CORONERS COURT OF SOUTH AUSTRALIA

INQUEST INTO THE DEATH OF GARY DALE SARGEANT

[2026] SACC 11

Inquest Findings of her Honour Deputy State Coroner Kereru

28 May 2026

CORONIAL INQUEST

Examination of the cause and circumstances of the death of a member of the Royal Australian Air Force. The Inquest examined the circumstances which led to the member being left unsupervised and then walking out of a military health centre after being identified as in acute mental health crisis.

Held:

1. Gary Dale Sargeant, aged 36 years of Semaphore, died at Outer Harbour on or about 9 September 2020 as a result of drowning.

2. Circumstances of death as set out in these findings.

Recommendations made.

Counsel Assisting: MR D EVANS

Witness: WARRANT OFFICER J GAWLEY, FLIGHT SERGEANT D CARTER, SQUADRON LEADER P BOYLE, CORPORAL R METCALFE, SERGEANT J LICUL, SERGEANT T GWINNETT, WARRANT OFFICER D RHODES (Retd), AIR COMMODORE D CLYDE, DR D DUNCAN
Counsel: MS K ROBERTSON-CLARK SC with MS S HEIDENREICH - Solicitor: AUSTRALIAN GOVERNMENT SOLICITOR

Witness: MS K MANSFIELD
Counsel: MS K FITZGERALD - Solicitor: GILCHRIST CONNELL

Witness: DR A DE SAVI
Counsel: MS J CLIFF - Solicitor: DW FOX TUCKER LAWYERS

Interested Party: THE AUSTRALIAN DEFENCE FORCE
Counsel: MS K ROBERTSON-CLARK SC with MS S HEIDENREICH - Solicitor: AUSTRALIAN GOVERNMENT SOLICITOR

Hearing Date/s: 12/11/2024-15/11/2024, 18/11/2024-20/11/2024, 22/11/2024, 19/12/2024 & 13/02/2025-14/02/2025

Inquest No: 44/2024 **File No/s: 1816/2020**

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

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Kids Helpline
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Introduction

1 Gary Sargeant was born in New South Wales in 1983. He joined the Royal Australian Air Force in 2008 at the age of 24. During his service, he was deployed to the Middle East twice, receiving numerous service medals. In 2020, he was posted to the 462 Squadron at Edinburgh in the Cyber Vulnerability Investigation Team. His rank was Leading Aircraftman.

2 Throughout his time in the Air Force, Leading Aircraftman Sargeant had experienced ongoing mental health issues. He received various therapies over time. He was an introverted and quiet person. In 2020, he experienced social isolation as a result of a new workplace, COVID-19 working from home requirements, and recovery from an injury to his foot which kept him from returning to the workplace.

3 In September 2020 he experienced an acute mental health episode, including symptoms of paranoia. He presented to the Joint Military Police Station and then to the Edinburgh Health Centre for assessment on 9 September 2020. He was assessed by two mental health professionals, a nurse and a doctor. Powers were exercised under the provisions of s 56 of the *Mental Health Act 2009* for the purpose of keeping Leading Aircraftman Sargeant at the health centre until an ambulance could arrive to transport him to hospital. There are no secure areas at the health centre. Leading Aircraftman Sargeant followed a nurse to a communal area of the health centre and asked the nurse to get him a phone charger. When she left to do this, he left the building, got in his car, and drove off base.

4 South Australia Police were notified and officers conducted a search for him. There were delays in this occurring. In the afternoon of the following day, 10 September 2020, Leading Aircraftman Sargeant's body was found on breakwater rocks at Outer Harbour. Post-mortem examination concluded that he had drowned. Examination of his residence and devices revealed strong suicidal intent.

5 This Inquest examined the circumstances leading up to Leading Aircraftman Sargeant's mental health crisis, the crisis support provided to him, the delay in notifying authorities that he was missing, and the possible contributions of routine employment-related reviews to Leading Aircraftman Sargeant's already fragile mental health.

