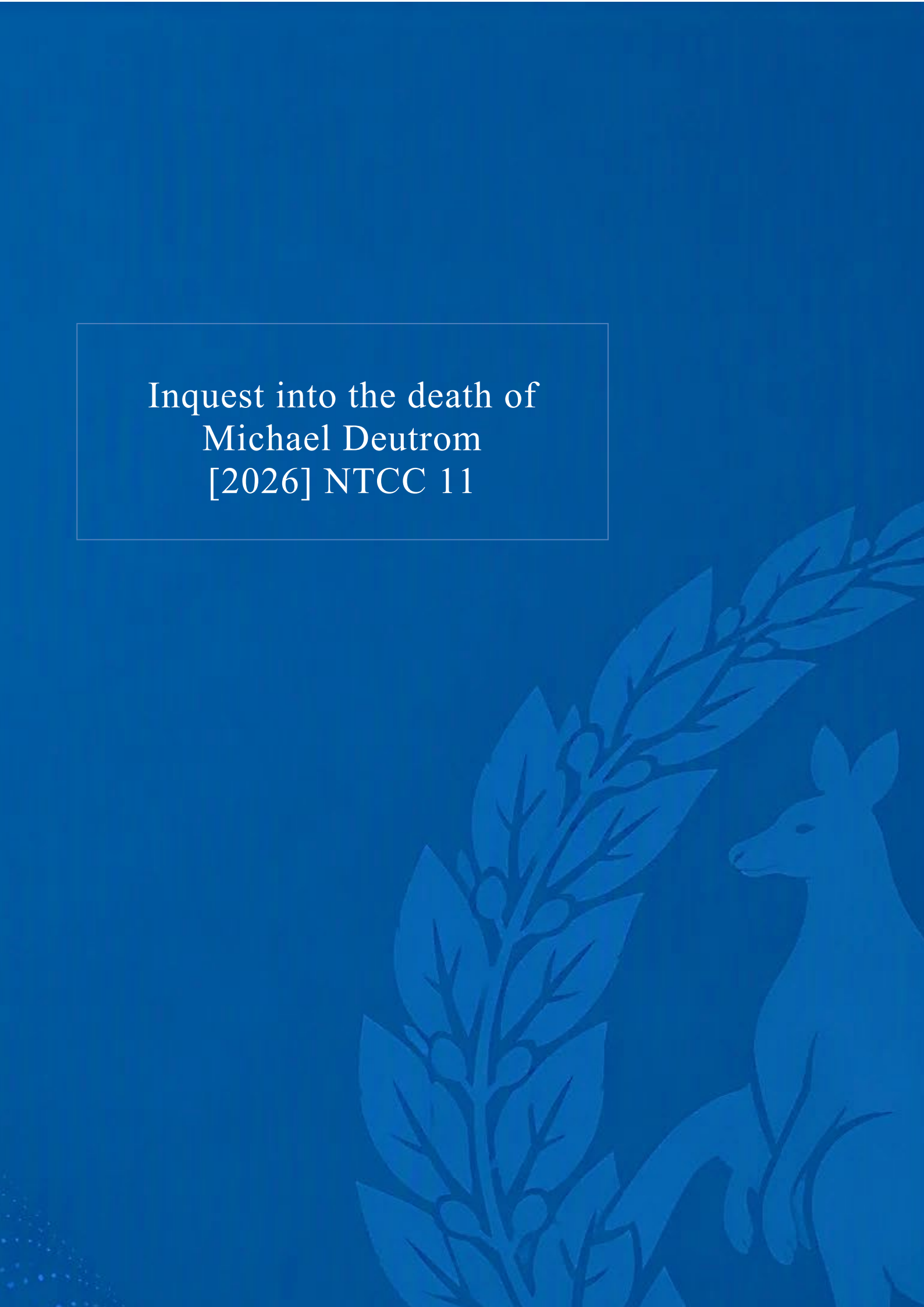
Inquest into the death of Michael Deutrom [2026] NTCC 11



Content Advice

These findings consider the suicide death of a serving member of the Northern Territory Police Force.

The content may be particularly distressing for serving and former members of the Northern Territory Police Force and their families.

CITATION: *Inquest into the death of Michael Deutrom [2026] NTCC 11*

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REPRESENTATION:

Counsel Assisting:	Chris McGorey
Counsel for Police:	Mark Roberts
Counsel for NTPA and Family:	Ray Murphy

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IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0077/2023

In the matter of an Inquest into the death of

MICHAEL DEUTROM

ON: 16 APRIL 2022
AT: SOUTH AUSTRALIA

FINDINGS

Judge Elisabeth Armitage

Introduction

1. This is an inquest into the death of Michael Deutrom (**Michael**).

2. Michael died on 16 April 2022 from a self-inflicted ligature asphyxiation. This occurred at his parents' home in South Australia, where Michael was temporarily staying. He was found deceased by his parents.

3. Michael is dearly loved by his parents, Victor and Meredyth Deutrom; his siblings, Gary, Antony, and Tiffany; and his extended family. His death has had a devastating impact on them, his friends, and his colleagues.

4. Michael was a sworn officer with the Northern Territory Police Force (NTPF) from March 1999, when he was 21, until his death at age 44.

5. Michael loved being a police officer. He was well-liked and respected by his peers. He received multiple commendations throughout his career. He primarily worked in *frontline* roles, including in regional and remote communities. He embodied the attributes the community hopes to see in its serving members.

6. Michael took his own life after suffering a severe mental health injury caused by his exposure to trauma and stress on the job, which had rendered

him unable to work. The symptoms of his injury, combined with the sudden need to go off work in late January 2022 and the uncertainty about his next steps after spending 23 years as a frontline police officer, devastated him.

7. I recognise Michael's family's participation in these proceedings. Many of his family were present in court and online throughout the hearing. Other NTPF officers, serving and former, also viewed the proceedings. Michael was dearly loved. Michael's family made clear their desire for Michael's experiences to be used to educate others about the risks posed to members' mental health and to ensure that lessons are learnt as to interventions and supports that might help other members in the future.

8. These proceedings offer all participants an opportunity to step back and ask what happened and whether there are lessons to be drawn from his tragic passing. What is learned from Michael's tragic passing will hopefully help others in frontline roles better understand the mental health risks they face.

9. This inquest has been assisted by the receipt of expert psychiatric opinions from Dr Mary Frost (Dr Frost) and Professor Andrew ("Sandy") McFarlane (Prof McFarlane). Both reviewed documentary material and prepared written reports, which were tendered. Both also gave oral evidence. I also received literature, including reports by Beyond Blue and reviews and findings of the Royal Commission into Defence and Veteran Suicide.

10. Ultimately, I accept Counsel Assisting's submission that there were missed opportunities regarding Michael's diagnosis and related interventions. This conclusion considers the evidence available in these proceedings and the expert opinions. I also agree that this conclusion must be understood as qualified by the following matters.

11. This is a conclusion reached with the benefit of hindsight that those involved in real time did not have available to them.

12. It is a conclusion reached with the advantage of a broader range of information than was available to the professionals involved with Michael in real time. Chief among those sources are Michael's journal entries, which only Michael had access to before his death.

13. It is important to recognise that Michael had a strong therapeutic relationship with a psychologist, Kim Groves, in the months before his death. His journal entries show how positively he viewed their sessions. They also reveal how appreciative Michael was of the support he received from his family, Ms Groves, his general practitioner, his colleagues, his manager, and members of the NTPF Support and Wellbeing Service. There is no doubt these people were genuinely doing their best to help Michael.

14. I have not definitively found that, *but for* these missed opportunities, Michael's tragic passing would necessarily have been avoided. This does not lessen the importance of my conclusions and the lessons to be drawn from Michael's experiences. This conclusion underscores the need to ask whether there are things that might be done differently in the future to assist members who might be experiencing the difficulties Michael did.

15. Finally, I recognise the profound impact Michael's death has had on a wide range of people, particularly his family and friends, but also his colleagues and the professionals who were endeavouring to help Michael in the months before his untimely death.

STRUCTURE OF THESE FINDINGS

16. In his submissions, Counsel Assisting outlined what he identified as non-contentious facts and separately addressed key issues.

17. I have considered the outline and the submissions, including those made on behalf of the represented parties. Where I have adopted matters submitted by Counsel Assisting, I am satisfied as to their accuracy based on my own review of the evidence.

18. My findings begin with a broad-level examination of Michael's injury, its impacts, and its prevalence in emergency responder occupations ("*Michael's Injury"*). This provides context for the examination of specific events and stages in Michael's career and well-being that follows. The sections that follow are titled:

    (1) Michael's Injury

    (2) Michael's Career.

    (3) Posting to Kintore in early 2021.

    (4) Onset of difficulties by September 2021.

    (5) Events in late December 2021-January 2022.

    (6) Going off work.

    (7) Treatment & Interventions in February-April 2022.

    (8) Michael's death.

    (9) Efficacy of treatment in February-April 2022.

    (10) Wellbeing reforms since 2022.

    (11) Prof McFarlane's review of the Wellbeing Strategy.

    (12) Other reflections / learnings.

19. Finally, before setting out my formal recorded findings under s 34 of the *Coroners Act 1993* (NT), I address the joint submissions made on behalf of Michael's family and the Northern Territory Police Association (**NTPA**). I have considered all written submissions from all parties; however, I consider it appropriate to address specific matters raised in the family/NTPA's submissions.

MICHAEL'S INJURY

Injury

20. I am satisfied that, at the time of his death, Michael was suffering from Chronic Posttraumatic Stress Disorder (Chronic PTSD), complicated by Major Depressive Disorder (MDD). These conditions constituted an injury. They resulted from the cumulative effects of Michael's exposure to trauma and stressors during his NTPF career.

21. These conditions developed over a long period and became debilitating by late January 2022. His symptoms included anxiety; insomnia; heightened vigilance and intrusive thoughts about past traumatic events; loss of pleasure; feelings of guilt and shame about the circumstances surrounding his going off work; and low mood.

22. I am satisfied that by late September 2021, if not earlier, Michael's symptoms had reached the subsyndromal stage. This is a concept I examine in further detail below. Michael managed to push on until the severity of his symptoms reached a *tipping point*, at which his resilience was completely overwhelmed, leaving him unable to continue in the job. The impact on him of going off work on 31 January 2022 was devastating.

Accumulated effects of long-term exposure

23. Michael primarily worked in frontline roles throughout his NTPF career, both in larger population centres (e.g., Darwin) and in remote community postings. He was, unremarkably, exposed to multiple traumatic incidents over his career.

24. In addition to the traumatic incidents he experienced, he was exposed to stressors in the job. The *stressors* referred to here extend beyond what most workers will experience from time to time in a job. Examples of this include:

(1) Members, particularly in a remote community setting, are always feeling "*on*" and unable to switch off after hours and recuperate.

(2) Members having to go to a disturbance in a remote community knowing that backup, if required, is many hours away.

(3) Members at times working extended shifts and after-hours when fatigued.

(4) Members' perception that they are being prevailed upon to push on in stressful conditions or feel that they are not being heard by the NTPF's upper echelon. This itself can cause stress separate to the difficulties in performing the duties asked of them.

(5) Members' worry about being criticised for a particular outcome. In Michael's case, he became increasingly anxious about attending jobs involving people experiencing acute mental health episodes and/or threatening self-harm. The experience of giving evidence in an inquest into the death of a person in custody made him feel he was viewed as responsible in some way.

(6) Members' concerns about letting their colleagues down if they could not perform their duties and the stigma around seeking mental health support. Objectively, there may be no basis in reality for these fears, yet they will nonetheless experience them that way.

25. Michael's injury did not result from exposure to a single traumatic or stressful incident. He continued after each experience, and there was no clear impact on his work performance.

26. His well-being was harmed by the accumulated effects of these exposures over time. Only in the latter stage of his career did the accumulated harm progress to a *subsyndromal* stage before manifesting as a complete injury.

27. As submitted by the Family/NTPA, it is important to understand that individual incidents that may appear to be managed at the time retain psychological significance and can resurface later when a member is under significant pressure.[1]

Subsyndromal symptoms

28. An important lesson to be drawn from Michael's experience is that an emergency responder who suffers a PTSD injury frequently experiences subsyndromal symptoms over a period of time before the injury onset.

29. Subsyndromal symptoms are emerging PTSD symptoms that are increasing in severity over time while falling short of the clinical threshold for a PTSD diagnosis.

30. The member may not recognise what these symptoms are. The member may attribute these symptoms to work pressures or fatigue instead of recognising that the developing symptoms are serious and that, without intervention, their presence is likely to manifest as a clinically diagnosable condition.

31. Once that threshold is crossed, the severity of the injury is such that the member is at significantly increased risk of self-harm, and the intervention required to treat their injury and symptoms is of far greater magnitude than if effective intervention had been identified beforehand. Early identification of members who may be developing subsyndromal symptoms, with effective intervention strategies, is of critical importance.

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1 Family / NTPA submission [248].

32. Prof McFarlane explained the emergence of subsyndromal symptoms as follows:[2]

"*Subsyndromal symptoms are not of sufficient severity to reach the threshold for a diagnosable disorder but are indicative of significant future risk of a full-blown disorder. Importantly, there is little awareness by health professionals, without specific training, that the development of psychiatric disorders needs to be understood across this spectrum of severity beginning with subsyndromal symptoms.*

Subsyndromal symptoms are major predictor of the risk of progression to PTSD with further trauma exposure. This highlights the importance of screening for emerging distress and providing effective [interventions]. There is a significant risk that psychologists without clinical training and specialist expertise in PTSD and related disorder, trivialize and dismiss subsyndromal symptoms as being a normal response to an abnormal event. There is a substantial risk of minimizing the need for intervention when officers present as a consequence. In a culture that requires toughness and the confrontation of danger this problem is compounded, as there are many disincentives to speaking of one's increasing reactivity. Aggression can become a way of coping with increasing anxiety and fear and this increases the risk of police using excessive force in the course of their duties.

It is important to understand from a conceptual point of view that the development and course of posttraumatic stress disorder goes through a series of stages from subsyndromal distress through to acute illness and then on to chronic and pervasive disorder, particularly if exposed to further traumatic events. It is this progression that a Wellbeing and Mental Health Strategy should aim to modify."

33. Examples of subsyndromal symptoms include:

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[2] McFarlane "*Scoping Report of the Wellbeing Strategy 2023-2027 for NT Police"* p.16.

(1) *Hypervigilance* – always feeling 'on', 'wired' or unable to switch off with heightened reactivity to a threat.

(2) *Sleep disturbance / insomnia* – Michael experienced sleep disturbances over multiple months leading up to his going off work. He often woke in the early hours and could not fall back asleep. This impaired his ability to recuperate and compounded his distress.

(3) *Irritability / aggression*: increasing anticipatory anxiety – for instance, Michael became increasingly anxious when dealing with people experiencing mental health episodes.

(4) *Impaired concentration / attention* - increasing difficulties processing multiple sources of information.

(5) *Intrusive memory and triggered reactivity* - intrusive thoughts and rumination about past trauma.

(6) *Numbing or loss of feeling / withdrawal* - a loss of sense of pleasure and increasing social withdrawal and an increasing loss of intimacy in personal relations.

34. Many individuals working long periods in frontline roles often become increasingly symptomatic until they can no longer function. The risk of PTSD injury increases the longer a member works in frontline roles.

35. A member may be able to perform their role even as their subsyndromal symptoms worsen. Their perseverance may *mask* the severity of their symptoms from others. This is what occurred in Michael's case.

36. The member often lacks insight into their developing symptoms and downplays their severity, which may stem from their devotion to their job, stoicism, and concern that they might be perceived as weak or be letting their colleagues down if they seek assistance.

37. For reasons articulated below in these findings, I am satisfied that Michael was experiencing subsyndromal PTSD symptoms by at least late September 2021.

38. There is a high likelihood that his symptoms had crossed the subsyndromal threshold earlier, before he applied for a posting to the Kintore community in the early part of 2021, if not earlier. However, I am not able to make a positive finding in this respect.

Difficulty in a member appreciating their developing symptoms

39. An individual's awareness of mental health risks does not necessarily mean they will realise, in themselves, the toll that the accumulated effects of trauma and stress are taking on their mental well-being.

40. Michael had undertaken on-the-job training in mental health. That did not mean he could recognise, in himself, the toll his exposure to trauma and stress was taking, at least until a very late stage. As he developed subsyndromal symptoms, he largely sought to push on in his job without appreciating the risk that posed to him.

41. This is a recognised phenomenon across many frontline roles involving exposure to trauma, including police, paramedics, and military personnel. Even with training, a member might think, '*never me.'* This is especially true for those who value stoicism and have been high-functioning for a long time.

42. No member can afford to think they are above the risk of a mental health injury. If it could happen to Michael, it could happen to anyone.

Impact of the member being rendered unable to work

43. A member who becomes unable to continue in a frontline role due to a mental health injury often experiences severe distress and shame at the

prospect of being unable to work. This was particularly significant in Michael's case.

Prevalence

44. Other NTPF members, both former and current, will also suffer a mental health injury stemming from their policing careers. This is not unique to the NTPF. It is recognised as arising in emergency responder and military roles.

45. The Beyond Blue's *Good Practice Framework for Mental Health and Wellbeing in Police and Emergency Service Organisations* (2nd version) (**Beyond Blue Good Practice Framework**), which is referenced in the *2022 Wellbeing Review* and informs the Wellbeing Strategy 2023-2027*,* reported:

    (1) One in three first responder employees experience high or very high psychological distress compared with 1 in 8 in Australian adults.

    (2) First responder employees and volunteers report having suicidal thoughts over two times higher than adults in the general population.

    (3) Employees who have worked more than 10 years in police and emergency services organisations "*were almost twice as likely to experience psychological distress and were six times more likely to experience symptoms of PTSD*".

    (4) One in four former employees experience probable PTSD (compared to 1 in 10 current employees).

46. Regarding the risk of suicide, the Beyond Blue Good Practice Framework found:

    "*Suicide prevention needs to be one of the ultimate objectives of any mental health and wellbeing strategy. Between July 2001 and December 2016, death by suicide was attributed to 197 police officers, paramedics*

and fire-fighters in Australia, highlighting the need for serious action to prevent suicide."

47. The risk of self-harm is significantly elevated when the member can no longer work.

48. Secondary to the tragic impacts this injury has on its sufferers are its effects on institutional capacity and resources. This includes higher rates of sick leave, the costs of treating injured workers, and the negative effects on recruitment, attrition rates, loss of experience, and associated costs.

MICHAEL'S CAREER

NTPF career

49. Michael completed his recruit training with the NTPF in March 1999 at age 21.

50. He was first posted as a probationary constable to Katherine. He then served across the Northern Territory, including Darwin, Alice Springs, and remote communities such as Yulara, Mutitjulu, Millingimbi, and Kintore, on both permanent postings and relieving duties. He also undertook a posting in East Timor through a secondment to the Australian Federal Police.

51. Michael preferred front-line duties ("on the road"), including postings to remote communities, and was not interested in promotion. His brother, Antony Deutrom, said Michael had the opportunity for promotion but regularly declined it because he "*knew what he was good at, and he didn't want to become an administrator or bureaucrat, for him this was not being a police officer*." He received numerous commendations over his career.

52. I accept the Family/NTPA's submission that, for Michael, policing was not merely employment – it was central to his self-identity, self-worth, and sense of purpose.[3]

Exposure to traumatic incidents

53. Unsurprisingly, as someone who worked primarily in frontline roles, Michael was exposed to multiple traumatic incidents over his career.

