this Report, the difference between those provisions is simply that the Category 3 offence is committed if the person (NHC) has a health and safety duty, and that person fails to comply with the duty, whereas the Category 2 offence has the additional element that the failure to comply with the duty exposes an individual employee to a risk of death or serious injury of illness. There were two additional possible breaches of regulations identified: Regulation 34 – Duty to identify hazards; and Regulation 39(2) – Provision of information, training and instruction. Obviously, they were subsidiary to the principal potential offences identified. They did not arise in my discussions with Keith and his family or with the SafeWork SA persons who I interviewed as a matter of significance to the Terms of Reference.

The Prosecution Minute shows that the investigators have identified each fact necessary to be proved to make out the charges to which they referred.

The hard copy of the Brief of Evidence includes 24 folders of material, including the necessary chains of evidence. It shows that the evidence obtained by the Coroner was obtained and carefully considered. It shows that the evidence obtained by SAPOL was also obtained and carefully considered. It shows that NHC and its officers were required by notices issued under section 155 of the WHS Act to produce relevant documentation held by NHC, and that those documents were also carefully considered. It shows that additional inquiries were made as considered appropriate to ensure that the evidence presented in the Prosecution Minute was as comprehensive as it should have been.

For those reasons, in short, in my view the investigation carried out by SafeWork SA was adequate. Indeed, in my view, it was comprehensive and thorough and conducted effectively.

In the circumstances, particularly having regard to matters of concern to Keith and his family, it is necessary to add something about why there was no prosecution.

As noted, the Prosecution Minute was submitted to senior and junior council. On 8 April 2022, shortly before the expiration of the 12 months additional limitation period, the advice was given to SafeWork SA that a prosecution should not be instituted. Mr Campbell accepted that advice.

I have confirmed that the advice given, in a lengthy session, is adequately summarised in the following (which I have confirmed with the senior counsel as an accurate summary). This is necessarily only a summary and broad overview of what was expressed at that meeting and does not reflect the detail and complexity of the issues which were canvassed at length in the legal opinion provided to SafeWork SA.

> The available evidence is not sufficient to prosecute NHC and its Directors contrary to provisions of the WHS Act. There is no reasonable prospect of convicting NHC for offence/s contrary to ss32 and 33 of the WHS Act and regulations 34 and 39(2) of the Regulations.
>
> Primary Duty of Care Owed:
>
> A primary duty of care under s19(1) of the WHS Act provides that:
>
> (1) A person conducting a business or undertaking must ensure, so far as is reasonably practicable, the health and safety of—
>
> (a) workers engaged, or caused to be engaged by the person; and
>
> (b) workers whose activities in carrying out work are influenced or directed by the person,
>
> while the workers are at work in the business or undertaking.
>
> According to section 30 of the WHS Act, this is a *health and safety duty*.
>
> Subsection 19(3) of the WHS Act provides that the duties of a person conducting a business or undertaking ('PCBU') include:
>
> (a) the provision and maintenance of a work environment without risks to health and safety; and
>
> (c) the provision and maintenance of safe systems of work; and
>
> (f) the provision of any information, training, instruction or supervision that is necessary to protect all persons from risks to their health and safety arising from work carried out as part of the conduct of the business or undertaking.

NHC had a health and safety duty to Gayle, who was a Community Health Nurse in Fregon, employed by NHC. However, it is unlikely to attribute from the evidence that NHC contravened its health and safety duty and committed offences under the WHS Act and the Regulations.

Breaches of the Health and Safety Duty:

It was explained that a provision constituting a breach of a health and safety duty owed by NHC will only apply if the prosecution can prove its respective elements beyond a reasonable doubt.

In relation to both the offences in sections 33 and 32, the prosecution would be unable to establish beyond reasonable doubt certain elements of the offences. These involved issues of causation and the proper identification and particularization of the risk to which an employee was exposed. Once that risk was particularised, a determination would need to be made that NHC failed to take all reasonably practicable measures to eliminate or minimise that risk. The failure to take all reasonably practical measures provides the connection between NHC's omissions and the particular risk.