Evidence at Inquest

6 The documentary evidence at Inquest comprised 78 exhibits.

7 In addition to the documentary evidence, oral evidence was heard from:

- Kathleen Mansfield, Clinical Psychologist
- Warrant Officer Jayne Gawley, Unit Welfare Officer
- Flight Sergeant Darren Carter, Leading Aircraftman Sargeant's direct supervisor
- Squadron Leader Patrick Boyle, Military Chaplain

- Corporal Rhiannon Metcalfe, Member of the Military Police
- Sergeant Josephine Licul, Military Police Team Leader
- Corporal Christopher Gwinnett, Member of the Military Police
- Nurse Natalie Jackson, Nurse Coordinator
- Nurse Amanda Smith, Mental Health Registered Nurse
- Nurse Lynette Glasson, Enrolled Nurse
- Dr Adrian De Savi, Senior Medical Officer
- Warrant Officer Darren Rhodes (Retd), Squadron 462
- Dr Darrell Duncan, Director of Strategic Clinical Assurance and Ethics in the Joint Health Command

8 I was assisted by the expert opinion of senior consultant psychiatrist Dr Maria Naso, who provided a comprehensive report prior to the Inquest, followed by oral evidence.

Standard of proof and hindsight bias

9 The civil standard of proof, the balance of probabilities, applies to the making of coronial findings. If findings which imply or express criticism of individuals are considered, I shall not make such a finding unless the evidence leads me to a comfortable level of satisfaction that the finding should be made. In this regard, I am guided by the principles enunciated in *Briginshaw v Briginshaw*.[1] The effect of this and similar authorities is that coroners should exercise caution when considering adverse findings against, or comments about, individuals or entities. Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demands a weight of evidence commensurate with the gravity of the facts sought to be proved.

10 I have also remained cognisant of the potential intrusion of hindsight bias. A description of 'hindsight bias' is given in *The Australasian Coroner's Manual*, namely:

> The tendency after the event to assume that events are more predictable or foreseeable than they really were. What is clear in hindsight is rarely as clear before the fact. If it were, there would be far fewer mistakes made. It is an obvious point, but one that nonetheless bears repeating, particularly when Coroners are considering assigning blame or making adverse comments that might damage a person's reputation …
>
> Hindsight, of course, is a very useful tool for learning lessons from an unfortunate event. It is not useful for understanding how the involved people comprehended the situation as it developed. The distinction needs to be understood and rigorously applied.[2]

11 Throughout my consideration of the evidence, I have remained mindful of this risk and of the need to assess events by reference to what was known at the time.

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1 (1938) 60 CLR 336
2 Dillon H and Hadley M (2015), *Australasian Coroner's Manual*, The Federation Press

Background

12 Growing up, Leading Aircraftman Sargeant lived with his mother and had occasional contact with his father, although later in life they stayed connected over the phone and became close. When his mother re-married, Leading Aircraftman Sargeant struggled to connect with his stepfather, who he reported some years later was often violent. Leading Aircraftman Sargeant described this as 'an abusive sort of upbringing… a lot of violence and yelling'.[3] It is documented that he left the house at the age of 16 to escape the abuse but it is also documented that his mother packed his belongings and asked him to leave the house at the age of 18.

13 Leading Aircraftman Sargeant completed year 11 schooling and had various jobs including powder-coating and dock work. He did further studies in Information Technology (IT). Dr Naso described him as a man who 'appeared to yearn for family but wasn't able to meaningfully reconnect'.

14 In around 2006, Leading Aircraftman Sargeant began to explore enlistment options in the Royal Australian Airforce and formally joined on 23 September 2008 at age 24. He told a recruiter that he wanted a job that he could be proud of. Dr Naso opined that this decision might have been with the aim of feeling a sense of belonging.

15 Upon joining, he commenced at the rank of Aircraftman, worked in Wagga Wagga for his initial training, and then worked in Victoria at the Defence Force School of Signals. He returned to New South Wales to provide operator and technical maintenance support. In 2010 he was reclassified to the rank of Leading Aircraftman.