54. The NTPF has a wellbeing unit for its members. This unit was previously known as the Employee Support Services (**ESS**), then as the Support and Wellbeing Unit, and since 2022 as Wellbeing Services. The unit monitored and supported members' wellbeing, including checking in with members who had attended a critical or traumatic incident. Check-ins with Michael give a flavour of the types of traumatic jobs he was exposed to.

55. This included check-ins:

    (1) In March 2012 following his attendance at a stabbing fatality,

    (2) In June 2014 following his attendance on a road fatality involving multiple deaths.

    (3) In December 2014 following his attendance on a truck fatality with the deceased suffering severe burns.

    (4) In May 2015 following the death of a person in custody.

    (5) In May 2017 following his attendance at another fatality.

56. At each of these check-ins, Michael reported that he was fine and had no ongoing difficulties with his well-being.

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[3] Family / NTPA submission [239].

57. This inquest received evidence from self-reports and journal entries Michael made between late 2021 and April 2022. In these, Michael repeatedly referred to three traumatic work experiences that continued to affect him. To be clear, these were not the only traumatic incidents he experienced in his NTPF career, but they were particularly significant in his lived experience.

58. The first concerned a car fatality in August 1999, when he was a probationary constable in Katherine. He was 21 and less than six months out of recruit training. A vehicle he and an offsider had pursued crashed and caught fire. Michael sustained burns to his arms while trying to pull the driver from the burning vehicle. The driver's life could not be saved. These burns left scarring on his arm, which were a constant reminder of the event. The magnitude of this trauma on Michael is evidenced by the fact that, in late 2021, nearly 22 years after the event, Michael reported having recurring thoughts about it when feeling stressed.

59. The second was the death of a male at the Darwin Watchhouse following an arrest in which Michael was involved. Michael was examined as a witness at the inquest into that death and felt he was viewed as partly responsible. The experience left him anxious and distressed when dealing with people threatening self-harm, particularly when he had to take them into custody.

60. The third was an event in Millingimbi in February 2020. At the time, Michael was providing temporary relief in this remote community. Michael and an offsider responded to a pregnant female who was experiencing an acute mental health episode. She verbally abused and assaulted both officers, spitting, biting, and throwing faeces. She falsely alleged a sexual assault against them and attempted self-harm to terminate her pregnancy (**the Millingimbi Incident**).

61. The Millingimbi incident likely contributed to his apprehension about dealing with mentally unwell persons on the job. The related contested hearing was adjourned twice, and the matter was finally resolved at the last

scheduled hearing in November 2021. The time it took for these proceedings to reach finality took a further toll on Michael.

Michael's wellbeing (as of 2020)

62. As 2020 gave way to 2021, Michael's brother, Antony Deutrom, noticed a change in Michael. Michael appeared increasingly frustrated by increased workloads and demands on frontline officers. This was out of character for Michael. Antony spoke with Michael about stepping out of frontline work, taking a break, and encouraged him to consider psychological treatment. Michael sometimes spoke about self-demoting to the rank of a police auxiliary instead of a police constable. There is no evidence of any noticeable decline in Michael's work performance.

POSTING TO KINTORE IN EARLY 2021

Application for a transfer to Kintore

63. In early 2021, Michael applied for an advertised Constable position at Kintore Station. The position had not been permanently filled since mid-2019 and had been covered by relieving members. It carried a minimum two-year tenure.

64. Michael's application was approved, and the role was gazetted to him on 18 March 2021. He formally commenced there on 5 May 2021.

65. In hindsight, some feelings described in Michael's application appear to have been symptoms of his deteriorating well-being. There is no evidence that those who approved the transfer recognised this, or that Michael himself saw them as signs of his worsening mental state. The application also demonstrates his character and willingness to persevere. His stated rationale was:

> *"There are several reasons why I want this position and I would like to focus on three of them. (1)* ***I am in my 23rd year of***

> ***policing in the Northern Territory, predominantly spent in operational response sections****...Earlier in my career I received greater job satisfaction working general duties with a higher volume of workload in both regional locations and in Darwin. At the same time I enjoyed the lifestyle available to living both in these regional areas and in Darwin. Now later on in my career, I am drawn to the opportunity of living and working at a location that is both remote and coupled with a reduced amount of workload compared to general duties in Darwin. (2) The reality for myself is that the longer I spend in my chosen career I am becoming firmer in my belief that my strengths are within community orientated policing. I will receive a greater amount of job satisfaction by becoming more involved in the community I serve.* ***At this time I do not feel the same sense of job satisfaction in my role as a general duties police officer in Darwin. Due to the high workload, I do not have the energy or time to serve the community further outside of work hours****....(3) I have articulated that community policing is my focus and passion. At the same time I am committed to balancing the requirement of enforcement and education within the community.* ***What I can offer the position and more importantly my colleagues and community is a police officer who is committed, faithful to his job and willing to persevere in order to serve the community as best as possible****."*

66. Michael's statements that he had lost a sense of job satisfaction (in general duties in Darwin) and that he felt he lacked energy and wanted to take on a role with a reduced workload were indicators of his deteriorating mental well-being.

Kintore Station

67. Kintore is a small, remote community in the Gibson Desert, with a population of about 493 people. It lies 530 km west of Alice Springs, of which 370 km is dirt road, and 40 km east of the NT/WA border. The NTPF operates a multi-jurisdiction station in the township. The Kintore Police District covers about 14,000 square kilometres, encompassing the township and seven small homeland outstations.

68. As of May 2021, the station was permanently staffed by a Remote Sergeant, Tanya Rutherford (**R/Sgt Rutherford**), who served as the officer-in-charge; a Constable (Michael); and one Aboriginal Liaison Officer. A second Aboriginal Liaison Officer was permanently based there starting in about October 2021.

69. A sworn Western Australian police officer, holding a special constable designation in the NT, also lived and worked in Kintore. That officer's primary responsibility was the remote WA communities near the border, the closest being Kiwirrkurra, about 186 km away. NTPF members in Kintore likewise held special constable designations in WA, and each force assisted the other with attendances and patrols. The WA officer did not attend jobs in WA without at least one NTPF offsider. During Michael's posting, the WA member was Sergeant Matthew Parsonson (**Sgt Parsonson**).

70. The standard roster was Monday through Friday, 8am to 4pm, with after-hours work as required. Community members can make after-hours calls to a non-emergency number. These calls are handled by the Joint Emergency Services Communications Centre (**JESCC**) in Darwin, which assesses them and determines whether locally based police should be recalled to duty.

Challenges involved in remote posting

71. Many officers find remote postings rewarding and love the work; however, it also comes with its own challenges.

72. R/Sgt Rutherford described her feelings about her time in Kintore as follows - "*I can say that it's the best time of my career out at Kintore, but it's also the worse, if that makes sense,"* and that it was not Kintore itself but "*just all the things you have to deal with*."

73. The challenges a remote posting may pose to a member include the following.

74. *First*, geographical and social isolation, with the member being distant from family and friends and lacking opportunities for social activities. There are likely to be limited professional supports available in the community (psychology, etc.).

75. *Second*, the member's proximity to the people they encounter in the job. The member is not separated from the community they serve in the same way as in larger population centres.

76. *Third,* the member will be one of two or three officers responsible for a large geographic area. There may be no other officers within several hours' travel. The member may have to respond to callouts after hours and on weekends. The member may be approached after hours as well.

77. Some remote communities may be far from transportation hubs, requiring significant travel time. For instance, when Airwing is unavailable for prisoner transport, members in a community like Kintore must drive the prisoner to a drop-off point that is a three-hour drive each way on a dirt road.

78. On occasion, a member may be required to work 'one-up,' meaning they are in the community and attending to jobs without an offsider.

79. *Fourth*, some communities are marked by dysfunction and social difficulties.

80. R/Sgt Rutherford described her experiences with outbreaks of communal violence in Kintore. These came in "*waves*" and could last days or weeks at

a time. While this was happening, members still had to tend to their usual duties (vehicle accidents, domestic violence incidents, break-ins, etc.). On one occasion, she had to be temporarily evacuated from the community. Even during lulls, she sometimes remained '*on alert'* in anticipation of another disturbance unfolding.

81. *Fifth,* members attending after-hours *callouts* and being contacted by community members after-hours. R/Sgt Rutherford described her experience with "callouts" in Kintore as follows:

> *"Callouts were common, but not every day. It would be in waves, depending on what was going on in community and if there were some people that were causing issues or disturbances. This could include assaults, domestic violence, mental health incidents, disturbances in general, property offences, missing persons, and deaths. There were times when after making an arrest and the offender being remanded, we would stay up all night looking after the prisoner, then drive them to a halfway point at Papunya, only to turn around and drive back to Kintore, making a round trip of over 6 hours. We were often exhausted from the process of handling the remanded prisoners. Calls could come at any time, day or night. Most calls were made to police communications who would assess the incident, then making a decision to call out members or not*."

82. Callouts also occurred *"[i]n waves. So we might not get called out for a couple of weeks, but then we might get called out, like, the following couple of weeks, we might have, you know, more than one callout."* In this respect, R/Sgt Rutherford said:

> "*…This was a tipping point for the stresses of the job working remote.*

...I just know that when we receive these calls, your stress levels would just bounce up. And it's like, "Why? Like, why?" Yeah. Sort of, you know, that sort of – that sort of stress."

[The possibility of the afterhours phone ringing was] in the back of your mind, it was always the phone's going to ring, the phone's going to ring. But you have to try and switch your mind off. I used to put the phone away so I couldn't see it in my house."

83. It is not necessarily the frequency of callouts that is important. It is the member being on-call and available to be called out that seems to have the bigger impact, as it undermines the member's capacity to 'switch off', rest, and recuperate.

Screening for long term remote community postings

84. If Michael wasn't experiencing subsyndromal PTSD symptoms when he submitted his application for Kintore, he moved into that stage within months of his posting there. The environment in Kintore posed significant challenges for anyone, let alone someone whose mental well-being was deteriorating.

85. It is now evident that Michael's posting to Kintore in May 2021 was harmful given his mental well-being. This highlights the importance of comprehensive assessments being conducted *before* the NTPF places a member in a longer-term post in a remote community.

86. I agree with the Family/NTPA's submission that identification of members at risk of developing a mental health injury cannot rely "*exclusively upon self-diagnosis and voluntary self-referral.*"

87. I also accept their submission that "*Michael's length of service, earlier traumatic exposure, reduced energy, expressed desire for a lower workload,*

and his excessive amount of accrued leave were not systematically assessed before his transfer to Kintore."[4]

88. As of 2021, the NTPF does not require a member to undergo a psychological assessment before approving a transfer to a remote posting. Psychological screening is mandated only at the recruitment stage. That remains the case to the present day. In contrast, the WA Police Force requires members to undergo a psychological assessment before transferring to a *Remote Multi-Function Police Facility* (an isolated station staffed by two or three members) and to undergo annual well-being reviews.

89. The purpose of psychological screening is to identify members at risk of mental health injury *before* the NTPF places them in an environment that increases the risk of that injury occurring. Its aim is to identify possible flags for deteriorating mental well-being or injury.

90. The assessment might consider "flags" (outlined further below with respect to accrued leave), a member's work history and performance (e.g., time spent in frontline roles and exposure to trauma), and may involve psychometric testing. The latter may include the DASS-21 and the PCL-5, and possibly the Trauma Symptom Inventory 2 (TCI-2) screening instruments.

91. The use of screening instruments is but one component of a comprehensive assessment. Most critical are the face-to-face interactions between the clinician and the member and the clinician's clinical impression.

92. There is a risk that a member may effectively engage in a "*tick and flick"* exercise with an instrument. This might result from a lack of appreciation or internal resistance to contemplating difficulties with their well-being. It is also possible that some members might intentionally downplay possible

[4] Family / NTPA [354d].

symptoms out of concern for the impacts on their career and/or for appearing weak (e.g., stigma).

93. The clinicians performing the assessments should, ideally, have specialized training in trauma and experience recognizing symptoms indicative of an emergent injury in the context of first responders. Experience managing interactions with members who present as confident and high-functioning is critically important. This will increase the likelihood that the assessment will detect subtle indicators of distress.

94. It may not follow that a member identified as having difficulties must have their posting blocked. Identifying these difficulties may, in some cases, merely require greater monitoring and supports to be put in place for the posting.

95. In Michael's case, the potential flags that a sufficiently experienced clinician might have noticed when he applied for the Kintore posting included:

    (1) The length of his career, with Michael stating he had spent 23 years as a police officer in the Northern Territory "*predominantly in operational response sections,"* is itself a flag that an individual is at increased risk of injury, given the length of time he or she has likely been exposed to trauma and stressors.

    (2) His excess accrued leave (discussed further below).

    (3) His reported growing dissatisfaction with a job he had performed well in for over 20 years.

    (4) Potentially, through questioning about what he felt was contributing to his reduced job satisfaction and his wish for a reduced workload, and by eliciting indications from Michael about his feelings of anxiety about dealing with mentally unwell persons in the job, and

possibly that he experienced recurring thoughts about prior traumatic jobs at times of acute stress.

96. Normalising screening within NTPF culture would be critically important for its effective implementation. This includes ensuring that members are well versed in its purpose, which is to identify in a timely manner whether they have or are at risk of a mental health injury, enabling intervention at the earliest possible stage. It also includes ensuring that an injured member is not placed in an environment that risks compounding their injury.

97. The NTPF said that a recommendation was made to the Executive in November 2024 proposing psychometric assessments for "*certain role types*." If that recommendation is approved, a separate matter for the NTPF to determine is whether that screening would apply to permanent or long-term transfers to remote postings. It is not known whether this recommendation has been approved and, if so, what is intended for transfers to remote communities.

98. I consider it appropriate to make a recommendation to the Commissioner, NTPF, in the following terms:

Recommendation No.1: The NTPF, as a matter of priority, develop and institute a requirement for psychological assessment when a member applies for transfer to a long term remote station posting and any other role that by its nature / demands may pose increased risks to a member's wellbeing (including the subsequent conduct of reviews at fixed times, in response to particular events and at the completion of such a posting).

Michael's excess leave accrual as of May 2021

99. Recreational leave is important for well-being. It enables members to recuperate.

100. NTPF members accrue six weeks of annual leave per year. The amount of leave a member is ordinarily able to accrue is capped at two years (560 hours).[5]

101. As of May 2021, Michael had accrued a considerable amount of recreational leave, totalling 723 hours or 90 days. His accrued leave itself is a 'flag' for increased risk of burnout.

102. Members were required to submit applications for recreational leave before the upcoming annual leave roster. The annual roster is expected to identify, by way of a footnote, any member who is not taking their allocated annual leave in that roster period. The footnote is also to outline the member's and/or the operational reason for why leave has not been rostered. A plan is to be developed for the use of accrued leave. Ultimate responsibility for this rests with the member's superior.

103. For reasons that have not been ascertained, the annual leave rosters for 2021-2022 did not identify Michael's excess leave accrual, nor is there evidence that Michael was required by his supervisors to develop a plan for its use. The NTPF acknowledged that this requirement was not always strictly adhered to in 2021 and as of 2025.

104. A further measure is the General Order requirements for transfer approval. When determining an applicant's suitability for transfer, the *Police Deployment Panel* (**PDP**) must consider whether "*the member is carrying excess leave without express approval or exemption."*

105. In his written Kintore application, Michael stated "*[i]n relation to my projected leave I am willing to renegotiate. I have excess leave and, if successful in my application, would be willing to utilise an amount prior to transferring in order to reduce my balance.*" It is unknown whether the

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[5] The 2019 NTPF consent agreement provided that accrued recreational leave was not to exceed two years' allocation which equates to about 560 hours.

panel considered his excess leave. There is no evidence that an actual plan was requested of him.

106. In July 2025, in response to the issues above, the NTPF:

(1) Issued an agency-wide broadcast reiterating the requirement to keep footnotes and records for annual leave, as required, and to manage excess leave upon transfer to new positions (issued 21 July 2025).

(2) Issued instructions for all members with excess leave to work to reduce excess leave accrual at the earliest reasonable time possible (issued 27 June to 3 July 2025).

(3) Amended the General Order for *Transfer and Promotion of Non-Commissioned Officers* to expressly require members to disclose excess leave and to take it before transfer (except in emergency situations).

107. The NTPF's *Wellbeing Services* is developing an electronic alert for excess accrued leave within its *IAPro* system as part of its *Early Intervention Program*. The alert will prompt an early intervention coordinator to notify the member's manager. This is intended to initiate a conversation between the member and their manager about how the leave will be managed.

108. From May through August 2025, intra-agency work was underway to enable the auto-population of leave data into the NTPF's *IAPro* system. It was estimated that this work would be completed in the latter half of 2025 (it is unknown whether the data project has been finalized or whether this alert is now functional).

109. The NTPF expects that, once the excess leave alert is operational, a member with the amount of leave accrued that Michael had in 2021 will be automatically 'flagged' to ensure the issue is managed.

110. Given the action the NTPF is taking to improve its systems to ensure automatic identification of excessive leave accrual, it is unnecessary for me to make a recommendation on this issue.

Initial period

111. There is no evidence that Michael did not perform his role satisfactorily or had difficulties in his relationships with his colleagues in the months after his posting to Kintore. He was known to be attentive to his fitness and regularly jogged. The officers stationed at Kintore formed close bonds, which were an important source of mental health support. One example was the walks Michael, R/Sgt Rutherford, and Sgt Parsonson frequently took. These walks provided an opportunity for them to unwind and share how they were feeling.

Report of a workplace incident on 28 September 2021

112. On September 28, 2021, Michael and R/Sgt Rutherford each submitted an Accident, Injury, Incident Report Form (AIIR) to the NTPF's Health and Recovery unit. This unit is separate from Support and Wellbeing.

113. The immediate catalyst was a community event both attended to address a recent spike in property offenses. An adult female began yelling erratically, became involved in a violent altercation, and had to be restrained. Later that day at the clinic, she threatened to take her own life.

114. The AIIR reported difficulties stemming from ongoing dealings with two recidivist domestic violence participants and from a spike in property offending, which was "relentless" and persisted despite their efforts. R/Sgt Rutherford's description of the incident is informative about what members are exposed to:

> *"...a female in the community, every few months she'd have, like, a psychotic episode or a really bad behaviour, and then she'd*

have -- and also claims that she's having domestic, like, involved with the domestic violence with her partner. He wanted to try and harm himself and she's she wants to do the same -- just ongoing. It's the same -- this person, every three about every three months she was going on like this. And it was just -- just a really stressful time trying to deal with it. We ended up having to deal with it all day and it happened -- it happened over the -- over the whole time I was there. And there was nothing we could do. Clinic said it's not a -- anything that they could do. We ended up having to deal with it all the time..."

115. The behaviour of the adult female was likely confronting to Michael, given what he experienced during the Millingimbi Incident and the anxiety he felt when responding to persons experiencing acute mental health episodes.

116. On 29 September 2021 a Support and Wellbeing social worker contacted Michael to check on his wellbeing. Michael reported that things were "*starting to take its toll*" and that he had "*experienced adverse mental wellbeing effects.*" He had already contacted Darwin Consultant Psychologists (**DCP**) to arrange a session with a psychologist and was waiting to hear back.

117. Michael otherwise took no leave in response to this notification and no changes were made to his duties.

ONSET OF DIFFICULTIES BY SEPTEMBER 2021

Onset of subsyndromal PTSD symptoms by late September 2021

118. I am satisfied that by the time he submitted the AIIR in late September 2021, Michael was experiencing subsyndromal PTSD symptoms. It is possible Michael had reached the subsyndromal stage earlier, before he submitted his application for the Kintore posting; however, it is not possible to confirm this was the case.