It is necessary to show beyond reasonable doubt why Gayle opened the cage gate/door on the occasion when, obviously, Dudley Davey was in the vicinity. The senior counsel pointed to the following features from the available evidence to support the view that it could not be shown beyond reasonable doubt that Gayle was doing work as part of her on-call nursing duties when she opened the cage door. First, the evidence showed that she was a careful person and would not open the cage door when she was confronted by an unknown male person. Second, there was no evidence that Mr Davey had pushed the buzzer, or telephoned the house, other than the fact that Gayle had got out of bed and gone to the veranda area. Third, the evidence was that Gayle had followed her usual on-call procedure with the placement of the nursing pouch, the keys of the house and the cage, and the keys to the ambulance, and laying out her work clothes adjacent to her bed. The evidence as to what happened to those items was unclear and in particular could not explain in what circumstances the keys of the ambulance had been removed. Also had Gayle been intending to leave the caged area to attend the clinic with a patient she did so without following her normal routine of dressing in her work clothes and putting in her dental plate. There would have been no reason for Gayle to open the cage door had anyone presented merely asking for analgesics which could have easily been passed through the cage. Those factors meant that it could not be shown beyond reasonable doubt that she had opened the cage door for an activity involving her nursing duties. There remained a reasonable possibility that could not be excluded that she opened the cage door for a reason unrelated to patient care and in circumstances which remain unclear. Ultimately it could not be established that Gayle was at work in the business or undertaking when she was attacked.

Another element requiring proof was what would have been reasonably practicable for NHC to do to eliminate or minimise that particularised risk, even assuming that it was the risk of being induced to open the cage door, in the course of nursing duties as the on-call nurse. The offences, require proof beyond reasonable doubt that a person must

be exposed to the risk and the employer has failed to take all reasonably practicable measures to eliminate or minimise that risk.

To establish measures which would have been reasonably practicable for NHC in eliminating and minimising the identified risk was challenging and cost prohibitive. Following the death of Gayle, NHC established a system whereby a second person would accompany on-call nurses at all times when performing their duties. Without being able to show that Gayle had been attacked and abducted by Mr Davey in the course of patient care, it could not be shown that such a measure would have protected her from the events which happened. On the available evidence, it could not be established that it would have been reasonably practicable to introduce such a system at the material time. There is an inherent risk in all interactions between nurses and patients. Other suggestions raised by the material, such as having an armed guard to protect the nursing staff from the identified risk in performing their duties as an on-call nurse, or the closure of the Fregon clinic altogether, or the closure of the on-call after hours nursing service, could have minimized or eliminated such risks but could not proved to be reasonably practicable or would necessarily have resulted in the complete withdrawal of services.

The main problem to prove a breach of those provisions beyond reasonable doubt is that it is unknown and unable to be credibly determined how Gayle was exposed to any risk that might be said to have existed and in particular that she was at work in the business or undertaking of NHC when she was attacked and abducted.

That assessment does not involve any matter of a shortcoming in the investigation. The primary reason for not prosecuting is the circumstance that the evidence cannot exclude beyond reasonable doubt that Gayle opened the cage that night for reasons unrelated to her nursing duties. Had she followed her normal practices in the circumstances to provide nursing duties, the cage would not have been opened. The Coroner's Report explains why, for the purposes of his findings, he was not confronted with that onus of proof.

I have considered specifically whether there was any other evidence that might have been explored on that topic. None was suggested either by my inquiries, including from the lawyer for Keith and his family.

It is also my view that, even if the inquiries made during 2021/2022 had been undertaken during 2016, or 2018, the evidence would not have been any different. The statements do not suggest that there was any difficulty in recalling the events of 23/24 March 2016 or the surrounding period. The documentary records of NHC are all still available and have been procured. There is no reason to think that any officer of NHC had any greater knowledge of why the cage came to be opened that night, even if questioned earlier. Their evidence to the Coroner does not suggest that.

The lawyer for Keith and his family also raised the correctness of the approach of counsel advising SafeWork SA in the period after the Prosecution Minute and the Brief of Evidence was delivered.