16 Between November 2011 and May 2012 Leading Aircraftman Sargeant gave the most any person can be asked for their country when he was deployed to Afghanistan. He described the experience as isolating, as he was the only Air Force member amongst Army members. He said he kept to himself and read books in his down time.

17 In 2014 Leading Aircraftman Sargeant was moved to Canberra where he became friends with Corporal Troy Cannon.

18 Between February and August 2016, Leading Aircraftman Sargeant was again deployed to the Middle East. Following his return, Corporal Cannon observed that he had developed a drinking problem and sometimes did not show up to work or was late. As a result of these issues, he had his security clearance reduced from Top Secret to Secret which meant that he did not have sufficient clearance to complete the day-to-day tasks of his role.

19 In December 2017, Leading Aircraftman Sargeant and Corporal Cannon were posted to Headquarters Air Command at Bungendore in New South Wales. Leading Aircraftman Sargeant still did not have sufficient clearance to undertake the new role he had been assigned. He attended work but was given nothing to do. He could not access higher security areas of the facility and remained in a separate office.

20 In the middle of 2018, Leading Aircraftman Sargeant's security clearance was returned to Top Secret level. He was then assigned a new role which was within this level of

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[3] Exhibit C24 at Annexure A

clearance. Soon after, Corporal Cannon was posted to Edinburgh and they began to drift apart socially.

21 In 2019, Leading Aircraftman Sargeant was also posted to Edinburgh, joining the 462 Squadron. This is a division of the Information Warfare Directorate which is tasked with protecting the Air Force's capability through the conduct of information operations. This was his dream job that he had always spoken about.

22 He commenced at Edinburgh on 13 January 2020 and worked in the Cyber Vulnerability Investigation Team, known as CVIT, within the engineering and maintenance section. His role was Vulnerability Assessor for the Air Force's IT systems. His direct supervisor within the team was Flight Sergeant Darren Carter, who gave evidence during the Inquest. Flight Sergeant Carter explained that CVIT is a capability within 462 Squadron which is usually used to upskill members before they move to different areas within the Unit, depending on their career path.[4] A normal posting is up to three years, depending on extensions.[5] There are approximately 150 people in the Unit.[6]

23 Members of 462 Squadron described Leading Aircraftman Sargeant as a closed-off, introverted person who became more comfortable and outgoing over time.[7] He was described as someone who would always strive for perfection and had to be reminded that perfection was not expected of him.[8]

24 At the beginning of the COVID-19 global pandemic there was a reduction in the number of people being in physical proximity to each other, so around 50% of members would work at the base while 50% would work from home in order to reduce physical contact across the Unit.[9] Leading Aircraftman Sargeant was approved to work from home. Leading Aircraftman Sargeant expressed initial frustration around his home IT infrastructure to Flight Sergeant Carter through text message but did not otherwise raise concerns about working from home.[10] He would communicate daily with Flight Sergeant Carter, either by video conference or by telephone.[11]

25 At around this time there was limited opportunity for Leading Aircraftman Sargeant to socialise with colleagues within the Unit due to formal social distancing and isolation restrictions, as well as a general distancing of people at the time.[12]

26 Around April 2020, Leading Aircraftman Sargeant sustained a non-work injury to his foot which required surgery to stabilise his first metatarsal. He took time off work to recover and, due to pandemic restrictions in addition to new mobility issues, spent a lot of time at home alone.

27 Leading Aircraftman Sargeant had the plates removed from his foot on 22 July 2020. He continued to work from home and began returning to base. During an informal catch up

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4 T153
5 T154
6 T117
7 T133, T135 and T165
8 T176
9 T154
10 T155; T175
11 T155
12 T127

with Warrant Officer Gawley, Leading Aircraftman Sargeant spoke about feeling isolated at home. His situation was raised with his chain of command who looked into it. Both Leading Aircraftman Sargeant and his superiors said that all was going well.

28 On 11 August 2020, Leading Aircraftman Sargeant attended a Unit Welfare Board review, which are held quarterly for the purpose of assessing recovery and ways that recovery could be assisted. This was described by Flight Sergeant Carter, a superior officer to Leading Aircraftman Sargeant, as a formal rather than informal process, which felt like an interview rather than a briefing.