119. By late September 2021, Michael's symptoms included (i) impaired sleep (waking in the early hours and unable to return to sleep) and associated fatigue; (ii) feeling unable to *'switch off'* from work and increased irritability; (iii) increasing anxiety; and (iv) intrusive thoughts about prior traumatic events (these thoughts are detailed further below with regard to Michael's first session with Ms Groves on 9 October 2021).

120. At this stage, Michael was continuing to perform his duties satisfactorily and had not revealed the full extent of his difficulties to his colleagues. This phenomenon, in which an individual absorbs mounting symptoms as they increase in acuity, is commonly referred to as "*compartmentalising.*" The individual's determination to push risks aside masks the severity of their symptoms from others. Because the individual pushes themselves to continue in the job, even as their symptoms intensify, may mask from colleagues and friends how severe their internal experience is becoming.

121. Michael's submission of the AIIR, and his seeking a session with a psychologist were '*flags'* of his deteriorating well-being. Michael, by nature, was stoic and did not like drawing attention to his difficulties. This was the first known occasion on which Michael had sought help for his well-being in his 20-plus-year policing career.

122. Other 'flags' that the NTPF should be mindful of, as well as members with regard to themselves or colleagues, include:

    (1) *Decreased motivation and engagement in exercise/self-care*: In the latter half of 2021, Michael's colleagues noticed that his exercise routine had declined.

    (2) *Reports of fatigue and sleep difficulties*: Michael began telling his colleagues that he was having sleepless nights, sleeping only 2 to 3 hours or, sometimes, not at all.

(3) *Increasingly negative perception of job-related dangers or risks:* Sgt Parsonson described Michael as becoming increasingly preoccupied with the possibility that something adverse would happen on the job and that he might lose his job. Michael also disclosed that he was considering breaking his tenure and going on stress leave, but he worried about how this would appear to others. Sgt Parsonson said he continually reassured Michael that this was not the case; however, Michael repeatedly returned to this topic.

(4) *Out-of-character irritability*: Michael told his brother, Antony, about an occasion when a community member came to his home after hours seeking assistance. Michael said he suddenly yelled at the person for coming to his house. This was uncharacteristic for him. He also described growing frustration with the community and the demands expected of members based there.

123. I accept the Family/NTPA's submission that there was a missed opportunity for the NTPF to identify, upon receipt of this notice, at the very least, his excess accrued leave to that point in time.[6]

124. The Family/NTPA further submits that the submission of the AIIR could have served as a trigger for a comprehensive assessment. I consider there is some force to that submission, accepting, of course, that the NTPF supported Michael in engaging with a psychologist (Ms Groves).

125. Assuming comprehensive screening is introduced in the future as part of the selection for long-term remote postings, it would be beneficial for the NTPF to consider whether events of this kind should trigger a further comprehensive review. I recommend that the NTPF examine this further as part of Recommendation No. 1.

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6 Family / NTPA submission [271].

NTPF mental health supports as of 2021

126. As of 2021, members could access mental health services through the Support and Wellbeing Unit (as it was then known) including: psychological counselling, the Employee Assistance Program, the Peer Support Program, pastoral care, critical incident support, *WellChecks* and return-to-work support.

127. The unit employed clinicians, including at least one psychologist, counsellors (social workers), chaplains and a peer support coordinator. It also had three Wellbeing and Health Officers (roles established in 2015), based in Darwin and Alice Springs, who provided informal mental health support. Peer support officers were trained in mental health and support colleagues by sharing lived experience of the job.

128. Members were also eligible for treatment with external clinicians. An initial "Stream 1" referral (the External Counselling Program) provided up to six paid, confidential psychology sessions (this is the stream through which Michael sought sessions with DCP). If the treating clinician considers more intensive therapy necessary, they can recommend "Stream 2" treatment, which provides ongoing paid sessions beyond the first six sessions.

Michael's engagement with Ms Groves

129. Michael began sessions with Kim Groves, a psychologist practicing through DCP in Darwin, on October 9, 2021.

130. He had telehealth (phone) sessions from Kintore on 9 and 16 October 2021, and an in-person session in Darwin on 23 November 2021 while on leave. Ms Groves did not have the AIIR or Michael's personnel file. Her information came from what Michael told her during their sessions.

131. Ms Groves is a registered psychologist with the Australian Health Practitioner Regulation Agency (**AHPRA**). She has provided employee

psychological services to the entire Northern Territory Public Sector since 2004 and, since 2020, specifically to the NTPF.

132. Her AHPRA registration does not include a clinical psychology endorsement. An endorsement indicates additional qualifications in specified approved areas. Holding a clinical psychology endorsement is not required to practice in the relevant area.

Michael's first session with Ms Groves on 9 October 2021

133. During her first session with Michael on 9 October 2021 (telehealth), Ms Groves noted that:

(1) Michael at times presented "*tearful [at] times discussing past trauma*" though his mood otherwise appeared stable.

(2) Michael reported being four months into a two year posting at Kintore.

(3) He described Kintore to be a "*very stressful environment*" with reference to "constant" shop break ins and a specific individual that threatened self-harm when being arrested and was causing himself and his colleague (R/Sgt Rutherford) significant stress (including, recently, at the community meeting).

(4) Michael reported being worried at arresting people who were at risk of self-harm and was "*sick of constant suicide threats.*"

(5) Michael said he always accepted the principle of "*Service Above Self*" but was "*now finding that difficult.*"

(6) He reported being "*virtually on-call 24 hours a day*" with only two members at the station. His sleep had "*been disrupted for past month*", since he became aware of the upcoming court date for the Millingimbi Incident hearing (set for 15 November 2021, after which he planned two weeks' leave).

(7) He described difficulty dealing with victims and felt increasingly "*negative views of community members*";

(8) He reported heightened anxiety when R/Sgt Rutherford was away; and "difficulties sleeping / anxious / on edge / wired", waking between 10.30pm and 2.30am and falling asleep about 4am.

134. Michael spoke about specific on-the-job experiences that he had recurring thoughts about, including the Millingimbi Incident and the 1999 Katherine car fatality (Ms Groves noted Michael's report "*unable to save. Still has thoughts of this when stressed*").

135. Ms Groves discussed the possibility of Michael taking leave. Michael reported that COVID-19 constraints had prevented him from taking leave. I pause to note that restrictions on recreational leave were applied across the board to NTPF members in 2020 and 2021 due to the response to the COVID-19 pandemic.

136. Michael said he planned to take leave in November 2021, after the contested hearing for the Millingimbi Incident, which was scheduled to commence in Darwin on 15 November 2021, was completed.

137. Ms Groves scored Michael using a K10 and DASS-21 questionnaire. Michael's scores indicated "mild stress" and "mild distress" respectively.

138. Ms Groves recorded her impression that Michael appeared "*well adjusted*" but was experiencing "*significant stressors, triggering event for residual trauma in the context of fatigue.*" There was no evidence of depression at that stage. He believed he could "*cope with work if sleep improves.*"

139. Ms Groves noted that strategies discussed with Michael included not taking work calls on his personal phone after hours and not responding when community members contacted him after hours (outside official reporting

lines). These strategies were primarily intended to improve his sleep patterns.

Michael's sessions with Ms Groves on 16 October and 23 November 2021 and his taking recreation leave in November 2021

140. On 16 October 2021, Michael had a short telehealth session with Ms Groves. He reported feeling "*much happier*" and having slept a full night after their 9 October 2021 session. His main difficulties at that time centred on the upcoming hearing for the Millingimbi Incident and dealing with persons, on the job, who were at risk of self-harming. Ms Groves and Michael planned to review his progress after the hearing was completed.

141. On 15 November 2021, the accused in the Millingimbi Incident pleaded guilty. The hearing was vacated and the witnesses, Michael included, were released. I am satisfied this resolution came as an immense relief to Michael. This is not because he had done anything wrong but because the prospect of giving evidence, which would require him recalling and recounting that traumatic event in court, and his unwarranted fear he might be subject to criticism in some way, was itself traumatising for him.

142. On 19 November 2021, Michael formally commenced recreational leave that continued until 6 December 2021. He spent this leave in Darwin.

143. On 23 November 2021, while on leave in Darwin, Michael attended on Ms Groves in person for what was their final session in 2021.

144. Michael presented as "*happy and relaxed*" and reported feeling relieved that the Millingimbi case was over. He brought chocolates for Ms Groves and her receptionist to thank her for the support she had given him.

145. Ms Groves noted Michael's report that his "*intrusions & focus on past traumas [were] not as significant [and] they are just things I live with but not causing me problems.*" He said he intended to remain in the community

(then approaching his seventh month). Once the posting ended, he thought he would "*explore alternative options in [NTPF].*"

146. Michael said he did not feel further sessions were required, and consequently none were scheduled. Ms Groves recommended that Michael reach out if he needed assistance in the future.

Possibility of PTSD being reasonably enlivened as of October to November 2021

147. I am satisfied that Michael's presentation and reported symptoms in his first session with Ms Groves on 9 October 2021 reasonably pointed to the possibility of PTSD. Accepting that a definitive diagnosis could not be made at that point, the possibility of such injury had to be assumed until it could be reasonably excluded through further sessions and investigations.

148. In reaching this conclusion, I have accepted the opinions of Dr Frost and Prof McFarlane and the matters they identify as significant.

149. I emphasise (again) that there is no doubt about Ms Groves' genuine concern for Michael's well-being and that she did her best to support him. I also accept the submission made on Ms Groves' behalf that, consistent with her concern for Michael, Ms Groves made herself available at short notice and outside normal business hours, including on weekends.[7] As noted at the outset of these findings, I have the advantage of considering a significant amount of information in its entirety, some of which was not known to Ms Groves in real time (e.g., Michael's own journal entries), *and* the benefit of hindsight.

150. Beginning with the matters that arose from the sessions (which Ms Groves noted), key matters were:

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7 Ms Groves submissions [17].

(1) Michael had worked extensively in frontline policing roles for 23 years. This was the first time he had reported significant difficulties with his well-being and coping. This was the first time he had sought psychological assistance for these difficulties. The change in his ability to manage is a significant 'flag' in itself.

(2) The matters noted on 9 October 2021 relevant to DSM-5 criteria for PTSD/depression diagnosis, namely (i) Michael's long-term exposure to traumatic/stressful events over his lengthy policing career; (ii) his recurring thoughts about past traumatic events; and (iii) his symptoms of anxiety, insomnia, nightmares, vigilance, and intrusive thoughts (recognized trauma symptoms).

(3) Michael's report of a loss of pleasure in activities (e.g., fitness), profound fatigue, pessimism about performing his duties, low mood, tearfulness, and reduced function, which were indicative of depressed mood.

151. In Dr Frost's view, Michael's evident distress (becoming 'tearful') when he spoke about his past traumatic experiences was itself a significant 'flag'. Dr Frost explained:

> "*Reading these notes, and particularly this very detailed trauma history that was taken at that first consultation, and then that comment in the mental state examination on the first page…"tearful while discussing earlier events" - and not to forget that this is done over the phone. And so over the phone, in my experience, it's much easier to hold one's - hold one's emotional steadiness than face to face. So when someone's in front of you and they start to become tearful, the empathic response of the clinician often makes people more tearful. They really start to break down, whereas over the phone they kind of go, "No, no. I'm fine, I'm fine, I'm fine. No, I can go - I can go on"…So because*

this was done over the phone - and I have no criticism at all that it was done over the phone. I mean, I think it's an amazing thing that Ms Groves was - allowed 90 minutes of her Saturday to - to be with an officer in distress who previously couldn't make an appointment because the phone lines were down. So I think she - she worked extraordinarily hard to - to provide a dependable service to him. But the fact that this was done over the phone, I think, also meant that the sort of - the - the distress in the room that is so often palpable couldn't be ascertained. ***But reading it I'm concerned by it. It - it - it worries me that somebody who's been such a resolute player for so long is crumbled - has crumbled****."*

152. Regarding the significance of his sleep difficulties, Dr Frost described them as critical to the diagnosis of PTSD, stating:

> "*…the sleep disturbance, it's…really critical in making a diagnosis of PTSD to examine sleep very carefully, and in order to do that, you need to know how somebody normally sleeps, and then you need to be aware of - I mean some of his disrupted sleep is actually disruption by community members, I'm assuming - - - But the fact that he cannot return to sleep, to my mind, is an indication of a mind that's no longer able to switch off, and that - again coming back to the PTSD diagnosis - speaks to that increased arousal, the vigilance, the - the not slipping into deep sleep because the brain is kind of worrying constantly about everything. And so again, if - if Michael were to say that, "look, when I worked in Yuendumu, or somewhere else, and I was disturbed in the middle of the night, I'd get up, I'd do the job, and then I'd go back to sleep really well. But now, no matter what the disturbance is, I cannot return to sleep", that's a change in sleep - in the sleep history*."

153. Another matter was Michael's report of "*negative views about community matters*." Dr Frost explained in evidence:

> *"…Because again, in my clinical experience, many of very loyal, dependable, reliable, police that I've treated love remote policing. They love getting in there in the community. They feel absolutely passionate about those communities. They want to go remote, they want to stay remote, they want to be remote. And so then to start becoming frustrated with the very people that they're there to serve, to my mind, is a sign of "What else is going on?" When I see my medical colleagues starting to become really irritated by patients, I wonder whether they're burning out, I wonder whether there's - so - so it's a similar sort of thing where those we're there to serve and protect - - - are actually now the source of our own irritability, and "I'm really" - you know, if I can use the word, "I'm really pissed off with everybody" - - - is very different from that kind of draw to help people in remote communities*."

154. Dr Frost acknowledged that Michael's Kessler 10 and DASS 21 scores on 9 October 2021 were not themselves clinically significant. Dr Frost emphasised the caution with which these scores must be treated, stating:

> "*…I'm very aware I'm applying a retrospective scope here - - - and I think that if I was faced with this at the time, I might view it a bit differently, so I've got to be very careful that I'm - with hindsight I can say different things from what I might have thought if this was me doing the assessment at the time. Again, as a psychiatrist, and particularly having worked with defence members, anything that is what they call a "tick and flick" - meaning you tick a box and then you flick it away, and now you're allowed out of the room - is something that many people will just kind of run through quickly. They have a - almost like an expectation of what the reader wants*

them to write. Now, I don't want to say that about Michael because that would be purely speculative on my part, but I've - I've got to acknowledge that those scores in themselves are reassuring, but there are so many other flags for me that aren't reassuring that I'd kind of - and again, am I just using hindsight - ***but I wouldn't place a lot of weight on those****. And also I think, because this is the first time Michael has opened up to somebody else, he himself may still be feeling that this is all going to kind of blow over fairly quickly - "I'll get this court case out of the way. I'll be fine. I'll be fine" - and so his own self-judgement and - the word that I would use in this setting is insight* ***- his own insight about the nature of his decompensation is probably quite limited, because it's alien to him at this point, he's normally functional****. I note - when I use the word insight, I'm using it very differently from Ms Grove's comment. She describes it - this is back on page 92 - "His insight is good, is evident by willingness to leave the community on sick leave if doesn't improve". Whereas to my mind, that's insight that "This is an option for me",* ***but I still think at this stage Michael didn't have a lot of insight into this was really the tip of a very big psychological iceberg****. He was thinking, "I've always been pretty good. I've dropped a bit. I'm having some therapy. The court case is over. I'm going to be good now", because he -* ***it was so alien for him to uncover this sort of less functional, distressed part of himself****. I mean subsequently we can see from his diaries that that was very, very manifest, but at this stage my feeling is that he's been able to cover - not cover over, but re-cover - from my perspective, superficially reasonably quickly*."

155. Regarding the noted impression of Michael being "*well adjusted*," in the context of experiencing "*significant stressors, triggering event for residual*

trauma in the context of fatigue," Dr Frost viewed this itself as a 'flag' for acute deterioration, stating:

> *"…[The view Michael appeared] well-adjusted, we know that, but he's struggling. And so I think sometimes when somebody is well-adjusted and they're struggling, as clinicians we can overemphasise the well adjust, and underemphasise the struggle. And in my - again hindsight is a powerful influence in my assessment but I don't feel somebody with a 23-year history of policing, who's telling me at this stage about three or four major traumatic events, who's tearful when discussing trauma, and who tells me that "I still have - I still have thoughts of something that goes back to my first or second year of policing when I'm stressed", is actually as well, as this formulation would suggest…."*

156. It is now evident that Michael experienced temporary subsidence in his symptoms due to immediate stressors such as the Millingimbi Court proceedings and his leave in Darwin. This tended to mask the severity of his condition from Michael and others and may have given him a false sense of confidence in his capacity to cope on his return to Kintore. As Dr Frost explained:

> "*…the way I would put that together was that in 2021, late 2021, he was extremely stressed by this court appearance, and that that had unravelled some of the - the stress of that had kind of unravelled some of his defences, like - and by defences what I mean is the habitual things we all use to kind of prop ourselves up. So I might have a sleepless night, but I still turn up at work the next day because being punctual is an important part of who I am. So he - he - he was highly stressed by this court case, he was highly stressed by being in the Kintore community, and all the demands of that role, and so he was*

really starting to kind of unravel. But then when the external stressor of the court case was lifted, and that went, I don't know, better than he anticipated, or ***the stress of it was over, he was then able to kind of rise back up to functional Michael, but that didn't mean that PTSD was over****."*

157. Regarding Michael's report that "*intrusions and focus on past traumas are not as significant, and they are just things I live with but not causing problems*," and his reluctance to continue with sessions, Dr Frost said:

> "*Although it's very tempting to take that improvement at face value, because of those flags that I've already identified I would probably say to - if Michael was my patient, I'd probably say, "Look, I can see that you're improved. I'm still concerned that there - there are some things that we haven't really had an opportunity to unpack or to talk about. I think we need to see each other again. Would you be happy to come back in six weeks?" So I'd leave the door open at that point. I'd be - not be quite as tempted to say, "Yep, you're good to go", even though he thinks he's good to go. And I think the other thing that's interesting is that here's a very definite PTSD kind of statement: "reports intrusions and focus on past traumas are not as significant." So that's not something that was really elicited - the intrusions and the focus - it was sort of - it could be inferred but it wasn't directly elicited to consults earlier, but now he's talking about it quite openly.*
>
> *Well, "things I can live with" means that "things I am familiar with, I have lived with for a long time", which makes me think that that PTSD, whether it was subsyndrome, or…at the level of a diagnosis, has actually been around for a long time*."

158. Ms Groves accepted that Michael's presentation and reported symptoms as of 9 October 2021 reasonably supported the possibility of PTSD and that this possibility had to be assumed until further investigation permitted a

definitive diagnosis or the exclusion of that possibility. She said that, as of 23 November 2021, she had not ruled out the possibility that he had PTSD. She considered there was a risk that his symptoms might resurface.

159. Ms Groves documented their discussion for Michael to re-engage with psychological treatment if he felt that would be beneficial, and for him to be aware of indicators of possible deterioration (e.g., difficulties with his sleep).

160. Ms Groves said she explained to Michael in their 23 November 2021 session they had not yet "*done any work around the trauma, that the trauma was impacting him at that time. And that – that I believe that he [needed] to address this past trauma issues*" however Michael maintained that he did not wish to continue sessions (Ms Groves accepted that she did not document this part of their discussion in her contemporaneous notes).

What interventions did Michael require (as of late November 2021)

161. Michael needed to continue psychological treatment and to take an extended break from frontline duties. Ideally, that would have involved him living in a large population centre where he could attend face-to-face treatment. His return to Kintore meant he returned to an environment that exacerbated his injury.