The short point is that it is not an element of the offences suggested by the investigation team in the Prosecution Minute that any person necessarily be injured. There can be a contravention without there having been an injury.

The lawyer pointed to the judgment of Doyle CJ in the Full Court of the Supreme Court of South Australia in *Diemould Tooling Services Pty Ltd v. Oaten* [2008] SASC 197, especially at [32] – [35]. That case involved an attack by the accused entities against the validity of the formal complaints against them under the predecessor legislation to the WHS Act, namely the *Occupational Health Welfare and Safety Act 1986* (SA). The senior counsel who advised SafeWork SA in the present circumstances, in response to that comment, accepted that the death of Gayle is not an element of the offences for which prosecution was suggested by the Prosecution Minute, but that it would be necessary to provide the detail of the nature of the risk to which Gayle was exposed to properly particularise the charge. NHC would be entitled to know what was the particular risk from which it had failed to protect Gayle, and other nurses employed by NHC. In the present circumstances, he said that would involve asserting and establishing why Gayle had opened the cage that night. I do not think that the decision of Doyle CJ referred to indicates that, for a prosecution to be undertaken of the character proposed by the Prosecution Minute, such particulars would not have had to be given (see at [35]).

THE COMMUNICATIONS WITH MR KEITH WOODFORD AND HIS FAMILY

I have referred above to the communications between SafeWork SA and Keith and his family to the time of the Coroner's Report on 15 April 2021. This section of my Report addresses their engagement in the period after 15 April 2021.

It is appropriate to repeat, however, that by that time Keith had lost faith in what SafeWork SA had done, or was intending to do, in investigating matters surrounding Gayle's death.

Keith and his family had a strong view that NHC by that time should have been prosecuted for a breach of sections of the WHS Act. That had not happened. Keith at least believed up to the letter of 28 September 2018 that SafeWork SA was still investigating with a view to prosecuting NHC because of some form of 'loophole, enabling a prosecution outside of the 2 year limitation period. He learned by that letter first that there was no such 'loophole' and that, in any event, SafeWork SA (although it accepted that Gayle was performing nursing duties at the time of her abduction and death) did not consider that there was material on which a prosecution should be brought. Mr Campbell's letter of that date explained that the 'loophole' was the prospect of a Coroner's Report with certain findings to extend the time to prosecute.

For the reasons explained above, I do not regard that letter from Mr Campbell to have been inappropriate or inadequate, given his state of knowledge.

In November 2018, Keith and his family engaged Oak Law for advice. His belief that there was a strong case for prosecuting NHC was not discouraged. That is understandable. A strong first impression of the circumstances is that such a prosecution would be appropriate. It was the more detailed investigation by SafeWork SA in 2018 that first raised some doubt about that. In any event, there was then a lapse in any significant communications during preparation for, and during, the inquiry by the Coroner. Keith and his family were represented at the inquiry by the Coroner. As noted, the Coroner's Report made findings (on the balance of probabilities) that also would support the belief that a prosecution should have been brought against NHC, and that during the renewed period of 12 months from 15 April 2021 the prospect of such

proceedings would be further investigated by SafeWork SA and that such proceedings were likely.

It is unfortunate that SafeWork SA did not promptly communicate with Keith after the Coroner's Report was issued. It did take the appropriate step of commencing a further investigation. But it did not contact Keith until some weeks after the Coroner's Report.

In fact, the contact was first made by Keith through his lawyer by letter of 14 May 2021 (that is, a month after the Coroner's Report). That letter referred in some detail to the finding of the Coroner. It referred to the 12 month time limitation. It asked SafeWork SA what action to prosecute NHC was in train, and if Keith and his family could be of assistance.

For reasons which are not clear but may be related to COVID-19 difficulties, that letter was not received by SafeWork SA until 1 June 2021. It was promptly acknowledged on that day, pointing out it was received only on that day. However, it was not until 28 June 2021 that SafeWork SA through Mr Campbell responded by letter to the lawyer. He said that SafeWork had commenced a further investigation (as it had), and that contact would be made with Keith and his family if further information from them was required. It also pointed out that the further investigation did not mean that a prosecution would necessarily result.