29 As Leading Aircraftman Sargeant returned to the workplace, he was noted to be more talkative as fellow workers were engaging with him about his moon boot and scooter. He disclosed concerns about the impact of his injury on his hobbies. He said that other people had gone home to their families during the pandemic and that he had nobody to go to. A conversation with another colleague was reported up the chain of command and resulted in Warrant Officer Rhodes speaking to Leading Aircraftman Sargeant. He said he wanted to leave the Air Force as he had reconnected with his mother and wanted to move back to New South Wales to try something different.[13]

Mental health history

30 A psychological assessment of Leading Aircraftman Sargeant conducted in October 2007, during the process of joining the Air Force, said:

> Gary presents as a young man who is attempting to make something of his life without a family support base. Gary has shown remarkable resilience to have negotiated his life circumstances, despite having to raise himself he is optimistic and persistent to achieve his service goal.

31 That report concluded:

> Gary presents as a young man who has not been given many opportunities but has consistently continued to strive to achieve and to improve his life and work opportunities. He has obvious undeveloped potential and great determination to succeed and he's recommended [for recruitment] because of that.

32 In 2011, Leading Aircraftman Sargeant made a comment to a peer that was suggestive of suicidal ideation. This was reported to his chain of command. A mental health assessment was arranged where Leading Aircraftman Sargeant clarified that while he was having a hard time, what he had said was taken out of context and he had no intent to self-harm. He was later found to have two firearms and live ammunition in his accommodation, contrary to both Standing Orders and civilian law. A formal report was prepared for his commanding officer. This report was unable to find any clear psychological issue, and Leading Aircraftman Sargeant was deemed suitable to continue his duties.[14]

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13 T132-T133
14 Exhibit C22 at [74]

33 Following his return from deployment to Afghanistan in 2012, a further psychological screening was conducted which found mild depression consistent with fatigue, which was expected to dissipate once a routine was established upon return to Australia.[15]

34 A routine psychological follow-up was conducted in October 2012 where Leading Aircraftman Sargeant reported social isolation and a difficult childhood. Strategies were discussed which included broadening his network of friends and he was given a list of resources to self-refer to if he found his 'sometimes depressed mood' to persist.[16]

35 In 2014 Leading Aircraftman Sargeant's chain of command referred him for further psychological assessment due to several episodes of late arrival in the context of excessive alcohol consumption. Leading Aircraftman Sargeant reported that he was feeling isolated during his posting to Canberra six months earlier and had turned to excessive consumption of alcohol due to boredom.[17] He said that he felt flat, lacked motivation, and was socially withdrawn, but did not have thoughts of self-harm and no intent or plan. He was referred to external psychological treatment to improve his resilience and modify his behaviour. As part of this process, he was diagnosed with severe anxiety, severe depression and severe stress.

36 Leading Aircraftman Sargeant commenced psychological treatment between August 2014 and November 2015, including monthly sessions of cognitive behavioural therapy.

37 He had substance abuse counselling in December 2015 and completed an Outpatient Alcohol Treatment Program in February 2016. During this he identified boredom as a trigger for his excessive alcohol use.

38 In March 2017, Leading Aircraftman Sargeant was referred to a psychologist for depression and excessive drinking. He was diagnosed with severe depression and significant anxiety. He went on to have five sessions with the psychologist. The psychologist reported that Leading Aircraftman Sargeant lacked insight and was not able to implement strategies between sessions.

39 Between March 2017 and July 2017, Leading Aircraftman Sargeant attended three different medical officers due to sleep disturbances. Referral to a psychiatrist was considered, as was commencement on antidepressant medication, but Leading Aircraftman Sargeant declined both options. By August 2017, he reported that his sleep pattern and mood had improved, but it was not recorded how or why he thought this improvement occurred.