162. Although this is obvious in hindsight, navigating a path forward in real time would have been challenging. Ongoing treatment requires an individual's willingness and consent.

163. In the context of frontline members, who may not have a clear sense of their own deteriorating well-being and for whom stoicism, dependability, and not letting their colleagues down are deeply ingrained aspects of their identity, that individual will very likely be resistant to or unwilling to agree to a sudden shift out of a role or specific posting.

164. Whatever a clinician's view of what is best for their patient, pressuring a patient to take a course the patient is resistant to may damage the therapeutic relationship and make the patient unwilling to reveal difficulties or seek help in the future. This can be a difficult line to manage.

165. Dr Frost spoke about this difficulty, stating:

> "*…So somebody who has experienced difficulty, acknowledges that they're not feeling themselves. Then the very presence of telling your story sometimes is - is extraordinarily powerful for people, being - being heard, being listened to, not being judged enables people to feel that maybe things aren't so bad after all. And so that therapeutic alliance with Ms Groves is - is without doubt, extraordinarily strong. And that's - that's manifest right throughout Michael's diaries. And I in no way wish to undermine, criticise or - that therapeutic alliance is extraordinarily strong. And so the therapeutic alliance is very containing for people. And so if you were to undermine that by insisting that he have ongoing treatment, there's a sense of - of instead of being collaborative, you're starting to be paternalistic."*

166. This also points to the potential benefits of involving a psychiatrist with extensive experience treating first responders with trauma injuries (ideally someone with the experience of Dr Frost).

167. In evidence, Dr Frost outlined how she might have approached engagement with Michael as of 23 November 2021, acknowledging that this was being done with the benefit of hindsight.

168. In this respect Dr Frost said:[8]

> *"...I think the first thing I would've said to Michael is that I think this is post-traumatic stress disorder, and that is something that in my*

[8] Frost 13.8.2025, T493.

experience - police, military, firefighters - suspect, don't want to hear, but they're almost relieved when you say it to them. I'd probably have an open mind about depression at that stage, because I think he's - he's probably been pretty good at being upbeat, positive, that's the sort of guy he - he appeared to be. And I'd say to him that "I think that you are not well enough to return to a remote community. I'm really worried about you being so isolated and facing these stressors on a daily basis, and I would like, with your consent, to speak to your employer and to take you out of that - that setting - even if just to access treatment." And I've certainly done that in my career, with police. I've taken people out of remote communities, you know, and I know it creates absolute havoc when I take someone out of Ramingining or Millingimbi, or Yuendumu, and they're two people there. But sometimes I think they have to be removed from isolation, lack of family, lack of friends, lack of support, and really not well enough to be doing those 24-hour on-call shifts, because there's - there's a lot of research around disruption of sleep and aggravation of PTSD, disruption of sleep/development of depression. And so I'd be wanting somebody to be - you know, if he said, "Look, I think I'm still well enough to work" okay, let's find you a - let's see if we can find you a desk job somewhere if that's - - -"

169. Assuming Michael remained resistant to that recommendation, Dr Frost said:

"*I think if I was sitting on the fence about it…I would probably, in a sort of cooperative, collaborative manner work with them and say, "But I need to see you in a week. I need to talk to you about this in a week. I need - you know - I'm not - I'm really concerned about this. I don't think it's going to be" - but I would just follow somebody up quite closely, because I would be very concerned about them returning to that remote community. Or in his case, staying in the remote community, because he hadn't left it at the time of the consultation*."

170. It is unknown whether a different approach might have persuaded Michael to accept that returning to Kintore was too dangerous and that he needed to continue treatment.

171. Michael's experience highlights the importance of ensuring a member is appropriately informed about their treatment, including what their symptoms may indicate (e.g., serious injury), the possibility that a subsidence in symptoms is temporary, and the risk to them if treatment does not continue or the member returns to a stressful work environment. This is to maximise the member's chances of appreciating their risks and making an informed decision. Such discussions should be appropriately documented in contemporaneous notes.

172. It is also important that a member who is willing to identify to *Wellbeing Services* that they are at risk of injury feels supported moving forward. This includes feeling supported in potentially taking leave to recuperate, returning from a remote posting earlier than expected, or, if they remain in the posting, implementing increased supports to reduce stressors in that environment.

EVENTS IN LATE DECEMBER 2021-JANUARY 2022

Events in late December 2021 through to late January 2022

173. On about 28 December 2021, the Southern Desert Division Senior Sergeant spoke with Michael about acting as Remote Sergeant while R/Sgt Rutherford took scheduled leave in late January 2022. Michael said he did not wish to do so. He was advised that this would depend on whether a relief member could be found and that he might be required to fill the role.

174. On about 15 January 2022, residents of Kintore began testing positive for COVID-19. This was the first outbreak in that community. As is common, the number of known positive cases was initially small but grew rapidly.

175. The restrictions in place required anyone suspected of having COVID-19 to quarantine at home. For many in Kintore, this meant being confined in large numbers in overcrowded houses in the middle of summer. There were often ten to twelve people isolated in houses for two-week periods. The hygiene in many of these residences was poor and confronting.

176. Responsibility for enforcing isolation fell to the NTPF members posted to the Kintore community. This involved ongoing compliance checks and delivering food to homes. It was confronting, gruelling work. It was in addition to the normal duties the officers were expected to perform, such as responding to reported offenses.

177. On 25 January 2022, Sgt Parsonson left Kintore on transfer to Perth. This had been scheduled for some time; however, another WA member was not posted to relieve in this role when Sgt Parsonson left.

178. On 26 January 2022, R/Sgt Rutherford travelled to Alice Springs to begin recreational leave scheduled to run until 9 February 2022. No other officer was available to act as Remote Sergeant. Michael was required to act up. This was a role he had not wished to take on. He had made that clear in conversations with others, including R/Sgt Rutherford. His reticence was likely linked to the increasing acuity of his symptoms and his belief that he would have difficulty coping with the demands of that role. This role meant he bore additional responsibilities when he was already struggling to cope.

179. On 26 January 2022, a Probationary Constable from Papunya travelled to Kintore and performed duties with Michael until 28 January 2022.

180. On Friday, 28 January 2022, Probationary Constable (**Prob Const**) Jack Scarfe began relieving duties in Kintore with Michael (the other Probationary Constable had returned to Papunya). His account of conditions on the ground is informative about what Michael was experiencing:

"[On arrival in Kintore Michael] explained to me the current situation on the ground which was that there were several persons within the community had tested positive for Covid and that police were expected to enforce lockdown measures.

[Michael] and I attended meetings with community stakeholders where we discussed the growing number of persons within Kintore testing positive for COVID-19, due to persons within the community not being compliant with lockdown requirements.

At this time police were expected to pick up food hampers from the local store and deliver them to families in lockdown, there had been heavy rainfall around the Kintore area, which had prevented the one store in the community from being resupplied. The store managers expressed concerns that they would run out of food and not be able to supply those in lockdown.

The clinic raised concerns about the growing number of people presenting and complaining about having sore throats and other Covid related symptoms and that they were running out of rapid test kits.

The store itself was continually being broken into by youths, in retaliation to this the store managers closed the store which resulted in approximately 100 persons surrounding the store and began throwing rocks at it. With no ALO's available [Michael] and I were the only members to disperse the hostile crowd.

On top of [delivery] food packages to persons in lockdown, and ensuring compliance with lockdown requirements, whilst wearing full Covid protective clothing where daily temperature was often above 40 degrees, [Michael] and I were also conducting policing duties.

…One domestic violence incident that I remember attending was…An intoxicated male attended his partner's residence, where she did not

want to see him, so the male began assaulting her by throwing rocks at her and other residents then attempting to smash the power box, the female then started picking up rocks herself then hitting herself in the head.

We obtained statements and gathered sufficient evidence to arrest the male, but with only [Michael] and I on the ground...[with] most of our days spent dealing with Covid duties, we were unable to locate the offender or attend other incidents."

181. In a subsequent journal entry, Michael mentioned this domestic violence job, describing it as a "*nasty*" incident in an overcrowded home. He also described feeling extremely fatigued after completing a 10-hour shift on what should have been a rest day for him.

Emails sent by Michael on 29 and 30 January 2022

182. On 29 and 30 January 2022, Michael sent three emails outlining the difficulties he was experiencing. I have included these emails below, as they provide the best evidence of the challenges he faced and how he was coping with them.

183. On the afternoon of Saturday, January 29, 2022, Michael emailed the NTPF's "EOC SRIMT," copying the Southern Desert Senior Sergeant, with the subject line "*Kintore update COVID 1633 hrs 29/Jan/2022, 3 x additional COVID cases*." He wrote:

"We are facing significant issues in Kintore in part as a result of high levels of community dysfunction, staff shortages for each of the stakeholders that are trying to keep this boat afloat, Kintore Clinic, Kintore Store and the police. The other police officer Jack Scarf and myself were called out this morning at 8:00am dealing with a break in at the store overnight that was followed by a disturbance outside the shop of around 100 community members with a number of them

throwing rocks at the shop itself, general lack of concern by many community members of efforts made by stakeholders, domestic today involving a victim (COVID positive) getting hit with a rock before hitting herself in the head with a rock and again concerning levels of non-compliance in relation to COVID risks. We can only do so much with what we have.

As of today 3 x additional positive cases, I understand currently at around 15 positive cases in community, 10 houses in lockdown, 70 people currently in lock down.

In several days the money for food supplies from Kintore Store for this increasing amount of people subject to isolation is going to run out. We are now awaiting deployment of Welfare staff to assist with enabling persons in isolation to purchase their own food from the store. I have requested that deployment of these staff be made a priority. Ideally this deployment is conducted by flight.

Please ensure that our senior leadership group and Government leaders are aware of the struggles remote stakeholders are currently facing in relation to this outbreak. With adequate resourcing for each of the stakeholders in Kintore we would be much more effective at managing the outbreak."

184. On the morning of Sunday 30 January 2022, Michael forwarded that email to an NTPA representative based in Yulara, stating:

"I am touching base with you from Kintore due to your NTPA role. Below was my daily report sent to our EOC in Alice Springs yesterday. It provides only a snapshot of the difficulties local stakeholders and police in Kintore are facing in relation to our efforts to keep our community as safe as possible. Yesterday my colleague and I were called out at 8:00 am and for 10 hours dealt with …community

members breaking into the local store, disturbance of around 100 people with several of them throwing rocks at the shop and an extended domestic violence incident involving a COVID positive victim at an overcrowded house in isolation of at least 16 family members. During our patrols we were simply not able to deal with all other incidents that were reported to us. Like many stations are recorded incidents on PROMIS are growing with insufficient resources to deal with these reports. This places our people (police) and the community at an increased risk.

…The fact is we are all currently under resourced while the expectations on all us (stakeholders including police that are sacrificing ourselves to keep this boat afloat) by our leadership, government and the community itself is extremely high and often unreasonable.

Right now in Kintore we have two police officers, myself (A/R Sgt) and another Constable who is an excellent member albeit 8 weeks out of the college. The two ALO's staff support us however they are not police officers. Due to the COVID outbreaks in Kintore and Docker River, there is a now a separation of policing commitments between WA and NT until the outbreak is cleared. Let's try and be realistic, this outbreak is not going to be cleared, it may be minimised however will not be cleared. In part as a result we no longer have a WA member here. This equates to two members on call to a highly demanding community 24 hours a day, 7 days a week.

My colleague and I are doing what we can and I have complete confidence [the Senior Sergeant] is doing all he can to offer us further support with an additional member. Remote Sergeant Richard Maza (usually based in Warakurna WA) is doing an amazing job from Docker River albeit on his own. How is this even possible?

The bond between the stakeholders and police in Kintore is strengthening. At the same time "just do the best you can" is wearing out. The community members in our stakeholder group are all feeling on our own out here. The clinic is not Territory Government run and has made requests to have additional staff and attendance by the rapid assessment team to assist with COVID duties and close contact tracing...Like everywhere else overcrowding is an issue, we have one home with 20 people trying to self-isolate, this requirement is inhumane and simply is a recipe for disaster when it comes to the family dynamics, dysfunction and low levels of hygiene.

As of 6:00 pm last night there is now a Territory wide outdoor mask mandate, that comes with an additional onus on police officers in bold ***Anyone caught breaching CHO Directions - including not wearing a mask - face a $5,000.00 fine****. A direction is a direction however what works in urban circumstances will not necessarily work in remote locations. I truly feel like we are on a different planet to Darwin.*

I have two requests as an NTPA member and hoping your team may be able to assist,

(1) Please ensure that our senior leadership group and government leaders are aware of the struggles remote stakeholders including local police with the responsibility for our Local Pandemic Action Plans are currently facing in this outbreak. With adequate resourcing for each of the stakeholders in Kintore we would be much more effective in managing the outbreak.

(2) We continue to hear that we are moving to a phase of "living with COVID". What does living with COVID look like when it comes to police in the next month? What we are doing is not sustainable and is having a an adverse effect on our people."

185. At about midday that same day (30 January 2022), in reply to the NTPA's President, Michael said he had *"[j]ust called in again on a day off for a break in at the shop last night" and that there was "ongoing noncompliance with the basic rules relating to COVID.*" He further added "*members are feeling the same strain. Too be honest for myself and a number of others truly starting to question how long I am wanting to continue on with this role and even job.*"

186. These emails reveal the strain Michael was under at the time. It is likely that his view of his capacity to cope was impacted, to some degree, by the acute deterioration he had been experiencing with his mental wellbeing in the months before this date.

187. It is also evident that Michael considered himself and other members to be pressured into providing a service beyond reasonable limits, given the number of members and resources available. He reported that he believed this left frontline police in his position "*sacrificing ourselves to keep this boat afloat*." This perception of not being heard and of his well-being being sacrificed was an additional stressor.

Michael goes off work on 31 January 2022

188. At 7am on Monday 31 January 2022, Michael emailed the Southern Division Senior Sergeant:

> *"Good morning Senior, I have made a very difficult decision that I will be taking personal leave from Kintore. I would like to be in Alice Springs by the end of this week to see a GP face to face. During this process I will keep you totally up to date with progress in order maintain staffing here in Kintore as best as possible.*
>
> *Today I am expecting to hear back from Inspector Wayne Hawes (WA Police) in relation my enquiry about using the WA police residence*

here for possible NT relief staff. In the interim I am going to make my residence available to any NT members that relieve...

I can only strongly recommend having three members out here in particular with our additional responsibilities for the COVID response. I will maintain my LEC duties until replaced. We will next be meeting as a group this morning at 9:30 am at the clinic."

189. Later that morning he emailed the Support and Wellbeing unit:

"I am touching base from Kintore. I have notified my [Senior Sergeant] in Alice Springs that I will be taking personal leave from Kintore. He is very supportive and assisting in organising a replacement for me. ***I guess like a number of other members things have caught up with me in particular with burnout, lack of staff and the additional onus relating to the COVID response****."*

190. On Tuesday 1 February 2022 Michael flew from Kintore to Alice Springs. He stayed with his brother Antony and his family for a couple of nights, then travelled on 3 February 2022 to Adelaide to see his parents.

191. His journal entry of 2 February 2022 reveals how severe his symptoms were at the time. Michael wrote:

"When I flew out of Kintore...Friday I did not even look out the window. Today I spoke with [a Support and Wellbeing psychologist] and told her about what was going on and about crash and burn in Katherine. I have one month of loading into 2 weeks rec [?]. To be honest I don't actually see myself moving back to Kintore...My memory is shot, started stuttering at times and not sleeping well. I am on the way to getting better and most likely will move back to Darwin..."

192. Michael made a further entry the next day (2 February 2022) in which he described the difficulties he had been experiencing in the days preceding 31

January 2022. These included being called out multiple times after hours for break-ins at the community store and for a "*DV*" job, while managing the duties required to enforce home isolation. He noted being unable to sleep (averaging 3-4 hours a night). He also noted having 'suicidal thoughts' on the day he went off work (31 January 2022) but feeling too "embarrassed" to reveal that to his immediate supervisor.

Onset of Michael's chronic PTSD / MMD injury

193. I am satisfied that by late January 2022, Michael's symptoms had progressed from the *subsyndromal stage* to chronic PTSD with MDD. The catalyst was the constellation of events in mid-to-late January 2022.

194. These events did not directly cause Michael's injury but were the final straw. The date he went off work was the point at which his conditions became so severe they overwhelmed his resilience and forced him off work.

195. Being forced to take time off work in these circumstances was devastating for Michael. I accept the articulation of this as submitted by the Family/NTPA that the remote environment and operational demands at Kintore materially aggravated an already accumulated burden of trauma. However, I would also add the accumulated burden of stressors.

Members being prevailed upon to make do

196. Although the NTPF is concerned with its members' well-being, it is sometimes under significant pressure to meet immediate operational demands with limited staff or resources.

197. Operational decisions are sometimes made that prevail on a member on the ground to '*make do'* in the face of significant stressors. Even though it is not the intended outcome the nett effect is that the immediate interests of the community is at times prioritised over the individual member's immediate wellbeing.

198. Members who are asked to perform their duties in extremely difficult conditions may feel unable to refuse or inclined to do so. They may worry that their refusal will place a greater burden on their colleagues, who will have to bear a heavier workload.

199. The member typically prevails without immediate signs of harm. What is not appreciated is the impact this has over time. The effects of the stress from this incident accumulates with other stressors over the years. These effects may not manifest for many years, but if they ultimately culminate in a mental health injury, the consequences will be severe.

200. The supervisors (e.g., Senior Sergeants) making the demands are not indifferent or unconcerned about the members' well-being. To the contrary, they may themselves be affected by what they are asking of the members.

201. In these proceedings, two examples of members being prevailed upon to make do were examined. They concern R/Sgt Rutherford and Michael separately. They are illustrative of how the circumstances can manifest. These cannot be taken as exhaustive of all the stressors each experienced in their careers.

202. First, the experiences of R/Sgt Rutherford working an extended one-up in Kintore in 2020. To be clear, the duration she worked one-up on this occasion was not typical in her experience. The requirement to work *one-up* in Kintore was typically for far shorter periods.

203. R/Sgt Rutherford described this experience as follows:

> *"Staff shortages were common at Kintore police station. There were times when I was left to serve the community on my own. I remember being alone for about 35 days during one stretch in difficult conditions which was a very challenging time. There were moments when I felt I couldn't continue and I had a brief breakdown in private. In that moment, I felt completely unsupported, and being so remote, there were*

no easily accessible support services. While a wellbeing officer and chaplain would occasionally visit for check-ins, it didn't address the root cause of the problem. Every Wednesday, all the remote Southern Desert remote station OIC's would have a dial in phone meeting with the [Senior Sergeant for Southern Desert Division]. I remember having a meeting on 5 February 2020 where the bosses informed me that I would be alone (1-up) at Kintore for the following week due to staff shortages. They then told me I would be 1-up for the entire roster and they were aware of the situation."

204. During the extended *one-up* period, R/Sgt Rutherford continued to attend to duties during regular business hours and on after-hours callouts on her own. This included callouts to communal violence involving weapons. Her workload became increasingly hectic, and she felt swamped and very isolated.

205. At the same time, R/Sgt Rutherford was aware that her Kintore WA offsider was prohibited by the WA Police Force from ever attending jobs *one-up*.

206. R/Sgt Rutherford knew from her discussions with other Remote Sergeants that other stations in the Southern Desert Region were experiencing similar difficulties and that they "*all knew there was little we could do, so we just coped with it*."