I think that the engagement of SafeWork SA with Keith and his family between 15 April 2021 and 28 June 2021, a period of almost 14 weeks, was not adequate. There was sufficient information available to SafeWork SA about Keith's concerns to warrant a more prompt contact, especially given the new 12 month time limitation. I do not attribute to SafeWork SA an awareness of the level of suspicion or distrust which I accept Keith held towards it, so the delay is not as egregious as it may have appeared to Keith.

Thereafter, in my view, SafeWork SA communicated with Keith and his family, principally through the lawyer, about the progress of the investigation in a timely manner. It also conveyed to Keith and his family what information it could properly share, having regard to section 271 of the WHS Act.

It is appropriate to record those communications. There is no dispute about them or their contents. It will be necessary to refer to the contents at the end of this record.

On 1 September 2021, Mr Campbell contacted Keith by phone to discuss what SafeWork SA was doing in some detail. Keith was reluctant to speak to him in detail. Mr Campbell then sent an email to him, copied to the lawyer, that day. It referred to the previous meeting on 23 March 2018 accurately (as I have accepted above), and then to the ongoing investigation. He said the aim was to gather as much evidence as possible. It was a careful and sensible email. Mr Campbell again pointed out that, despite the investigation, there was a risk that there would be no prosecution, or that a prosecution would fail. It invited Keith to contact him if he wished, and to contact Mr Farrell (who he said was in charge of the investigation) if Mr Campbell was not available.

It is a measure of Keith's attitude to SafeWork SA (according to a document produced by Keith's lawyer dated 22 May 2022 describing the communication process) that Keith was then critical of Mr Campbell because he had become the Executive Director of SafeWork SA in September 2017 and so could have influenced the course of events before the expiration of the 2 year limitation period, and that he (Keith) understood that Mr Farrell had led the earlier

investigations and so should not have been involved at all. I have noted earlier that Mr Farrell did not have that role.

On 27 September 2021 the investigation team also contacted Keith to arrange a time to take a statement from him. That meeting took place on 12 October 2021 at the Office of the Commissioner for Victims' Rights.

Ms Killmier had been consulted by Keith and his lawyer, and on the basis of that consultation she had written to Mr Campbell at SafeWork SA on 7 October 2021. Her letter says that she had been assisting the Woodford family for some years. Her letter expressed concern 'about the treatment of the Woodford family' and about the resources of SafeWork SA to understand and inform victims of work occurrences appropriately. It was a forceful letter. In my interview with Ms Killmier, it was apparent that she was not fully informed about the extent of the SafeWork SA's earlier investigations and communications with Keith and his family, or the significance of section 271 of the WHS Act. It is not useful or necessary to deal with all the contents of her letter. It also reflects a different understanding about the purpose of the meeting on 12 October 2021 – the investigation team thought it was to take a statement from Keith; Keith and Ms Killmier thought it was to address 'wider questions about service delivery'.

The meeting on 12 October 2021 was unhelpful, and somewhat rancorous. The investigation team agreed to provide a short statement for Keith simply adopting his statement to the Coroner. That involved two further emails during October and November 2021; it was received on 12 January 2022. From Keith's perspective, it simply provided another occasion showing lack of progress towards a prosecution. It also resulted in Keith requesting future communications to him be sent through his lawyer.

On 12 October 2021, Mr Campbell for SafeWork SA responded to the letter from the Commissioner for Victims' Rights in which he refuted the majority of her assertions and explained why they were erroneous.

In the meantime, Mr Campbell had put in place a procedure whereby the investigation team and senior management of SafeWork SA met on a fortnightly basis to review the progress of the investigation, to make any comments to or to give any advice to the investigation team, and to discuss how Keith and his family could be kept abreast of the investigation progress. They commenced on 2 August 2021, although the fortnightly report to Keith started a little after that. The relevant officer of SafeWork SA was present at those meetings, namely the Contact Liaison Officer (that officer moved to another position in January 2022 but was immediately replaced). Both the persons holding that office were interviewed. They were both well qualified, and I formed the impression that they each undertook their responsibility with proper concern for Keith and his family. As I have noted, their ability to convey to Keith details of the investigation was constricted by section 271 of the WHS Act. They each expressed frustration with the extent to which section 271 inhibited the detailed provision of information to him.