40 In late 2018, Leading Aircraftman Sargeant applied to transition from Permanent Air Force to the Reserves. He underwent a separation health examination which noted his previous psychological care and counselling and referred him to the Vietnam Veterans Counselling Service for a mental health assessment. This assessment concluded that Leading Aircraftman Sargeant was 'fit to separate'. However, Leading

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15 Exhibit C22 at [75]
16 Exhibit C22 at [76]
17 Exhibit C22 at [77]

Aircraftman Sargeant withdrew his application and remained in his permanent role after expressing uncertainty about his prospects of employment as a civilian.

41 On 27 November 2018, a routine psychological check was conducted which recorded him as experiencing moderate symptoms of psychological distress. However, all these results scored below the cut-off levels and no further action was taken.

42 On 12 August 2020 Leading Aircraftman Sargeant underwent a review in relation to rehabilitation following his foot injury. He disclosed lack of family and social support as issues he faced. He was encouraged to contact Open Arms 'if required'.[18] He raised further concern about his isolation at his review on 19 August 2020, however declined a formal mental health review.

43 Following prolonged work from home requirements, Flight Sergeant Carter raised concerns with the officer in charge of the CVIT, Flying Officer Alexander Gee, about Leading Aircraftman Sargeant struggling at home, and they discussed him returning to work from the office instead. Flight Sergeant Carter hoped that being in the workplace together would allow Leading Aircraftman Sargeant to confide in him more organically. He later observed this change to be beneficial to Leading Aircraftman Sargeant.[19]

44 Leading Aircraftman Sargeant emailed his Rehabilitation Consultant on 1 September 2020 to advise that his isolation had improved, however the actions taken by him two days later indicated that this may not have actually been the case.

Events leading to death

The Unit Welfare Board

45 Leading Aircraftman Sargeant was notified that he was required to attend an upcoming Unit Welfare Board (UWB) meeting on 11 August 2020. The UWB meetings are conducted for members of the Unit with medical injuries, conditions, or personal circumstances that might impact their ability to undertake their roles.[20] They are held quarterly.[21]

46 There are five categories within the military employment classification system which indicate a member's ability to perform the tasks within their role, and their ability to be deployed, if so required. A member at J1X has no restrictions, J2X includes things such as a need to wear glasses or have access to prescription medication, and J3X is a condition or injury which requires rehabilitation in order to medically improve.[22] Members classified J3X are given an initial term of 12 months to improve, although this can be extended for a further 24 months if required.

47 If a further extension to a J3X classification is required, the request goes to a paper-based medical review board-based interstate for consideration of a J4X classification, which designates a member as 'not deployable'. This is granted at the discretion of the service and is dependent on the specific medical condition under consideration.[23] It is normally

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18 Exhibit C22 at [91]
19 T169
20 T110
21 T118
22 T107
23 T107

considered in complex situations or when a member needs an extension of their J3X classification.[24] The final classification is J5X which is when a member is deemed unfit for further service.

48 Warrant Officer Gawley told the Court that Leading Aircraftman Sargeant was a J1 or J2 classification.[25]

49 As his direct supervisor, Flight Sergeant Carter was informed that Leading Aircraftman Sargeant was going to attend the UWB for 11 August 2020. He recalled asking if Leading Aircraftman Sargeant wanted a chaperone or if he wanted Flight Sergeant Carter to attend with him, however Leading Aircraftman Sargeant declined this.[26] The notification, which would have been sent to Leading Aircraftman Sargeant by email, included a list of the attendees and attached a form which would have allowed a member attending to raise any discomfort they might have with any of the attendees.[27] Ordinarily, the attendees would be the commanding officer, the member themselves, the member's supervisor,[28] a medical officer[29] and a rehabilitation provider if the member is undertaking a rehabilitation program.

50 The UWB itself is a rolling meeting where the attending members present over a period of a couple of days.[30] It is described as assessing a 'snapshot' of the member's condition.[31] Each member's meeting is opened with the commanding officer welcoming the attendees. If the member does not know the attendees, the commanding officer introduces them.[32] This is followed by a statement from the member about where they see their injury or illness and how their recovery is going. The medical officer would then provide clinical input followed by the rehabilitation provider if there is one. The member's supervisor would then provide updates including whether there is any impact on employment capacity, and the commanding officer would then ask questions of the member.