207. R/Sgt Rutherford described her Senior Sergeant as being very distressed at his inability to find relieving staff and at R/Sgt Rutherford being expected to continue in Kintore alone.

208. This is an instance of the NTPF providing Kintore with a policing service by prevailing on R/Sgt Rutherford to '*make do*' in the situation. R/Sgt Rutherford got through this experience. She remained in her post and continued performing. That is not to say that this experience has not had a lasting impact on her. The risk is that the undue stress she experienced may,

over time and in accumulation with other stressors and traumatic experiences, injure her mental well-being.

209. The second example is the one Michael experienced in Kintore in mid to late January 2022.

210. The outbreak of COVID-19 led to a significant increase in demand on the Kintore members. There was no increase in the number of NTPF officers posted to Kintore during that period. Michael was also required to act as the remote sergeant. Along with the demands of the COVID-19 outbreak, he had to contend with a spate of property offences and other disturbances.

211. The emails Michael sent on 29 and 30 January 2022 make plain the distress he was experiencing. Some of Michael's statements, such as *"just do the best you can" and "is wearing out,"* echo sentiments expressed by R/Sgt Rutherford, who felt she "*just [had to] cope with it."* Later, after he went off work injured, Michael wrestled with the NTPF motto "*Service Before Self."* In his mind, there was a connection between that motto and what was being expected of him and other members by the NTPF and the community.

212. Again, it is not a case of Michael's immediate supervisors being unconcerned or indifferent to his situation. In his emails, Michael made clear his belief that his immediate supervisor was "*doing all he can to offer us further support with an additional member*."

213. The Commissioner of Police submitted that events in January 2022 did not reflect the ordinary circumstances that Michael ordinarily experienced during his posting in Kintore.[9] I accept that the COVID-19 outbreak in Kintore was sudden, with the number of suspected cases rapidly expanding within a short time. This created significant resourcing demands and institutional challenges for the NTPF. It cannot be viewed as a typical event or occurrence. That was a factor in what unfolded for Michael and

[9] Commissioner of Police submissions [18].

other officers in that region more broadly. However, even accepting that fact, the NTPF's institutional culture of '*making do'* was a material factor in how Michael came to be in a situation where he was exposed in his job to significant stress and trauma. This particular exposure came at a time when Michael's wellbeing and resilience was, after lengthy exposure to stress and trauma, in a vulnerable state.

214. An institutional culture in which members are made to feel they must '*make do'*, in which they absorb undue stressors to enable the NTPF to deliver policing services at a given moment that the community demands of it, poses a significant risk to the long-term well-being of members.

215. Again, this is not a situation in which the immediate manager is indifferent to the member's predicament or is not trying to do the best with the resources available to him. The bigger issue is whether, institutionally, the NTPF may have to take some action, such as ceasing the provision of services in a community for a given time, even when the outcome will likely be harmful to the community in question. There may be situations where the NTPF must temporarily cease services in a community if continuing to provide a service will pose too great a risk to the mental well-being of its own members.

216. This is not an issue that can be resolved by increased resources for the NTPF's Wellbeing Unit. Reforming this culture is essential.

217. Moving forward, the NTPF needs a specific strategy that expressly tackles this issue. The starting point must be an acknowledgment and recognition of the harm that some work scenarios pose to members' well-being. While the NTPF has recently introduced a *Fatigue Management* procedure (*addressed further below)*, these procedures do not expressly acknowledge the occurrence of 'make do' decision-making and nor does it provide guidance on the types of situations in which this might manifest. Something more explicit is required.

218. The implementation of a strategy is important not only for the education of NTPF members. It may also inform the community that the NTPF, with the resources vested in it, may not always be capable of delivering a service if doing so poses too great a risk to members' well-being. Everyone needs to understand that the harm comes from repeated exposure to stressors over the longer term; and there may be occasions when this is managed by the withdrawal of police from situations which are putting them at foreseeable mental injury risk.

219. I consider it appropriate to make a recommendation to the Commissioner of Police on this matter in the following terms:

Recommendation No.2: The NTPF develop and implement a strategy that:

Recognises that the pressure commanders / middle managers may experience to ensure the delivery of services may come at the expense of the members wellbeing.

Examines ways in which commanders / middle managers can feel supported by the NTPF Executive to make decisions that appropriately prioritise members' wellbeing, potentially to the detriment of the community's interests in receiving policing services, particularly in times of acute demand for services and or shortages in staff. This includes but is not limited to situations where consideration is given to requiring a member to work one-up in a remote community and when there is a significant increase in the demands on the ground relative to the number of members in the community.

Examines what indicators or markers might be captured to enable evaluation of the effectiveness of this strategy and ensuring accountability for its performance at the Executive Level.

GOING OFF WORK

Immediate period after going off work

220. Michael's journal entries indicate that, in the immediate aftermath of leaving work, he was struggling with uncertainty about his future, shame, and suicidal thoughts.

221. Between 3 and 8 February 2022, Michael's handwritten journal entries recorded his thinking about what would come next; suicidal thoughts; feeling he was a burden on others; and his ongoing disturbed sleep and intrusive thoughts about past trauma. For instance, entries that read:

> *1240am awake and was up till around 4:00am, mind racing thinking of all the incidents at work that have got me to where I am. Still some suicidal thoughts and feeling like a burden…I don't think I can go back to policing", and "Mind racing thinking about what I am going to do longer term, angry this is work related on my mind. Milling, Crash & Burn Katherine, guilty about not pulling the [?] lever".*
>
> *…highly stressed about going back to work and am slowly coming to terms with the fact that these work incidents have got me to this situation. At moments feeling suicidal thoughts and not wanting to cause my family more stress being here. I don't think I can go back to work and to be honest right now not even wanting to go back to the NT. I have to work on getting better before I even think of going back to the NT. I am not resigning and not going back to Kintore. I can't stand many of the people and who I am turning into from having to deal with them. I have to work on getting better.*
>
> *…[I feel] shame and guilty about leaving Kintore however staying there will kill me, likely kill me.*
>
> *…[I feel] suicidal and numb in my head. Can't see an end to this feeling…*

....I have not ever truly understood what people are going through when they feel as down and suicidal as I do.

Impact on Michael

222. A key lesson to be drawn from Michael's experience is the impact when a member becomes unable to continue in their role because of their injury.

223. I accept the Family/NTPA's submission that Michael's departure from Kintore, under the circumstances, created a dangerous transitional period in which (i) he had lost his operational role, (ii) was now separated from his close colleagues, (iii) perceived himself as having failed, (iv) feared the judgment of others, (v) was uncertain about whether he could continue as a police officer, and (vi) was at that point without a settled diagnosis and a long-term treatment plan.[10]

224. This underscores the importance of ensuring that appropriate interventions and supports are in place for a member during this immediate period. It also brings into sharp focus the importance of identifying a member at risk of injury early and providing effective interventions early, to avoid the individual reaching the point that Michael did.

225. The increased risks experienced by individuals in frontline roles, when required to transition out of frontline roles, whether temporarily (e.g., if experiencing a mental health injury) or permanently (e.g., leaving their profession), are well recognised, including in the 2020 Beyond Blue Good Practice Framework and the findings of the *Royal Commission into Defence and Veteran Suicide*.

226. Michael's journal entries make it clear how distressed and tormented he felt about leaving work as he did. It was not only a sense of failure and shame about his sudden departure, but also anguish about "*Where do I go next?"*

[10] Family / NTPA submission [316].

Dr Frost explained the impact and risks this event posed for Michael as follows:

> "*It's huge. Here's somebody who - I mean I think in about his second or third year of policing, he was policeman of the year…that sense of failure, of letting others down, of betrayal of shame, would be enormous…. I think, given that this is now the second time Michael - if I can use the phrase "broken down" - I don't mean like a "breakdown" as in the movies - but he's psychologically decompensated, he's - he's basically saying, "I cannot go on. I've taken this" - what, for him I think, is a radical step to exit the community. In his diary he wrote he couldn't even look out the window of the plane, which to me just says so much about his shame. He - you know, shame is we're about two and we hide our face in shame, and we don't want people to see us. That's what shame is…I think he's extraordinarily unwell at this point, and is really starting to fight for all the values that he's exemplified for so long, and if he were to be my patient, I'd be talking medication to him, I'd possibly be talking inpatient treatment…"*

227. Another lesson that can be drawn from this period is, with the benefit of hindsight, identifying potential areas where interventions to assist Michael could have been better optimised. In my view, this underscores the benefits of early involvement of multidisciplinary teams, led by a psychiatrist with experience in trauma, for someone who was experiencing what Michael was.

TREATMENT & INTERVENTIONS IN FEBRUARY TO APRIL 2022

First session with Ms Groves on 9 February 2022 (after going off work)

228. After going off work Michael re-engaged Ms Groves. He ultimately had about 12 sessions with her between 9 February and 7 April 2022.

229. In his first telehealth session with Ms Groves on 9 February 2022, Michael described the difficulties he had experienced in Kintore. This included him

being on call and a sharp rise in workload expectations due to the COVID outbreak.

230. Michael reported that things came to a head on Saturday, January 29, 2022, when he responded to yet another break-in at the store and, uncharacteristically, found himself yelling at a large group gathered there. Later that day, he responded to the domestic violence job and felt extremely fatigued. The following morning, 30 January, he was called out to another break-in. That night, he experienced suicidal thoughts.

231. Michael said that after 23 years of front-line work, he needed to "*get off the road*." Ms Groves noted that he presented "*very distressed and labile,*" was anxious to find a role in Darwin, and was struggling with the circumstances surrounding his departure from Kintore.

232. On 15 February 2022, Michael made a journal entry identifying key incidents he considered likely to have contributed to his feelings of anxiety and stress related to particular jobs. That entry included:

> *…The significant cause of the problems I am feeling stems from the anxiety and stress I experience when faced with the risk of serious custody incidents, risks this places on me and other members. I feel like I can narrow this down to around five incidents I will need to focus on:*
>
> *1. Crash + burn Katherine.*
>
> *2. [Mutijulu incident Est. 2005].*
>
> *3. Death in custody -- 2015.*
>
> *4. [Millingimbi Incident 2021].*
>
> *5. [Community member's] -- Threat Suicide Kintore.*
>
> *6. [Kintore incident] -- injury on duty.*

7. [Kintore incident] adverse interactions.

8. COVID LEC stressors.

233. Michael's entries at this time also noted ongoing contact with, and support from, a Support and Wellbeing psychologist and NTPF officers, including the Southern Desert Division Senior Sergeant.

234. During a telephone session on 17 February 2022, Ms Groves noted that Michael presented as "less distressed" but still felt guilty about being away from work. He reported 'fleeting' suicidal thoughts with no intention to act. A safety plan was discussed, including who Michael would contact for assistance. The next day, he journalled:

> *It was very beneficial speaking with Kim yesterday. Tears and my thoughts of head on into a truck...I think my thoughts on hopelessness and suicide are strongly based on my feelings of failure, letting people down and returning to Darwin with my tail between my legs. Speaking with Tanya and closing down from the [?] has also been helpful. I will miss her very much if I left....*
>
> *....Last night was my first solid sleep in 18 days. I am feeling relief this morning...I am due to speak with Kim today at 2pm, I don't want to make the big decision of transferring until my mind and body is [?]...*

235. In a session later that day (18 February 2022), Michael was noted to present with pressured speech. He reported that "*pressure for transfer now feels rushed*," that this decision had "*massive implications*" for himself, and that he was experiencing "*overwhelming thought[s] of what's ahead.*" After his discussion with Ms Groves, Michael no longer felt pressured and was considering options for a Darwin posting, though he still felt guilty about leaving Kintore and "*leaving Tania there.*"

236. In another session on 23 February 2022, Michael reported that he had discussed possible work options with the Health and Recovery Unit. This included workers' compensation (leaving the NTPF), return to work in a non-operational role in Darwin, or transfer to another role that did not require him to be on the road, although no permanent jobs were currently available.

237. On February 28, 2022, Ms Groves emailed the Support and Wellbeing unit, recommending that Michael move to Stream 2 once his allocated Stream 1 hours were used. She was "*optimistic he will be able to return to ongoing duties by the end of March.*" The recommendation was approved.

Michael's return to Darwin on / by 1 March 2022

238. By about 1 March 2022 Michael had travelled to Darwin, initially staying in a hotel. He planned to base himself there while focusing on recovery and his next career moves. A journal entry that day captured his conflicted feelings about wanting to return to Kintore, and his realisation of the harm this was causing him:

> *"My first night in Darwin and to be honest a lot on my mind. I am very much feeling down about what is happening. I feel like I am no longer keeping up in this job and everybody knows it. I am very much comparing myself to other sand that is also bringing me down. As much as I want to do my time in Kintore I am very concerned about going back and fining myself in the same position. It would only take one serious custody incident for this to happen....I know I have supports while at the same time I am feeling very much on my own...Everyone is moving up and forward I am feeling stuck in my own world. I have never experienced this. Much of this comes down to my negative feelings with throwing the towel in. I don't want to give up."*

239. That same day Michael emailed the Senior Sergeant that he, his psychologist and his general practitioner were "*working towards me having a clearance to return to Kintore for duties for the 15th of March.*"

240. In a face-to-face session on 1 March 2022, Ms Groves advised Michael against an early return to Kintore, as he required further assessment and treatment.

241. Michael later wrote a chronological list of 21 'traumatic' events, from his posting to Katherine in March 1999 to his departure from work in January 2022. The list included vehicle fatalities, homicides, deaths linked to petrol sniffing, assaults against himself, and multiple incidents in Kintore. It is confronting to put oneself in Michael's shoes and contemplate the sheer number of traumatic incidents he attended during his lengthy policing career.

Provisional diagnosis made as of 1 March 2022

242. By 1 March 2022, Ms Groves had formulated a working diagnosis of Adjustment Disorder with Mixed Emotion. In a letter addressed to Michael's general practitioner, Ms Groves stated:

> *"…There is also the presence of symptoms suggestive of post-trauma stress, although* ***I am <u>reluctant</u> to diagnose Post-traumatic Stress Disorder at the current time as he has generally functioned well up until recently****…I consider him totally unfit for all duties at the current time, pending the progress of sessions over the next two weeks. However,* ***I believe it is likely he will be able to return to his normal duties in Kintore by mid-March 2022****, considering various stressors associated with the COVID-19 response have reduced and with the proviso that ongoing weekly psychological treatment and review is conducted via telehealth….*

I will keep you updated on his progress. ***I understand Michael plans to return to work on 15 March 2022 and I am supportive of him being cleared to be fit for work as of this date****. I will be regularly reviewing him before that date and would make further contact if I have any concerns."*

243. As is seen from the above, there appeared to be a hope on Michael's part that he would regain sufficient fitness to return to work by 15 March 2022. Moreover it appears Ms Groves considered this was reasonably achievable.

244. I return to the issue of the working diagnosis, and the severity of Michael's condition at this point, further below.

Self-harming acts on 3 and 4 March 2022

245. Overnight on 3 to 4 March 2022, Michael made journal entries about searching for hanging points in his hotel room and applying ligatures around his neck. This began with a Velcro belt and later with a hair dryer cord. His entries about this included:

...I could not sleep and my mind was racing. I think things may be deteriorating for me mentally…

...I am feeling very low about the prospect of going back to Kintore...

...I have to put on to go back for what others think. I truly don't know if I can do it...

...I don't think I can do this job for much longer

...Very much feeling like a drain on others…

246. As for the use of the ligature, Michael wrote:

...I felt some feeling of peace. At the same time I could not do this to others, the poor staff member finding me, my family and my...friends…

....I am ashamed of time away from work and a complete let down...

...I very much feel like a looser and not the person I want to be. Again I don't think I can keep doing this work or life I just don't think I can keep doing it. I want to be well again....

247. He noted the support he was receiving from various persons, including Ms Groves.

Session with Ms Groves on 4 March 2022

248. On 4 March 2022, Michael attended an in-person session with Ms Groves. He disclosed placing ligatures around his neck. Ms Groves assessed him using the DASS-21 and PCL-5 questionnaires.

249. On the DASS-21, Michael scored 20 for depression, 15 for anxiety, and 14 for stress. Each score fell within the *extremely severe* range.

250. On the PCL-5, his total severity score of 58 out of a maximum of 80 indicated the presence of moderate to severe PTSD symptoms.

251. Ms Groves and Michael developed a plan to manage his immediate risks. It was agreed that Michael would stay temporarily with a friend rather than alone in a hotel until he travelled to South Australia to stay with his parents.

252. Ms Groves also raised with Michael the possibility of his seeking admission to the hospital for treatment. Michael opposed that option.

253. Ms Groves noted speaking to Michael about their safety planning and that Michael did not want his family told of the safety planning.

254. Owing to his reported difficulties with his then general practitioner, Ms Groves referred him to another, Dr Justin Sykes of the Stuart Park Surgery, for assessment for possible antidepressant medication.

Attendance on Dr Sykes on 7 March 2022

255. On 7 March 2022, Ms Groves wrote to Dr Sykes recommending Michael be assessed for antidepressant medication. She advised that Michael had recently developed an "*Adjustment Disorder with mixed Depressed Mood and Anxiety on a background of residual [PTSD] symptoms*", arising from an escalation of stressors in his Kintore work.

256. Ms Groves also advised that Michael's DASS-21 scores were extremely severe for depression and anxiety and severe for stress, and that his PCL-5 results indicated "*trauma symptoms that would warrant a diagnosis of [PTSD]*"; however, she had not diagnosed PTSD "*at the current time, as it is highly likely that his current symptoms are amplified in the context of his depressed mood and his normal strategies are compromised.*"

257. Ms Groves reported developing a plan with Michael to manage his suicidal ideation (the specific events on 3 and 4 March 2022 were not mentioned). Ms Groves said her plan was to monitor Michael closely and that she supported his plan to travel to Adelaide on 10 March 2022 to stay with his parents.

258. Michael saw Dr Sykes that same day. Dr Sykes noted Michael's reports of anxiety and stress, as well as thoughts of self-harm involving a firearm, hanging, or a motor vehicle accident. On the Kessler Psychological Distress Scale (K10), Michael scored 41, which falls in the "very high" distress category.

259. Dr Sykes noted his impression that Michael fell at a "*[l]ow/Medium risk [for suicidal ideation]*" as Michael had not disclosed "*anything concrete*" by way of planning.

260. Dr Sykes prescribed Michael three medications being Stilnox (for sleep), Venlafaxine SR 75mg daily (an SNRI-class antidepressant prescribed for

patients with acute depressive symptoms) and Diazepam (benzodiazepine) to manage anxiety in the short term until the Venlafaxine took effect.

261. Dr Sykes expected that two to four weeks would be required for the Venlafaxine to achieve therapeutic effect. He prescribed Michael the Diazepam, to use on an as needed basis to manage instances of acute stress/anxiety, while the Venlafaxine took effect.

262. Dr Sykes considered the plan going forward – involving Michael staying with family (a protective factor), continuing regular psychology sessions with Ms Groves, and Michael's agreement to present to an emergency department if he felt acutely unwell – reasonable.

Michael's journal entries on about 8 March 2022

263. On about 8 March 2022 Michael journalled about being unable to return to Kintore, his doubts about returning to police duties at all, and his poor sleep. He also made an entry that included as follows:

> *...I have just got to a state where I cannot keep going. I am especially sorry to my family, friends and truly to Kim my psychologist. She has done everything possible to help me find my strength. I have got to a stage where I do not have the strength to go on. Much of this is to do with my choice to leave Kintore. The turmoil in me relates to what I now think of myself and how I would be judged by others. In many ways I don't blame them as I have done the same myself...*

264. I am satisfied this entry appears to be a type of suicide note. Michael was evidently contemplating taking his life when he made this note but did not act on this at the time.