The data extracted from SafeWork SA records includes records of the telephone calls, emails and email reports after the two weekly meetings referred to, as made by the Contact Liaison Officer for SafeWork SA. I am satisfied that the communications were regular and, so far as section 271 would allow, meaningful. Those records show such contacts started in August 2021. After the meeting on 12 October 2021, they tended to be fortnightly. Generally, a telephone contact was followed up with an email. They invited Keith to contact them if he

wished to do so. They did not convey any basis for optimism about the prospect of a prosecution.

Keith regarded the information, that the investigation is progressing, as unhelpful. In fact, some information from the emails, or confirmatory emails is somewhat more informative, but restricted by section 271. It included that further statements are being obtained, and a visit to Fregon was being planned to collect evidence and to speak to other witnesses; subsequent to that visit in November 2021, some general information about the visit and the follow up work was referred to. Later, the need for further section 155 notices, and the procuring of signed statements from witnesses was referred to. When the new Contact Liaison Officer was appointed, she promptly emailed Keith and his lawyer to introduce herself and to provide a little further information about the investigation progress.

That officer informed Keith and his lawyer of the completion of the investigation by email of 31 January 2021, and that the Brief of Evidence had been forwarded to the Crown Solicitor's Office for review. It was made clear that the decision regarding prosecution would be named by the Crown Solicitor's Office and SafeWork SA would be notified of the decision. SafeWork SA then planned a meeting with Keith and his lawyer.

To this point, as I have indicated, SafeWork SA from 28 June 2021 kept an appropriate degree of communication and engagement with Keith and his family. He was sent copies of all communications with his lawyer. It was a conscientious effort, and intended to be as informative as section 271 of the WHS permitted. It regularly invited Keith to contact the Contact Liaison Officer if he wished to do so. There was an ongoing invitation from Mr Campbell for Keith to contact him directly if he wished to do so. From Keith's perspective, from 12 October 2021 he had largely left the responsive communications to his lawyer. The communications during this period were polite.

Having regard to the terms of section 271, I also consider the content of the communications appropriate.

Consequently, apart from the period between 15 April 2021 and 28 June 2021, in my view the engagements of SafeWork SA with Keith and his family during its investigation into a possible offence under the WHS Act was adequate. In my view, it was as frequent as the circumstances called for, and the content of the communications was appropriate and as extensive as permitted by section 271 of the WHS Act.

It is clear that Keith and his family do not share that view. I have endeavoured to explain why that is the case, namely their high expectation that the investigation would lead to a prosecution of NHC, and the progressive development of mistrust of SafeWork SA being prepared to conduct a thorough and reliable investigation, and to reliably report to them of its progress. The mistrust arose from the early decision in 2016 not to accept that Gayle was engaged in nursing duties as the on-call nurse when she was abducted and murdered, and then from a conversation shortly after 23 March 2018 about whether the further investigation then directed by Mr Campbell might lead to a prosecution outside the 2 year limitation period (which was in Keith's view exposed by the result of the 2018 investigation conveyed to him by letter of 28 September 2018).

It is in that perspective that Keith and his family were frustrated yet again by SafeWork SA telling him of the result of the subject investigation – namely that there would be no prosecution

– only on 8 April 2022, but a few days before the 12 month period from the Coroner's Report expired.

It is therefore important to record the communications between SafeWork SA and Keith and his family, and their lawyer, in the period between the email of 31 January 2022 and that date.

The process from the submission of the Brief of Evidence to the Crown Solicitors Office was a little complex. Internally, the Brief of Evidence was referred to the Crown Counsel Section which recommended engaging independent experienced counsel to provide the advice. That recommendation was made on 9 February 2022. Enquiries were made about the availability of counsel to advise. Their engagement required the formal approval of a senior officer under a Treasurer's Instruction. That approval was given, after the proposed counsel indicated their availability, on 16 February 2022. The counsel were then formally engaged and proceeded to consider the Brief of Evidence. They were aware of the deadline expiry date for any prosecution, namely 15 April 2022.