51 While the intent of the UWB was explained to be a way to collaboratively determine the best way to support recovery,[33] there is no statement given about the purpose of the meeting when it is opened, as it is expected that the member's supervisor would explain the reason for the meeting to the member in advance.[34] It is spoken of as an 'informal discussion', however Flight Sergeant Carter gave evidence that he did not find this to be an accurate description,[35] and Warrant Officer Gawley confirmed that it can be intimidating to attend.[36]

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24 T145
25 T107
26 T164
27 T157
28 Leading Aircraftman Sargeant's direct supervisor, Flight Sergeant Carter, did not attend his UWB in the capacity of his supervisor
29 The nominated medical officer for the unit, not the member's primary physician, although the nominated medical officer has access to the member's medical records
30 T156
31 T120
32 T112
33 T112
34 T112
35 T161
36 T112

52 For Leading Aircraftman Sargeant, the UWB was held within a meeting room inside the Edinburgh Health Centre.[37] It is a conference room with a rectangle-shaped conference table. Warrant Officer Gawley explained that the commanding officer ordinarily sits at the head of the table, Warrant Officer Gawley to their left or right, and the member to their other side so that the meeting does not feel confrontational.[38] However, Flight Sergeant Carter explained that the 11 August 2020 UWB had all attendees sit on one side with the member sitting on the other.[39] It was the first time he had experienced a layout where everybody faced the member.[40]

53 As Leading Aircraftman Sargeant's UWB was only to determine the progress of his foot injury, no psychologist or psychiatrist was present.[41] His foot was healing well and he was expected to be able to continue to undertake the requirements of his role, and there was no intention to alter his classification.[42]

54 Warrant Officer Gawley made an observation based on his behaviour that Leading Aircraftman Sargeant appeared intimidated during the meeting. She said he was not making eye contact, was looking down at the desk and appeared to be hesitant to speak.[43] Flight Sergeant Carter explained that the questions being asked were not uncomfortable for him, but that he expected it would be different for somebody who did not know all of the participants already.[44] He gave evidence that he found the meeting to be intimidating to a degree.[45]

55 After the meeting, Flight Sergeant Carter spoke to Leading Aircraftman Sargeant to ask how it went, and he recalled in his evidence Leading Aircraftman Sargeant shrugging and saying 'meh', which was not an out of character response for him.[46] Warrant Officer Gawley could not recall whether she was concerned Leading Aircraftman Sargeant had taken anything negative from the meeting, but thought it was possible he did.[47]

56 On 16 August 2020, Leading Aircraftman Sargeant sent an email to Warrant Officer Gawley. She recalled having a conversation with him about the purpose of the UWB and gave evidence that he appeared to be comfortable with the explanation she gave.[48] He told her he felt unsupported by his team.[49]

57 Warrant Officer Gawley notified Warrant Officer Rhodes who spoke to Leading Aircraftman Sargeant. Warrant Officer Rhodes did not form the same impression she had, but that did not cause her concern. Warrant Officer Gawley recalled asking Leading Aircraftman Sargeant if he was considering self-harm, though she did not think he was

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37 T158
38 T123
39 T158
40 T160
41 T120
42 T111
43 T126
44 T161
45 T160
46 T165
47 T127
48 T143
49 T139

giving that impression at the time. In any event, she recalled him saying 'no' when she asked.[50]

58 On 3 September 2020, Leading Aircraftman Sargeant visited the Edinburgh Health Centre. He spoke with a mental health nurse, Leanne Shepherd. Nurse Shepherd assessed Leading Aircraftman Sargeant as low risk of suicide and self-harm but noted that he was guarded and asked many questions about confidentiality and what she would document in his record. Following the assessment Nurse Shepherd prepared an urgent referral to for him to see an independent psychologist. In the referral she wrote about longstanding suicidal ideation since childhood, including that, when young, Leading Aircraftman Sargeant had fantasised about taking his bedding to a train track, falling asleep on the tracks, and being killed by a train while asleep. This was obviously a quite concerning revelation about his childhood and had the capacity to reflect unresolved serious mental health issues. It was quite appropriate for Nurse Shepherd to recount this in detail in her referral. Further, this was an appropriate course of action based on the concerns she had.