265. It is important to note that while Michael reported to others having suicidal thoughts at time, he did not reveal the fact of him having this note or others like this that he would subsequently make.

Ms Groves' update to the Support and Wellbeing Unit on 9 March 2022

266. On about 9 March 2022, Ms Groves wrote to the Support and Wellbeing Unit seeking approval for Michael's continuation of sessions under "Stream 2".

267. In her letter Ms Groves noted her working diagnosis (Adjustment Disorder with Mixed Depression with Anxiety) and stated, "*this may be revised to Major Depressive Disorder and [PTSD].*" Ms Groves also noted that Michael "*identified that it is situations where he is trying to affect and arrest and there are threats of self-harm, that he becomes distressed.*"

268. Ms Groves considered Michael needed about six months of intensive treatment with an immediate focus on stabilising his symptoms, improving his regulation skills and progressing to cognitive behaviour therapy (CBT).

Further session with Dr Sykes on 9 March 2022

269. On 9 March 2022, Michael saw Dr Sykes again. The reason for the consultation was recorded as "*suicidal ideation.*" Dr Sykes requested "*very close follow-up*" given Michael's reports from their first consultation and Dr Sykes's concern for Michael. Dr Sykes also noted the ligature events of 3 and 4 March (which had not been noted in the 7 March 2022 consultation). A medication review was planned in about a month. Dr Sykes also noted in his progress note "*the 'Service above self' motto from the commissioner",* which was a reference to a statement made to him by Michael during their session.

Michael's journalled thoughts of returning to Kintore

270. In journal entries Michael made between March 10 and 16, 2022, it appears he considered whether he could return to Kintore as a third posted member.

271. This would have involved three members being posted long term to that station rather than two. He may have hoped this would reduce the shame he

felt about his sudden departure from Kintore and that it would mean he could return to help his colleagues.

272. By about 16 March 2022 Michael had concluded this option would not be possible. This meant his most viable option was a transfer to a non-frontline role in Darwin (at the teaching college). It is clear from his entries that his feelings of shame, guilt and poor esteem intensified upon him coming to this realisation.

273. To my mind these entries reveal Michael's anguish about how best to move forward and his feeling of shame at not being able to complete his Kintore posting.

Travel to stay with his parents in Adelaide by about 10 March 2022

274. By about 10 March 2022 Michael went to stay with his parents at Morphettville, South Australia. He remained there until his death on 16 April 2022. Antony and his family also visited, returning to Alice Springs about 23 March 2022. Thereafter Michael and Antony spoke by phone daily.

275. On 14 March 2022 Michael made a journal entry that, on its face, read as a suicide note (his second such note since 8 March 2022). In that entry he expressed love for his family and said:

> *I have come to the realisation that I could not keep going on. My mind has not stopped since Feb or around that date. I don't blame anyone from work and am happy that they have all done all what they could to help me...I have much shame for not making my time in Kintore.*

276. Michael concluded this entry by asking that his thanks be passed to several named family members, friends and professionals, including Ms Groves and Dr Sykes.

277. On 25 March 2022 he made a further entry in similar terms, thanking his family, friends, colleagues and supports and stating that he could not "*deal with this pain any longer.*"

278. As with his journal entry on 8 March 2022, Michael did not tell anyone about what he had written.

Sessions in March to April 2022

279. Michael continued telehealth sessions with Ms Groves into April 2022, including on 27 March, 2 April, and 7 April. In these sessions, he was noted to deny suicidal ideation. Discussions were held regarding his proposed transfer to a Youth Engagement role in Darwin and the benefits of that move. Michael continued to report poor sleep and low mood.

Approval for a transfer / return to work to a non-frontline role

280. In early April 2022, approval was given for Michael to return to work in a non-general duties position in Darwin while he recovered.

Ms Groves' revised diagnosis by 5 April 2022

281. On 5 April 2022, in a report prepared for the Health and Recovery Unit, Ms Groves stated that she had revised her working diagnosis, stating:

> *"...The initial diagnosis was that of an Adjustment Disorder with Mixed Depression and Anxiety, due to situational stressors. I had delayed formal diagnosis of Post Traumatic Stress Disorder (PTSD) until some trauma focused intervention has occurred. However,* ***I am now of the opinion that the diagnosis is consistent with PTSD****..."*

282. Ms Groves considered Michael was unfit to work in Kintore or in a general duties' role owing to his injury.

283. Ms Groves considered he would be fit to commence a non-operational role, such as in Youth Engagement in Darwin, within about three to six weeks,

but would be unfit to return to Kintore or general duties in the coming six to twelve months.

Michael's realisation of his PTSD diagnosis

284. Michael's journal indicates that by 4 April 2022, Ms Groves had informed him that she now believed he had PTSD. The entry Michael made that day is the first in which he speaks of being diagnosed with that condition. The relevant portion of the entry is as follows:

> *Think it was Saturday Kim [Groves] and I spoke as always helps me feel more clear about what I am going through. Diagnose PTSD which I was already pretty sure of.* ***I wish I had have acted on this prior to leaving Darwin for Kintore and addressed it all earlier****. Last few days suicidal thoughts, depressed, not sleeping at night, in bed all day, feelings of failure, guilt and shame about not finishing my time in Kintore. I am very grateful for family, friends, management, Kim & Justice for doing all they can to help me. If I cant fight these feelings of guilt & shame its likely going to kill me...Some moments just don't...know if I want to go back to policing or even to live. Finding this very hard to navigate through.*

285. Michael's statement that he wished he had "*acted on this prior to leaving Darwin for Kintore and addressed it all earlier*" tragically underscores, in his own words, the importance of early identification and the implementation of effective interventions for at-risk members. That includes requiring members to undergo comprehensive screening before they are posted to a remote community for an extended period.

Last sessions with Ms Groves and Dr Sykes

286. On 7 April 2022, Ms Groves held her final session with Michael (by telephone) before his passing. He was optimistic about his future. They discussed the logistics of moving to Darwin and the challenges of Youth

Diversion. He planned to visit Kintore to collect his belongings and see R/Sgt Rutherford, and to have a review with Dr Sykes the next day. A further session with Ms Groves was scheduled for 18 April 2022, after Easter.

287. On 8 April 2022, the Manager for Health and Recovery, relying on Ms Groves' 5 April 2022 report, sought approval from an acting Assistant Commissioner for the formal transfer of Michael's posting from Kintore to the Youth Engagement and Judicial Services Division (Darwin).

288. That same day, Michael had a telehealth consult with Dr Sykes, his last known professional contact before his passing. He reported a "tough month" but felt he was "getting better." He was awaiting paperwork confirming his transfer, planned to start work in Darwin in late May or early June, and would stay in South Australia until he needed to travel to Kintore to pack up his belongings. He again reported feeling guilt and shame about leaving his posting early.

289. Michael had been taking his medication as directed. He had taken 48 Diazepam tablets since the last consult, which, in Dr Sykes' view, indicated the stress Michael had experienced during that period. He reported suicidal ideation at times over the preceding month, but "*with no plans*". The plan was to continue the antidepressant, begin tapering the diazepam, and continue psychology sessions with Ms Groves. There is no evidence that Dr Sykes and Ms Groves communicated about Michael's progress after this consult.

290. Dr Sykes later told investigators that in both consults Michael had repeated the motto '*Service Before Self*' which Michael said he had heard from the Police Commissioner. Dr Sykes' impression was that this sentiment weighed heavily on Michael.

Michael's journal entry on 12 April 2022

291. On 12 April 2022 Michael made a journal entry which again, on its face, read as a suicide note. It included the following:

> *…I am carrying a very heavy weight of guilt and shame over leaving Kintore early and returning to Darwin.* ***I don't blame Kintore. Just some straws that broke the camels back****. I have found like the tide going out these feelings go when speaking Tony, Tany R, Parso, [?], Tim Kingston, Kim Groves and both times when speaking with Justin Sykes my GP. Afterwards like the tide coming in they come back. Just so tired of this feeling and see & feel it getting worse. Work side of things, quite proud that we have moved this far from older times. Family & friends have tried so hard, I am sorry…*

292. In the same entry Michael named many others he wanted to thank for their support, expressing how much they meant to him.

293. Clearly, at this point, Michael realised that his experiences in Kintore were not the sole cause of his injury. His injury had been developing for some time before events in January 2022.

Events on 15 and 16 April 2022

294. On 15 April 2022 Michael spoke by phone with Antony about his pending move to the youth diversion position. Later that day he texted Antony: "*Hey Tony thanks again for the call, yeah just been in a dip. Certainly, like you say, many going through similar times*."

295. At about midday on 16 April 2022, Michael spoke with R/Sgt Rutherford by mobile phone. She and Sgt Parsonson had stayed in regular contact with him while he was on leave. He spoke about the support he was receiving from his psychologist and doctor, at times saying he was not doing well and at others that he felt better.

296. In her oral evidence she described his concern about how his peers would perceive him not completing his two-year posting:

> *"He was worried that people form Darwin that know him well - he's a very well-known police officer, and he was concerned that they would think not highly of him or that he couldn't finish his bush term. And yeah, he didn't want to go back, feeling that he didn't complete what he was there to do, the two - the two years. And he didn't want everyone thinking badly about that.*
>
> *[I]... told him that no one would think badly about him. Lot of people haven't even gone out remote, or they don't even know what it's like. And for him to come out there and not finish it, it doesn't matter. He's so well-respected that no one would - no one would care if he didn't complete that term."*

297. Nothing Michael said in their last conversation together indicated, to her, that he would go on to self-harm.

MICHAEL'S DEATH

298. At about 8pm on 16 April 2022, Michael's parents left home for a church service.

299. On their return, they found Michael deceased in the rear yard.

300. Michael had evidently laid out items being his wallet, NT Police identification, driver's licence, medical journal, medication boxes and prescriptions, and a handwritten journal open to a last entry dated 16 April 2022.

301. South Australia Police investigated Michael's death. The South Australian Coroner found that Michael died on 16 April 2022, aged 44, from compression of his neck in keeping with hanging.

EFFICACY OF TREATMENT IN FEBRUARY-APRIL 2022

Should a diagnosis of chronic PTSD with MDD been made earlier?

302. Dr Frost, in her evidence, expressed concern about the diagnosis of adjustment disorder with mixed depression and anxiety, as, in Dr Frost's view, it did not do justice to the severity of Michael's condition and his risks. Dr Frost said:

> "*[In Ms Groves' referral letter on 7 March 2022] there was an understatement of both risk and severity of illness. An adjustment disorder and I won't go through the DSM criteria - but it basically says that you're struggling to adjust to something that's happened. But implicitly, you're expected to make a full return to function. As we talked about before, with post-traumatic stress disorder, if somebody's had that chronically for many, many years, that return to function is going to require a lot more therapy, management and time than somebody with an adjustment disorder*."

303. Ms Groves, in her oral evidence, looking back in hindsight, accepted that at least by 9 March 2022, if not before, a diagnosis of Complex PTSD with MMD was reasonably open to have been made in Michael's case.

304. Ms Groves said the initial working diagnoses did not mean she wasn't "extremely concerned" about Michael. She considered his depression, anxiety, and stress scores on 4 March 2022 to be "*extremely severe*" and his condition to be "extreme[ly] serious." Her evidence on this is consistent with the steps she took on 4 March 2022 following Michael's disclosures, which included:

    (1) Developing a plan to manage his risks of self-harm.

    (2) Referring Michael to a general practitioner to be assessed for antidepressant medication.

(3) The number and frequency of their sessions together after that.

305. There is no doubt that Ms Groves was appropriately concerned for Michael's well-being and was acting in good faith in attempting to support him.

306. It is important that sight not be lost on the fact that Ms Groves did not have access to Michael's journal entries, which themselves provides a unique insight into Michael's anguish at the time. As Dr Frost observed in evidence:

> *"One of the difficulties for me writing [Dr Frost's supplementary report], was I didn't get the diary until, I think, two days ago…It was only when I got the 32 pages - I - I can remember sitting there going, "Oh my god. I think I've underestimated just how seriously unwell he was when I wrote my second report." And so based on the I mean, if I'd had the diaries and the clinical notes almost side by side, I may have answered question 4 in that second report differently. But I didn't have the diaries at the point of - - - And so my response was because - so Ms Groves had assessed him at that point as being, "Future oriented. Not focused on settling his affairs." Although we know he's written - now we know he's written suicide notes, "Well supported by his treating psychologist, his parents and siblings and his colleagues. He was consenting to treatment. He was engaging with both his psychologist and GP." So at that point he's not refusing treatment but he's also not revealing the extent of his despair. He is to his diary but not to [Ms Groves and Dr Sykes] - - -*"

307. However, even with reasonable allowance for the above matters, I am satisfied that it was reasonably open to diagnose Michael with chronic PTSD, with MDD closer in time to his going off work and otherwise no later than 4 March 2022, when he made his disclosures about the ligature incidents.

308. Ms Groves' working diagnosis as of 1 March 2022 of adjustment disorder with mixed emotions, her stated reluctance to diagnose PTSD owing to Michael's good functioning until recently, and her support for his possible return to work by mid-March 2022 all point to an underappreciation of the severity of Michael's condition. The maintenance of that working diagnosis until early April 2022, even after Michael's disclosure on 4 March 2022 of his *rehearsal*-type self-harming behaviour, strengthens my conclusion in this respect.

309. This constituted a missed opportunity to arrive at a proper diagnosis of Michael's condition at the earliest time reasonably possible.

310. I accept that it cannot be ascertained what difference an earlier diagnosis of Michael's chronic PTSD with MDD would have made (if any). This, of course, does not lessen the importance of making diagnoses of this kind when the diagnostic criteria are met.

Benefits of the early involvement of a psychiatrist in treatment

311. To my mind, the above underscores the benefit of an early referral to a psychiatrist with experience in frontline trauma.

312. The psychiatrist does not necessarily need to be the patient's primary point of contact. They would be part of a multidisciplinary team approach that would, ideally, also involve a psychologist and a general practitioner.

313. The psychiatrist can provide clinical oversight in collaboration with the treating team, particularly regarding diagnosis and recommendations on medication and risk management.

314. Referrals to a psychiatrist can follow two pathways - (i) A patient is referred by a general practitioner to a private or public psychiatrist (through the public health system), or (ii) a patient approaches a private psychiatrist directly without a referral if the psychiatrist is open to accepting such

referrals. The Darwin Private Psychiatry clinic is based within the Darwin Private Hospital. A challenge for the Northern Territory is the limited availability of psychiatrists for outpatient treatment in both the public and private systems.

315. Ms Groves, in her notes made on 4 March 2022, recorded "*Discussed inpatient option - Michael advised that he did not need that, emphasised no intent and it would make him much worse."* Ms Groves, in evidence, said this note was in reference to the possibility of Michael having a psychiatric consult. Ms Groves said Michael was opposed to this option as it would have involved his attendance on a psychiatrist at the Darwin Private Hospital.

316. It appears Michael was apprehensive (understandably) about seeking treatment in a hospital setting that he himself had previously taken mentally ill persons to for treatment as part of his general policing duties. He may have believed he would know people at that venue from these duties and have been concerned about himself seeking treatment there.

317. The NTPF's *Wellbeing Services* has assisted members with referrals to psychiatrists. This has occurred on a case-by-case basis. In such cases, a psychiatric consultation has typically been arranged within 10 days. These consultations have been funded by the NTPF (not by the members themselves).

318. A formal referral pathway for this does not presently exist. These referrals are treated as "*off-contract referrals*." By May 2025, a new Employee Assistance Program (EAP) procurement process had begun. It is anticipated that the finalised EAP procurement, if approved, will provide a formal psychiatric referral pathway. That procurement process had not been finalised when the hearing concluded in August 2025.

319. I am satisfied there would be benefit to the NTPF's *Wellbeing Services* working to develop a pool of psychiatrists, preferably those experienced in treating emergency responders, to whom it can refer NTPF members. This may extend to interstate-based psychiatrists who consult the member via telehealth or on a fly-in/fly-out basis.

320. I make the following recommendation to the Commissioner of Police:

> *<u>Recommendation No.3:</u> the NTPF, as a matter of priority:*
>
> *Introduce a formal psychiatric referral pathway for members suspected to be suffering a mental health injury (e.g. PTSD), which includes the possibility of referrals to interstate psychiatrists experienced in treating mental health injuries.*
>
> *Inform external clinicians, to whom members are referred through the Employee Assistance Program, of this pathway and the NTPF's expectation that this option will be canvassed with patients if judged appropriate by the clinician (with those discussions contemporaneously noted).*
>
> *Develop a strategy to educate NTPF members about the benefits of a psychiatric consultation, potentially using Michael's case as part of that education strategy.*

321. It cannot be known for certain whether Michael would have been open to a psychiatric consultation if there had been an opportunity for that to occur outside a hospital setting in Darwin. Providing this option nonetheless remains important for members experiencing symptoms similar to Michael's. Ideally, a referral to a psychiatrist would occur before the member's symptoms reach the point they did in Michael's case, when they manifested as a severe injury (PTSD).

322. It is important to appropriately discuss the benefits of a psychiatric referral with a member like Michael. This may increase their willingness to engage

a psychiatrist and enable them to make an informed decision about this option.

323. Informing members about the benefits of possible psychiatric involvement, improving members' understanding of these benefits, and reducing stigma around consulting with psychiatrists, are of critical importance.

Efficacy of the medication prescribed to Michael on 7 March 2022

324. In Prof McFarlane's view, the 75 mg Venlafaxine (SNRI) antidepressant prescribed to Michael was "*relatively low*." Prof McFarlane expects he would have recommended a higher dose had he been treating Michael on 7 March 2022 (possibly as high as 150 mg).

325. Although Dr Sykes did not dispute the validity of Prof McFarlane's opinion on this, in evidence Dr Sykes maintained that the dose he prescribed, based on his expertise and the information available to him in real time, was reasonable.

326. Dr Frost, while agreeing with Prof McFarlane's opinion about the dosage, said she may have supported an initial dose of 75mg with a view to weekly reviews thereafter to assess the possibility of increasing the dose after two weeks.

327. I am satisfied that Dr Sykes' prescription of 75 mg was reasonable given his training and experience. Nor can it be known what difference (if any) a higher dose at an earlier stage might have made for Michael. This once again underscores the value of involving an experienced psychiatrist in a multidisciplinary team approach.

Should safety planning have required Michael to attend face to face GP consults during his stay with his parents in South Australia

328. In Dr Frost's view, it would have been preferable for Michael to have face to face reviews with a general practitioner in Adelaide when he went to stay with his parents in mid-March 2022.

329. Dr Frost explained the importance, in her view, of face to face consults, stating:

> *"Up - up until the point where I felt that somebody needed that face to face assessment, particularly if suicide risk was part of it. And as I said before, I find assessing suicide risk over the phone or internet much, much harder. Because essentially appealing to somebody's humanity requires almost, like, eyes locking. To know somebody's safety you actually - you've kind of got to fix them in the - in the eye and, you know, "Let me tell" - "Let me ask you what is really going on." Using the medium of - of - of their internet, of the - of video conferencing is - I think is very difficult in that setting."*

330. The risk is that the general practitioner, in telehealth reviews, is "*not really getting a big picture.*"

331. Ms Groves, in her oral evidence, said she discussed with Michael during sessions the possibility of his having face-to-face sessions with a provider in South Australia. Michael said the only general practitioner he knew in Adelaide was his parents' doctor, and he did not want to engage that practitioner. Ms Groves said she offered to find Michael another general practitioner in Adelaide (*which Michael presumably declined*).