As noted, the advice was given orally on 8 April 2022. Mr Campbell telephoned Keith on 11 April 2022 to inform him of the advice, and of the decision not to prosecute.

SafeWork SA during that period had no control over the process. It made enquires as to its process and confirmed the critical expiration date. On 14 February 2022 the Contact Liaison Officer reported that there were no developments, and that the next fortnightly meeting would be on 28 February 2022. The lawyer for Keith and his family was also conscious of the passing of time. He expressed concern in an email to SafeWork SA on 14 February 2022, and received a sympathetic email response on 17 February. The lawyer for Keith followed up, expressing increasing concern, on 8 March 2022. The response of that date indicated that it was anticipated that an update would be provided shortly. That was given on 10 March 2022, conveying that an independent counsel was reviewing the Brief of Evidence. The lawyer wrote again on 21 and 22 March 2022 saying that the delay was 'very concerning' and that leaving Keith and his family 'in limbo' until the last minute would be most distressing, and would leave them believing that they had been denied justice. SafeWork SA through the Contact Liaison Officer acknowledged that in their correspondence, but could not do more than point out that the Brief of Evidence was being reviewed by senior counsel. It was followed by an invitation to a meeting on 29 March 2022 to answer the concerns of Keith and his family, after the Contact Liaison Officer spoke to Mr Farrell about the ongoing and understandable concerns of Keith and his lawyer.

That meeting took place electronically on 29 March 2022. It was obviously a somewhat unhappy meeting. SafeWork SA could say little more than that the investigation had been thorough, with a large number of interviews and extensive documentation. It referred to the Brief of Evidence being reviewed by senior counsel. Keith did not take much part because he was so upset with the then state of affairs. His lawyer was forcefully critical of the delay, describing it as 'unforgiveable'. Ms Killmier also attended and expressed concern if SafeWork SA allowed the limitation period to elapse.

That was followed by the telephone notification given to Keith by Mr Campbell on 11 April 2022.

It should also be noted that the lawyer for Keith and his family on 12 April 2022 requested a copy of the written opinion of the counsel immediately. On the same day, SafeWork SA responded, saying that the release of the written opinion was for the Crown Solicitor's Office

to determine. However, it offered that the senior counsel who had provided the advice to SafeWork SA at a conference on 8 April 2022 was prepared to give the same presentation to Keith and his family, and the lawyer, on 14 April 2022, and also to make the investigation team available to Keith and his family for discussion and questions. There was further communication about that request and proposal. The end result was that the written opinion was not made available because it is the subject of legal professional privilege, and the offer of the meeting was refused by Keith and his family.

During this inquiry, the counsel indicated to me that he was prepared to make the offered presentation to Keith and his family. I conveyed that, and consistently with their view that there should have been a prosecution but that opportunity was lost to them, the family conveyed that there was no point in having such a meeting.

That course of events indicates that, despite the suspicion of Keith and his family that the lateness of the decision not to prosecute NHC was at least in part to preclude them from having any direct input into that decision before the time limitation expired, SafeWork SA had no role in the progress of the consideration of the Brief of Evidence after it was delivered to the Crown Solicitor's Office, and it impressed on the relevant officers the date when the time limitation would expire.

MATTERS ARISING FROM THE REVIEW

This aspect of the Terms of Reference can be addressed briefly. The comments above have foreshadowed them.

First, I consider it appropriate to review the terms of section 271 of the WHS. It is the 'Confidentiality of information' provision. Its relevant terms are set out in the section of this Report describing the legislation.

Its terms are very prescriptive. They have played a part in the extent to which SafeWork SA conveyed to Keith and his family the progress of the investigation, and hence its capacity to satisfy him that the investigation was progressing in an appropriate way. SafeWork SA, through Mr Campbell and its two officers directly responsible for communicating with Keith and his family, was mindful of the difficulty of passing to them as much information about the progress of the investigation as they would have preferred.