332. This part of their discussions was not recorded in Ms Groves clinical notes and I cannot find what exactly was canvassed with Michael around this.

333. I accept that Michael had a positive view of Dr Sykes and was inclined to retain that connection rather than involve another with whom he had no familiarity.

334. Dr Frost acknowledged the complexity of a clinician managing a patient who is interstate. On the one hand, the best place for the patient is with their family. But that arrangement prevents regular face-to-face contact with the treating clinicians based in Darwin.

335. Dr Frost said her approach would likely have been:

> *".. [I] try and highlight to people the importance of actually being in the room with someone. That suicide is much - completed suicide often happens at a time people feel really disconnected. And so I would say to somebody, I don't think it's safe that you're seeing - I think you must be seeing, even if you go on seeing [Dr Sykes], there needs to be somebody seeing you face to face on say, a weekly basis."*

336. While accepting it would have been preferable for Michael to have had face-to-face reviews with a general practitioner while in Adelaide, it cannot be known what difference this arrangement might have made in Michael's case. This, again, is another example of the value an experienced psychiatrist is likely to bring to multidisciplinary treatment.

Whether Michael's family should have been told about Michael's disclosures on 4 March 2022 and their importance to his safety planning?

337. Ms Groves and Dr Sykes did not notify Michael's family about Michael's disclosures on 4 March 2022 or the significance, in their minds, of Michael staying with family as part of the safety planning.

338. I accept that Ms Groves spoke to Michael about the possibility of her notifying his family about these matters. This is something Ms Groves expressly noted on 4 March 2022, when she recorded that Michael did not "*want family informed of plan – Michael confident to discuss himself what is appropriate to share."*

339. Ideally a clinician would be able to directly involve a patient's family in safety planning of this kind. At the same time the efficacy of treatment depends on the patient's consent and maintenance of confidentiality.

340. Although there are exceptions that permit disclosure against a patient's wishes, or without their informed consent, that is an extraordinary step and can be justified only in exceptional circumstances.

341. The consequence of a clinician acting contrary to a patient's wishes in this respect can result in the patient being less trusting and less willing to engage with clinicians in the future.

342. I am satisfied that it was reasonable for Ms Groves to respect Michael's wishes.

Qualifications and experience of the psychologist

343. An issue considered was whether it would have been preferable for Michael to have been referred to and treated by a psychologist with a clinical psychology endorsement.

344. In Prof McFarlane's view, patients like Michael are complex and should be referred to psychologists with a clinical psychology endorsement who specialise in trauma-related injuries.[11]

345. While it might be ideal if EAP psychological referrals were limited to psychologists with clinical accreditation. The practical reality is the limited availability of psychologists in the Northern Territory, particularly those with a clinical endorsement.

346. However, such accreditation is likely to be less material assuming experienced psychiatrists are involved in treatment at an early stage.

[11] Frost 2nd report 20.7.2025 p.7 Vol 8 Tab 122.

WELLBEING REFORMS SINCE 2022

2022 Review

347. In March 2022 Hatch Solutions completed a review of the then NT Police Fire and Emergency Services' (NTPFES's) *Support and Wellbeing Services* (**2022 Wellbeing Review**).

348. The key finding of this review was that *"[t]he current model for support and wellbeing is not meeting the current nor future needs of the NTPFES and requires considerable change.*"

349. The review identified shortcomings across multiple domains and made recommendations for reform.

350. In response, a Wellbeing Project Team was established in July 2022 to develop the NTPFES's first formal strategic framework for wellbeing being the *Wellbeing Strategy 2023-2027* (**Strategy**) launched on 22 May 2023.

351. The Strategy was informed by the Beyond Blue Answering the Call study and its associated Good Practice Framework for Mental Health and Wellbeing in First Responder Organisations (2020).

352. The Strategy addresses three career stages - recruitment (including career change and promotion points), operational service, and leaving the service - and set a delivery timeline for implementing, embedding, reviewing and evaluating its reforms by 2027.

353. The NTPF, in its institutional evidence in this inquest, said it is continuing to strengthen its focus on well-being and to improve its monitoring and interventions. It also "*recognizes that members may be exposed to a range of psychosocial and occupational risks that can impact their mental health and, in some cases, contribute to suicidality.*" It has identified these risks through internal policy development, operational experience, well-being

case management, and consultation with national evidence, including the Beyond Blue research.

354. The Initiatives implemented under the Strategy to mitigate psychological harm from occupational trauma exposure include:

(1) Enhanced critical incident response and post-incident outreach;

(2) Improvements to its *WellCheck* program, and exploration of individualised psychological screening;

(3) Suicide intervention training and Mental Health First Aid delivered to members across roles and ranks;

(4) An Early Intervention Program that uses risk indicators to identify and engage members;

(5) A wellbeing portal with digital resources and self-screening tools; and

(6) Work to strengthen the Peer Support Program and improve trauma-informed access to EAP and psychological services.

355. The NTPF recognises the following risk factors as contributing to elevated suicide and self-harm risk among members:

(1) Exposure to potentially traumatic events, including suicides, child deaths, serious threats to safety and multiple fatalities;

(2) Cumulative or repeated trauma exposure through frontline duties;

(3) Fatigue and burnout, formally recognised as workplace hazards under its Fatigue Management Policy;

(4) Psychosocial hazards, such as high job demands, limited control, low support, interpersonal conflict, unclear role expectations, and exposure to bullying and harassment;

(5) Mental health conditions, including PTSD, depression and anxiety;

(6) Isolation, particularly among members deployed to remote or very remote areas;

(7) Stigma and help-seeking barriers, often linked to cultural norms of self-reliance, confidentiality concerns and fears of negative career impact;

(8) Organisational stressors, such as role uncertainty, performance management or medical downgrading; and

(9) Unique high-exposure events, including the suicide or sudden death of a colleague.

356. The NTPF monitors these risks through mechanisms which include:

(1) The Critical Incident Notification (CIN) process alerts Wellbeing Services when a member has been involved in or exposed to a potentially traumatic event, enabling clinicians to offer support, triage responses, and provide psychoeducation or follow-up. Contact under this process is consistent with the check-ins conducted for Michael between 2007 and 2017.

(2) The Early Intervention Program uses integrated data sources to identify members who may show early warning indicators of psychological or psychosocial risk. Supervisors are notified of flagged concerns and supported in initiating early conversations and referral pathways.

(3) Performance of *WellCheck* assessments (explained further below).

(4) The Peer Support Program, which provides short-term support and informal check-ins after potentially traumatic events or periods of stress. Peer Support Officers, trained in Mental Health First Aid and suicide awareness, act as a bridge to professional help.

(5) Fatigue management monitoring, including overtime claims and on-call hours.

357. As of April 2025, the NTPF's Wellbeing Services Unit, based primarily in the Darwin/Palmerston area, comprises clinicians (two psychologists and five social workers); two occupational rehabilitation advisors (an exercise physiologist and an occupational therapist); two chaplains; a peer support coordinator; three administrative staff (including the director); an Early Intervention Coordinator; and a Mental Health First Aid Facilitator.

358. *WellCheck* assessments are now conducted by clinical psychologists within Wellbeing Services or by social workers they have trained.

359. *WellChecks* typically involve a one-hour conversation between a wellbeing clinician and the member, with psychometric testing using self-report instruments such as the DASS and PCL-5. One objective is to establish a baseline for the member as a benchmark for future assessments. The results of these checks are confidential and are not disclosed to supervisors without the consent of the individual member involved.

360. All current recruits undergo, at a minimum, psychometric testing consistent with that used in *WellChecks*. The NTPF's Wellbeing Services aims to conduct annual *WellChecks* for members in specialized units and remote station postings. It also educates members, at both the recruitment and operational stages, about the purpose and benefits of *WellChecks* to encourage their participation.

361. To be clear, a *WellCheck* is not a comprehensive screening of the kind suggested for approval of long term postings to remote communities.

Fatigue management

362. As of 2021-2022 the NTPF did not have policies directed to fatigue management although it expected members and managers would manage this issue under other protocol.

363. In November 2024, the NTPF enacted the *Fatigue Management (Statement of Intent) (Policy – 21 November 2024 - V1.0)* (**Fatigue Management Policy**) and the *Fatigue Management (Statement of Intent) (Standard Operating Procedure – 21 November 2024 – V1.0)* (**Fatigue Management SOP**). These measures were identified in the 2022 Wellbeing Review and the 2022 Consent Agreement.

364. The *Fatigue Management Policy* outlines principles for identifying and managing fatigue and specifies roles and responsibilities across multiple levels, including the supervisor, officer-in-charge, divisional officer, and Superintendent/Watch Commander.

365. The *Fatigue Management Policy* defines fatigue and its effects and specifies risk management processes. The latter includes identifying fatigue by consulting with workers and examining worker records (e.g., overtime claims, callouts, respite from duty, shift changes, and whether excessive hours were worked). It relevantly provides:

> *"At times, stations in remote and isolated locations can experience prolonged hours of work or recall to duty without access to relief staff, contributing to the risk of fatigue.*
>
> *The fatigue of the workers should always be considered in line with the Standard Operating Procedure-*

Fatigue Management and recorded to ensure it is visible to their divisional superintendent, divisional senior sergeant and / or OIC's and the TDS for future taskings.

When necessary, workers should communicate with all stakeholders including both the divisional Superintendent and/or the Watch Commanders / TDS to enable the implementation of appropriate fatigue management controls."

366. The enactment of formal fatigue management protocols is an important step for member well-being. Time will tell whether this measure is effectively implemented and beneficial.

367. An adjunct to this policy is the monitoring of overtime hours. The NTPF's electronic rostering system ('*myRoster'*) is being reconfigured to capture overtime electronically and provide real-time visibility for monitoring by a Territory Duty Superintendent.

368. The NTPF expects this will better inform decision-making on how to best utilise members while reducing the risk of burnout from fatigue, particularly in remote stations. The reconfiguration was originally slated to be completed in 2025. The inquest was told it is now expected to be finalised in 2026. It is not known whether the reconfiguration has been completed yet.

369. It goes without saying that ensuring the efficacy of its Fatigue Management Policy and the systems for monitoring overtime is fundamental to the NTPF's efforts to safeguard its members' well-being.

PROF MCFARLANE'S REVIEW OF THE WELLBEING STRATEGY

370. Prof McFarlane, after giving his oral evidence in these proceedings in August 2025, was briefed by the NTPF to review the *2023-2027 Wellbeing Strategy* and to offer preliminary recommendations on reforms.

371. In October 2025 Prof McFarlane completed "*Scoping Report of the Wellbeing Strategy 2023-2027 for NT Police.*" A copy of his report tendered in these proceedings.

372. Prof McFarlane expressed the following 'preliminary' views in his report.

373. The Strategy does not set out key points and interventions that are "*likely to have the greatest benefit and impact"* on members' well-being. Other interventions and programs need to be spelled out, as they are necessary for a comprehensive prevention and management strategy.

374. This extends to primary prevention (e.g., teaching coping strategies), secondary prevention (early intervention once a disorder or early levels of symptomatic distress become apparent), and tertiary prevention.

375. Prof McFarlane also stated that:

> *"…the major difficulty with the Wellbeing Strategy 2023-2027, is that it does not clearly state the importance of considering how the progressions occur in officers to increasing levels of distress in the course of their duties. Secondary and tertiary prevention are key elements of a strategy that should be called a Mental health and Wellbeing Strategy. The barriers to care and the impacts of increasing psychological distress on officers functioning are not set out in a manner that provides clear direction as to how to assist them. In essence, the focus on the concept of wellbeing is at the expense of any proper discussion of workplace psychological injuries and their impact on an officer's ability to perform his or her duties."*

376. Prof McFarlane made several interim recommendations, namely:

    (1) A major review of the Strategy should be undertaken to align it with the evidence base and to incorporate strategies expressly addressing mental health.

(2) Shifting the NTPF's focus toward providing a system of care informed by occupational health and safety principles, with both prevention *and the* provision of optimal clinical pathways to manage mental health injuries.

(3) Ensuring the Strategy expressly addresses the different risks and needs of members as their length of service increases. This is to account for the increased risk associated with cumulative trauma exposure for long-term carers in frontline policing roles.

(4) Ensuring the strategy expressly defines adverse occupational health outcomes due to policing (e.g., increased risk of PTSD and general psychological distress) and provides guidance on specific approaches and clinical pathways.

(5) Ensuring the Strategy has an effective quality assurance and improvement program that is updated as new knowledge about prevention, risk management, and treatment emerges.

(6) The system for managing injured officers should be reviewed, including ensuring that meaningful alternative roles are available when members are at risk of deteriorating wellbeing or injury.

(7) Ensuring that health services for injured members include a designated professional to manage high-risk cases. A key part of that role is to ensure access to required clinical services that the NTPF itself provides.

(8) Examining the development of a program to assist and support officers considering transitioning to civilian employment.

(9) Examining ways of extending and reinforcing other parts of the strategy such as the role of leadership, the *WellCheck* program, the education of the workforce, and addressing stigma.

377. It is commendable that the NTPF took the step of briefing Prof McFarlane to seek his views on improving its wellbeing strategy.

378. It is now of critical importance that the NTPF goes further and acts on those recommendations in a timely manner.

379. To that end, I make a recommendation in the following terms:

> *Recommendation No.4: The NTPF continue its engagement with Prof McFarlane to progress and give effect to the interim recommendations set out in his October 2025 Scoping Report as a matter of priority.*

OTHER REFLECTIONS / LEARNINGS

Shorter periods for remote posting

380. Michael's transfer to Kintore was approved for a minimum of two years. The length of this term and his inability to see it through weighed heavily on him. There would be benefit in the NTPF examining approval for shorter terms (e.g., 9 to 12 months), with a member potentially having the right to extend for further periods of similar duration if there are no work performance issues. I recommend the NTPF consider this possibility as part of its engagement with Prof McFarlane on its Wellbeing Strategy.

Developing meaningful non-frontline positions / career pathways

381. In Prof McFarlane's view, agencies must plan in anticipation of members "*like Michael and getting well-structured roles that are meaningful that he could be moved into*."

382. It is critically important that the NTPF create opportunities for frontline members to take on meaningful non-operational roles. This includes short- and longer-term alternative positions. These opportunities are intended to provide members with a period of recuperation and, potentially, in the latter stages of their careers, a move away from roles involving regular exposure

to trauma and stressors. In the latter case, members are at increased risk of a mental health injury if their policing career to that point has involved extensive time in operational roles.

383. The NTPF does not at present have a formal policy for the routine rotation of members into non-operational roles for respite purposes. It would be beneficial for the NTPF to examine this matter moving forward. If planning an alternative career pathways only begins when a member becomes injured, there is a real risk of delay and uncertainty which may hinder their recovery.

384. Appropriate advance planning may also assist to reduce or avoid the type of uncertainty that caused Michael so much anguish when he faced being unable to return to a frontline role when he became injured.

385. I recommend the NTPF give this matter attention as part of its engagement with Prof McFarlane and review of its Wellbeing Strategy.

Ensuring appropriate resourcing for NTPF Wellbeing Strategies

386. During the 2024-2025 the NTPF employed about 1,375 sworn full-time members. The *Wellbeing Services* employed two psychologists and five social workers along with other staff (e.g., rehabilitation advisors, support and intervention coordinators, administrative staff, etc) as of April 2025.

387. As of July 2025, *Wellbeing Services* had six clinicians available to perform *WellChecks*. It estimates it presently has the capacity to undertake about 450 *WellChecks* each year.

388. *Wellbeing Services* was awaiting approval of a proposal to fund two senior clinicians and eight clinicians based in Darwin, two clinicians based in Katherine, and two clinicians in Alice Springs (along with three occupational rehabilitation advisors based in Darwin and one in Alice

Springs). If implemented, this is expected to increase capacity to perform about 2550 *WellChecks annually*.

389. As of the date the hearing in these proceedings ended (August 2025), this proposed model and its funding had not been approved. It is trite to say that the Executive will need to ensure the NTPF receives sufficient resources to continue its work in safeguarding members' well-being *and* achieving its stated well-being goals.

SUBMISSIONS ON BEHALF OF THE FAMILY / NTPA

390. Comprehensive written submissions were prepared for the family and the NTPA. I have given careful attention to these submissions and the findings and recommendations it proposes I make.

Distinction between concern and effective systems

391. I agree with the submissions that a distinction arises between the institution's concern for its members' wellbeing, on the one hand, and it having adequate systems to manage risks arising to members' mental wellbeing, on the other.[12]

392. I accept that the NTPF's Wellbeing systems did not identify Michael's deteriorating mental well-being or the flags that indicated he was at risk (e.g., excessive leave accrual) *before* his symptoms became subsyndromal, let alone before they crossed the threshold of actual injury.

393. It is hoped that improvements made since 2022, and those that will hopefully occur in response to Prof McFarlane's review, will materially increase the likelihood of the early identification of a member's decline *before* it becomes entrenched.

[12] Family / NTPA submission [14]-[15].

394. I cannot predict to what extent Prof McFarlane's review and recommendations will be acted upon by the NTPF, other than to state that, based on the NTPF's evidence and position at this inquest, I understand that serious attention is being given to them.

395. The Executive and the NTPF's stated commitment to member well-being will, in time, be judged by the extent to which that review and its recommendations are given effect.

Findings proposed at [30]-[39]

396. Before addressing the findings sought in the Family/NTPA's submissions at [30]-[39], it is necessary to comment on the inquest proceedings and the obligations arising under the *Work Health and Safety (National Uniform Legislation) Act 2011* (NT).

397. The primary purpose of an inquest is to the findings that a Coroner is statutorily obligated to make under s 34(1)(a) of the *Coroners Act 1993* (NT). In Michael's case, that includes the manner of his death. Secondary to that, a Coroner is permitted under s 34(2) to comment on any matter, including public health or safety, that the Coroner considers is connected to the death.

398. The *Coroners Act 1993* (NT) prohibits any comment or statement that finds a 'person', which includes an Executive body like the NTPF, is or may be guilty of an offence. This reflects longstanding coronial practice that the purpose of inquest proceedings is not to decide issues of criminal or civil liability.

399. Doing otherwise runs counter to the objective of the inquest to find how a person died and in what circumstances. To facilitate that objective, coronial proceedings are relieved of the formal procedures and rules of evidence that ordinarily arise in criminal or civil proceedings.

400. Subdivision 2 of Part 2 of *Work Health and Safety (National Uniform Legislation) Act 2011* (NT) specifies obligations a business or undertaking bears for the health and safety of its workers which includes ensuring, so far as is reasonably practicable, that the health and safety of other persons is not put at risk from work carried out (including the provision of safe systems of work and the monitoring of the health of workers to prevent illness or injury): s 19. It is a criminal offence under the *Work Health and Safety (National Uniform Legislation) Act 2011* (NT) to contravene this obligation.

401. Regarding the proposition that the NTPF did not, at the time of Michael's death, have a work health and safety system reasonably capable of identifying, assessing, and controlling the foreseeable psychosocial hazards arising from cumulative operational trauma, particularly with regard to remote policing, this inquest has focused on the NTPF's systems and arrangements with respect to Michael and his experiences. It is beyond the reasonable scope of this inquest to examine the experiences of other members to enable it to be properly placed to contemplate findings of the kind sought.

402. Regarding the submission that the present evidence does not establish that the NTPF has a mandatory system applicable to all remote operational postings that requires pre-posting psychological assessment, I have found accordingly, as set out above.