Obviously, there is a balance to be struck between the disclosure of information procured in the course of an investigation by an authority such as SafeWork SA on the one hand, and the desirability of protecting both the integrity and effectiveness of the investigation and the privacy of those who give information to the investigating authority on the other. It is not for this Report to propose any particular form for an amendment to that section. That balance is a matter of public policy. The Commissioner for Victims Rights established under the *Victims of Crime Act 2001* (SA) would obviously have an input into setting an appropriate balance. In my interview with her, she indicated that both SAPOL and the DPP, under the applicable legislation, are able to meet an acceptable balance.

Second, I draw attention to section 231 of the WHS Act headed 'Procedure if prosecution is not brought'. It provides for circumstances where a person (and relevantly for present circumstances a victim of crime) considers that a Category 1 offence or a Category 2 offence has occurred and there is no prosecution within the period of not less than 6 months and not more than 12 months after the relevant event said to constitute the offence, the person may

request the regulator to bring the prosecution. The regulator is then required to respond within 3 months, and depending on the terms of the response, the person may in effect require the regulator to refer the matter to the DPP, who in turn must advise whether a prosecution should be brought.

The procedural steps specified clearly have in mind the 2 year limitation period.

That provision might have been acted upon by Keith following the first investigation, and when he was first told by letter of 25 November 2016 that the file had been closed and no prosecution was then intended. The later events took place well outside the outer 12 month period.

It may be appropriate to consider whether that section might be amended in some way to accommodate circumstances where section 232(1)(b) has been enlivened by a coronial report to create a further 12 month period within which to bring proceedings.

I am not to be taken to be suggesting that any advice from the DPP in this matter might have been different from that of the independent counsel engaged by the Crown Solicitor's Office to give advice on that matter.

An alternative suggestion that emerged from Keith and his family is to consider reviewing the benefits of a limitation period for prosecutions as opposed to the benefit of being able to prosecute employers who do not comply with their duties under the WHS Act after any limitation period expires. It was also a matter raised by the Commissioner for Victims' Rights at the interview with her. That topic was not much explored, save to make the point that, as the events unfolded in early April 2022, Keith and his family effectively had no time to consider the decision not to prosecute NHC or to make any representations they might wish to make before the limitation period expired. Consideration might be given to extending the limitation periods specified in section 232, or to provide an opportunity to formally seek from a Court an extension of time in certain circumstances. The scope of my inquiries does not enable me to do other than to note the suggestion.

Third, Gayle's Law came into force on 1 July 2019. Pursuant to section 77M of the *Health Regulation National Law (South Australia) Act 2010* (SA), it was required to be independently reviewed within 2 years. The review has been carried out and was tabled in the Parliament on 27 May 2021.

Keith and his family made submissions to the review.

SA Health responded to the recommendations in the review in September 2021.

Keith and his family were invited to make any additional suggestions about the amendment of Gayle's Law in the light of their knowledge of the risks to which nurses in remote and isolated areas must work. They indicated that they would prefer to make any further suggestions in the event of any further review of Gayle's Law.

SUMMARY OF CONCLUSIONS

As the detailed discussion in this Report indicates, I have concluded that:

1. The investigation by SafeWork SA into whether Gayle's death following the Coroner's Report of 15 April 2021 gave rise to a reasonable prospect of conviction for an offence contrary to the WHS Act was adequate, and was a comprehensive and careful investigation;

2. The engagement of SafeWork SA with Keith and his family during that investigation into a possible offence under the WHS Act:
   (a) The engagement was generally as extensive as permitted by section 271 of the WHS Act, and in that context was adequate, but in the period from 15 April 2021 to 28 June 2021 there should have been some communication about the commencement of the investigation;
   (b) from the perspective of Keith and his family, the engagement was not adequate but their perspective was coloured both by their expectation that the investigation would lead to a prosecution, and by a misunderstanding that arose as to the significance of the earlier investigation conducted by SafeWork SA in 2018;
3. It is appropriate to consider amending section 271 of the WHS Act and appropriate to consider whether to amend in some way sections 231 and/or 232 of the WHS Act.