403. Regarding the submission that there is presently no evidence of structured monitoring of fatigue, leave, callouts, and periods of one-up policing in remote community postings – the evidence reveals that the NTPF enacted a formal Fatigue Management Policy and relevant standard operating procedures in November 2024. The examination of the efficacy of these systems, introduced some years after Michael's passing, would necessitate a

broad-ranging inquiry that goes beyond what can reasonably occur in this inquest.

404. I acknowledge the importance of this matter for safeguarding the well-being of NTPF members. I have also found that reforming the NTPF's institutional culture is important. Again, as stated above, the Executive and the NTPF's stated commitment to member wellbeing will be judged by the extent to which they prioritise reform of this culture and the efficacy of their practices for managing fatigue.

405. Regarding the submission that this inquest should examine whether the NTPF, at present, has an occupational risk-management structure that accords with its obligations under the *Work Health and Safety (National Uniform Legislation) Act 2011* (NT), in my view it would not be proper to do so. An examination of the kind suggested would, effectively, amount to a broad criminal inquiry into whether the NTPF previously or currently has satisfied its statutory obligations under the *Work Health and Safety (National Uniform Legislation) Act 2011* (NT). This runs contrary to the purpose of this inquest and my legal framework.

406. I have identified shortcomings and areas of relevance to Michael's experiences and made several recommendations to ensure that the attention of the Executive, particularly the NTPF, is directed to those matters in the manner provided for under s 34(2) of the *Coroners Act 1993*.

Risks posed by remote community postings extend beyond Kintore

407. I accept the family/NTPA's submission that the stressors that arose in Kintore are not unique to that community and that not all remote stations present identical risks.

408. Regarding the submission that the risks posed by some remote station postings are sufficient to warrant a "dedicated Territory-wide risk-management framework," I accept, at a minimum, that it would be beneficial

for the NTPF to examine developing a specific protocol or framework directed to this matter.

409. This may be something that could be addressed as part of the further work to be undertaken, as recommended by Prof McFarlane.

410. I am satisfied it is appropriate to make a recommendation to the Commissioner of Police on this matter in the following terms:

> *<u>Recommendation No.5:</u> The NTPF examine the benefits of developing and introducing a Remote Operational Policing Psychosocial Risk Management Framework. Without being exhaustive, this would provide a framework for assessing and monitoring the risks posed to member's wellbeing at specific remote community postings including but not limited to (i) remoteness / travel time, (ii) staffing, (iii) the potential for 'one-up' duties at that station; (iv) callout frequency and on-call exposure; (v) prisoner transport requirements and access to Air Wing; (vi) potential disturbances in the community. This policy would extend to providing a framework for members to provide ongoing feedback on risk during their posting and following the completing of the same.*

Organisational culture

411. I accept the submission that the significance of "service before self" extends beyond formal policies to the broader culture of the NTPF. As I remarked earlier, greater resourcing and improvements to well-being services will not, in themselves, safeguard members' well-being if the NTPF continues to pressure members to perform under extreme stress to enable a service to be delivered. Without change to that culture, members' well-being will continue to be at risk.

Findings sought at [50], [354], [634]-[658], [661]-[664]

412. I have considered the findings sought in the family/NTPA's submissions. The essence of many of those sought findings is expressly or implicitly reflected in many of the findings I have made. I otherwise consider that some of the sought findings come close to contravening the prohibition against findings as to criminal liability or are otherwise unnecessary to make.

Longitudinal monitoring across a member's career

413. I accept the Family/NTPA's submission that the management of risk ought to require longitudinal monitoring of a member throughout their career.

414. I understand that that is what the NTPF Wellbeing Services' Unit is seeking to do through the extension of its *WellCheck* program. It aims to ensure that all willing members undergo a *WellCheck* to establish a baseline, with periodic *WellChecks* performed at different intervals in the future.

415. This is not to say that longitudinal monitoring should be limited to *WellChecks*. Other data sets or 'flags' can be monitored and recorded over a member's career, including the number and type of traumatic exposures in the job and excessive accrued leave or insufficient use of leave.

416. Moreover, to be clear, the *WellCheck* program should not be relied on in place of a comprehensive psychological screening for long-term remote community postings. There may be other instances in which comprehensive screening is required, such as when a member seeks a posting to a high-intensity role (e.g., TRG). This is a matter the NTPF may wish to examine as part of its planned work with Prof McFarlane.

Sufficiency of the current Strategy

417. Regarding the sufficiency of the current Strategy, I have summarised above the key findings of Prof McFarlane and his recommendations. I have also made a recommendation in that regard.

Whether there should have been an independent organisational mechanism to ensure follow-up of Michael after his 23 November 2021 session with Ms Groves

418. There was no 'independent organisational mechanism to ensure follow-up after Michael's last session with Ms Groves, and that Michael was not required to undergo a clinical review on his return to Kintore'.[13]

419. There may be value in the NTPF examining, as part of its work with Prof McFarlane, whether such reviews should be mandated in response to an AIIR reporting a decline in mental well-being or when the member discontinues Stream 1 psychology sessions. This may not be as straightforward, as mandating a clinical review which might deter some members from seeking help in the first place.

Minimal staffing and a prohibition on 'one up' policing in remote communities

420. Regarding the submission that 'minimum staffing should…be treated as a safety control, not merely a desired establishment figure' – I accept that requiring members to work 'one-up' in a remote station can pose significant risk to their mental well-being. The duration for which they are required to do so, and the conditions on the ground at the time, will be material factors in assessing that risk.

421. It is telling that the WA Police Service does not, itself, permit its members stationed in Kintore to attend jobs 'one-up'.

422. However, I am not sufficiently placed, on the evidence received and on the basis of the depth to which this issue was examined in this inquest, to make the findings or recommendations sought.

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[13] Family / NTPA submission [290].

Ensuring members that are stationed to a remote community should undergo proper induction in preparation for that posting

423. I accept the Family/NTPA submission that the NTPF should ensure that any member who is to be posted long term to a remote community receives proper induction as part of preparation for that posting. That said, in Michael's particular case, he had undertaken temporary relief work in Kintore and the surrounding area before his long-term posting. I am not satisfied that the absence of induction in his case was a material factor in the decline of his well-being.

Whether the NTPF should have carried out its own investigation of the circumstances of Michael's injury

424. The Family / NTPA are critical of the NTPF for not, of its own volition, investigating the circumstances that resulted in Michael's mental health injury, outside the investigations performed at the SA police's request for the SA Coroner and the work done at my request (for these proceedings).

425. I consider there is some force to this submission. It is important that the NTPF, as an institution and an employer, be proactive in examining whether a long-standing officer suffers a suspected self-inflicted death.

426. There may be utility for the NTPF to have a root cause analysis procedure in such cases to enable a detailed review, conducted with frankness and candour in the knowledge that its findings will, except for inquests, be confidential, to ensure it identifies relevant systemic issues and makes immediate changes where appropriate.

427. I am satisfied it is appropriate to make a recommendation on this matter to the Attorney General and the Minister for Police, Fire and Emergency Services in the following terms:

Recommendation No.6: The Executive consider legislative amendment of the Police Administration Act 1978 (NT) and/or governance and policy amendment to introduce a root cause analysis model directed to the review / investigation of the circumstances where an NTPF member suffers a suspected self-inflicted death. The purpose of that review / investigation would be to enable the timely investigation of the circumstances of the member's death, whether systemic work factors materially contributed to that death and whether changes or improvements to workplace practices should be implemented.

Submissions concerning the Evaluation of the Strategy

428. I have considered the submissions and proposed findings set out in the Family/NTPA submissions at [511]-[533]. In my view, the findings sought are not necessary in these proceedings. This conclusion takes into account the findings I have already made regarding NTPF's practices before Michael went off work injured, the efficacy of his treatment, and the work NTPF proposes to undertake with Prof McFarlane after his review of the Strategy.

Evidence of the institutional witnesses

429. I have considered the submissions and proposed findings set out in the Family/NTPA submissions at [544]-[587] with respect to the NTPF's institutional witnesses. I am not persuaded that it is necessary or appropriate to make the findings sought as these findings address the issues I consider most significant to understanding the circumstances (manner) of Michael's death. However, I was perturbed by what appeared to me to be a reluctance on the part of the NTPF to robustly investigate and understand for themselves the circumstances of Michael's passing and the contribution his work (trauma and stressors) played in the development of his mental injury. This concern is addressed by '*Recommendation No. 6'*.

Recommendations proposed by the Family / NTPA

430. Regarding the proposed recommendation that the Commissioner of Police, in conjunction with Prof McFarlane or another suitably qualified expert, revise the Wellbeing Strategy 2023-2027 and develop an integrated Occupational Mental Health and Psychosocial Risk Management Framework, I consider '*Recommendation No. 4'* set out above addresses the former. As to whether an integrated framework ought to be developed, in my view such a decision should await the completion of Prof McFarlane's further work with the NTPF. It would be premature to determine what conclusions should be reached in that respect.

431. Regarding the proposed recommendation that the NTPF develop a secure system capable of recording and clinically evaluating cumulative exposure to traumatic incidents and other recognised psychosocial hazards across each member's career, I understand that work on this has been underway since the Wellbeing Strategy 2023-2028 took effect and will continue as part of the NTPF's work with Prof McFarlane. '*Recommendation No. 4'* can be read as me recommending that this occurs as part of the ongoing work with Prof McFarlane.

432. As for the proposed recommendation that the Commissioner implement a Remote Operational Policing Psychological Risk Management Framework applicable to every remote station and workplace, '*Recommendation No. 5'* is appropriately directed to this matter.

433. Regarding the proposed recommendation that members selected for extended remote operational postings undergo an appropriately designed pre-deployment assessment and periodic review during and after the posting, I consider there is merit in this proposal and that it is best addressed through '*Recommendation No.1'*.

434. As for the proposed recommendation that the NTPF establish enforceable safe minimum staffing and one-up policing controls for remote operational

locations[14], I am not persuaded that it is appropriate to make this recommendation for the reasons set out above.

435. Regarding the proposed recommendation that the NTPF develop and implement a centralized system for recording, monitoring, and controlling on-call exposure, actual callouts, hours worked, interrupted sleep, deferred leave, and long-distance driving, the NTPF implemented a formal fatigue management policy and standard operating procedures in November 2024, as outlined above. Based on the evidence I have received, I am not appropriately placed to make a recommendation of this kind.

436. As for the remaining recommendations proposed by the Family/NTPA, I consider that the recommendations I have already made, sufficiently address those matters. To be clear, some of the proposed recommendations relate to matters that I would expect the NTPF to review as part of its work with Prof McFarlane. That extends to the systems implemented to ensure auditing and compliance and, potentially, to implementing a requirement for independent evaluations to be performed every 3 years.

437. Regarding notification to me within 12 months of the changes implemented in response to my recommendations – this type of feedback is welcome; however, I am not persuaded it should be the basis of a recommendation.

Submissions at [720]-[778] as regards a referral under s 35(3) of the *Coroners Act 1993* (NT)

438. The Family/NTPA submit I should make a referral under s 35(3) of the *Coroners Act 1993*.

439. The submissions do not identify who should be the subject of the referral or the offence, nor do they particularise the date range and the specific omissions relevantly alleged for that period.

[14] Family / NTPA submissions [683]-[685].

440. I take these submissions as proposing a referral of the NTPF for a possible contravention of its primary duty under s 19 of the *Work Health and Safety (National Uniform Legislation) Act 2011* (NT).[15]

441. The *Work Health and Safety (National Uniform Legislation) Act 2011* (NT) permits proceedings for an offence to be brought within 2 years after an offence first comes to the notice of the Regulator or within 1 year after a coronial report was made or a coronial inquest ended, if it appeared from the report or the proceedings at the inquest that an offence had been committed against this Act: s 232.

442. The power to refer a matter under s 35(3) is discretionary, subject to my forming a belief that an offence may have been committed. The threshold for 'belief' is higher than 'suspicion' but falls short of positive satisfaction or proof of the relevant matters: *George v Rockett* (1990) 93 ALR 483 at 491.

443. Simply put, to enliven s 35(3), the available evidence would need to induce a state of belief on my part that:

(1) There was a foreseeable risk that Michael's exposure to trauma and stressors in his employment posed risk to his health and safety, namely his mental health / wellbeing.

(2) The NTPF, so far as is reasonably practicable, did not provide and maintain a safe workplace to manage those risks including through its provision of information, training, instruction or supervision and or through its monitoring of conditions and its systems to manage that risk.

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[15] That legislation provides that proceedings for an offence against that Act may be brought by the Regulator (Work Health Authority) or an inspector approved by the Regulator, although it expressly preserves the jurisdiction of the Director of Public Prosecutions to also bring proceedings for alleged offences under that Act: s 230.

444. Even if I form that belief, it is open to me to decline to exercise the power in s 35(3) on discretionary grounds.

445. On balance I am not satisfied that a referral under s 35(3) should be made in this case. This is a view directed to the discretionary aspect of s 35(3).

446. At the outset, this inquest identified its primary objective as identifying what happened with regard to Michael's well-being, what lessons might be learned, and what might be done differently in the future. Thepurpose of this approach has been to encourage open and frank exploration of the issues.

447. These proceedings have benefited from the parties' willingness not to raise overly technical procedural or evidentiary objections. This has enabled the examination of a significant amount of evidence. It has also meant that many of the individuals who provided statements were not required to be examined in court.

448. It is possible that a different approach would have been taken had it been flagged at the outset by Counsel Assisting or any other party that there was a reasonable likelihood of my being asked to consider the exercise of s 35(3) at the conclusion of the evidence.

449. It can be detrimental to proceedings of this kind, which are examining systemic issues and have encouraged the parties to engage in a frank manner, to then contemplate the possibility of a referral under s 35(3).

450. Although there will be cases where a referral is appropriate, it is prudent to exercise discretion cautiously. Doing otherwise risks contributing to an adversarial approach being adopted in future inquests by persons and institutions. This can undermine the efficacy of those matters and result in more distressing outcomes for all participants, particularly witnesses.

451. On balance, I am not persuaded it is appropriate, as a discretionary matter, to consider the exercise the power under s 35(3) in Michael's matter.

452. It of course remains open to the Family and the NTPA to consider, if they wish, making their own submission to the Regulator (WorkSafe) or the Director of Public Prosecutions as to the possibility of commencing criminal proceedings for possible contraventions of the *Work Health and Safety (National Uniform Legislation) Act 2011* (NT).

FORMAL FINDINGS

453. Pursuant to section 34 of the *Coroners Act 1993* I find that:

(i) the deceased person is Michael Stanley Deutrom born 1 February 1978 in Papua New Guinea;

(ii) he died at 08:28pm on 16 April 2022 in South Australia;

(iii) the cause of death was self-inflicted ligature asphyxiation;

(iv) the particulars needed to register the death under the Births, Deaths and Marriages Registration Act have been provided to Births, Deaths and Marriages.

CONCLUSION

454. Michael loved being a police officer and selflessly served the Northern Territory for 23 years in that capacity. Being a police officer was not simply a vocation but central to his self-identity and sense of purpose. The community needs individuals like Michael performing the roles he did. That he suffered the harm he did through his service, and took his own life, is a momentous tragedy for him, his family, his colleagues and the community.

455. There is much to be learned from what unfolded in Michael's case.

456. I have sought to include detail in these findings, in part, in the hope it furthers other persons' understanding of the risks posed to the mental wellbeing of frontline responders.

457. Whatever their fortitude and resilience, and even when they have shown a capacity over the long-term for high performance in challenging conditions,

frontline responders need to remain vigilant that their experiences may be taking a toll that they themselves are not aware of in real time. They cannot afford to think '*never me'*. If it could happen to Michael, it could happen to them.

458. I recommend that the Commissioner of Police consider Michael's story in the context of how it might inform training at the recruitment stage and in subsequent ongoing training provided during members' careers. This of course should be done in consultation with Michael's family.

459. To that end I make the following recommendation to the Commissioner of Police:

Recommendation No.7: The NTPF, in consultation with Michael Deutrom's family, consider incorporating these findings and learnings from Michael's experiences into the training it provides to police members during recruitment and in ongoing training provided to serving members during their careers, with particular emphasis on the risks to mental wellbeing from the cumulated effects of trauma and stressors.

460. Although I have not made it the subject of a formal recommendation, I recommend that other agencies that employ persons in frontline roles in the Northern Territory, such as in fire and rescue, emergency services and paramedic type roles, also consider the possibility of using Michael's experiences and these findings in the training of their members (again in consultation with Michael's family).

461. I extend my sincere condolences to Michael's family.

462. His passing is of profound significance to them and the community he served.

RECOMMENDATIONS

Recommendation No.1: The NTPF, as a matter of priority, develop and institute a requirement for psychological assessment when a member applies for transfer to a long term remote station posting and any other role that by its nature / demands may pose increased risks to a member's wellbeing (including the subsequent conduct of reviews at fixed times, in response to particular events and at the completion of such a posting).

Recommendation No.2: The NTPF develop and implement a strategy that:

Recognises that the pressure commanders / middle managers may experience to ensure the delivery of services may come at the expense of the members wellbeing.

Examines ways in which commanders / middle managers can feel supported by the NTPF Executive to make decisions that appropriately prioritise members' wellbeing, potentially to the detriment of the community's interests in receiving policing services, particularly in times of acute demand for services and or shortages in staff. This includes but is not limited to situations where consideration is given to requiring a member to work one-up in a remote community and when there is a significant increase in the demands on the ground relative to the number of members in the community.

Examines what indicators or markers might be captured to enable evaluation of the effectiveness of this strategy and ensuring accountability for its performance at the Executive Level.

Recommendation No.3: the NTPF, as a matter of priority:

Introduce a formal psychiatric referral pathway for members suspected to be suffering a mental health injury (e.g. PTSD), which includes the possibility

of referrals to interstate psychiatrists experienced in treating mental health injuries.

Inform external clinicians, to whom members are referred through the Employee Assistance Program, of this pathway and the NTPF's expectation that this option will be canvassed with patients if judged appropriate by the clinician (with those discussions contemporaneously noted).

Develop a strategy to educate NTPF members about the benefits of a psychiatric consultation, potentially using Michael's case as part of that education strategy.

Recommendation No.4: The NTPF continue its engagement with Prof McFarlane to progress and give effect to the interim recommendations set out in his October 2025 Scoping Report as a matter of priority.

Recommendation No.5: The NTPF examine the benefits of developing and introducing a Remote Operational Policing Psychosocial Risk Management Framework. Without being exhaustive, this would provide a framework for assessing and monitoring the risks posed to member's wellbeing at specific remote community postings including but not limited to (i) remoteness / travel time, (ii) staffing, (iii) the potential for 'one-up' duties at that station; (iv) callout frequency and on-call exposure; (v) prisoner transport requirements and access to Air Wing; (vi) potential disturbances in the community. This policy would extend to providing a framework for members to provide ongoing feedback on risk during their posting and following the completing of the same.

Recommendation No.6: The Executive consider legislative amendment of the *Police Administration Act 1978* (NT) and/or governance and policy amendment to introduce a root cause analysis model directed to the review / investigation of the circumstances where an NTPF member suffers a suspected self-inflicted death. The purpose of that review / investigation

would be to enable the timely investigation of the circumstances of the member's death, whether systemic work factors materially contributed to that death and whether changes or improvements to workplace practices should be implemented.

Recommendation No.7: The NTPF, in consultation with Michael Deutrom's family, consider incorporating these findings and learnings from Michael's experiences into the training it provides to police members during recruitment and in ongoing training provided to serving members during their careers, with particular emphasis on the risks to mental wellbeing from the cumulated effects of trauma and stressors.