59 The referral was received by Kathleen Mansfield, a clinical psychologist, who was engaged via Bupa Health Insurance. She explained that she did not receive Bupa referrals very often, and in September 2020, estimated she had only received around five to ten. Ms Mansfield gave evidence that she was unable to open the document summarising the reasons for referral. An appointment was booked for her to see Leading Aircraftman Sargeant on 8 September 2020 at 8 am.

60 On 6 September 2020, Leading Aircraftman Sargeant called his father for Fathers' Day and spoke about feeling at risk at work. He said that someone had made a gesture towards him using their finger to simulate cutting their throat. During this conversation, Leading Aircraftman Sargeant said something like 'I may as well just do myself in'. Neither Warrant Officer Gawley nor Flight Sergeant Carter were aware of any person having threatened Leading Aircraftman Sargeant;[51] he appears not to have reported this to any other person. Based on the events that followed it is highly unlikely that this actually occurred. Rather it was a product of Leading Aircraftman Sargeant's increasing level of paranoia.

The appointment with Ms Mansfield

61 Ms Mansfield gave evidence that during her consultation with Leading Aircraftman Sargeant, she read a section of the consent form which related to limitations around confidentiality. When this occurred, Leading Aircraftman Sargeant asked what Ms Mansfield would do if there was an imminent risk to either him or somebody else. She asked if that was something that applied to him and, notwithstanding having raised the issue, he responded 'no'.[52]

62 Leading Aircraftman Sargeant spoke of feeling stressed and tense and of his isolation. Ms Mansfield formed a preliminary diagnosis of major depressive episode. He declined to have a further appointment scheduled.

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[50] T133
[51] T134 and T182
[52] T33

63 I will return to examine in detail the content of Ms Mansfield's consultation as well as her approach to the meeting later. For present purposes I observe that, following the consultation, Ms Mansfield formed the view that there were no concerns for Leading Aircraftman Sargeant's wellbeing.

9 September 2020

64 On the morning of 9 September 2020, Leading Aircraftman Sargeant did not log on for work as usual. He called a landline phone number for the Edinburgh Chaplaincy Centre and spoke to a chaplain, Squadron Leader Patrick Boyle. He had never met or spoken to Chaplain Boyle prior to this call.[53] It was clear to me during his evidence that Chaplain Boyle was deeply affected by Leading Aircraftman Sargeant's death.

65 It was quite by chance that Chaplain Boyle answered the phone, as it was not within his office and Chaplain Boyle thought that all landline phones had been switched off following transfer to new services.[54] He simply heard a phone ringing and walked towards it.

66 Chaplain Boyle explained that initially Leading Aircraftman Sargeant was very reluctant to provide him with any information, including his identity or the issue he was calling about.[55] The call was filled with long periods of silence. He explained that he began to ask Leading Aircraftman Sargeant questions to determine what kind of support he needed, and very plainly asked if he had thoughts of suicide. He said that Leading Aircraftman Sargeant said 'yes', he had thought about it, and that after he had revealed that, he appeared to be relieved and was immediately more willing to confide.[56] When asked in oral evidence, Chaplain Boyle said it was almost as though Leading Aircraftman Sargeant was waiting for him to raise that topic, and once he had, he became much more forthcoming.[57]

67 After managing to build a good enough rapport, Leading Aircraftman Sargeant gave Chaplain Boyle his mobile number in order to facilitate a plan to help. Chaplain Boyle explained that anybody who he felt was at risk of self-harm was required to be taken to mental health professionals for a mental health assessment.[58] He accepted that it was not ideal for him to end the call with Leading Aircraftman Sargeant, but explained that he had done so because he was at a landline, without a computer, and wanted to call Leading Aircraftman Sargeant back on his mobile phone.[59] I found this explanation to be entirely plausible in the circumstances Chaplain Boyle faced, particularly given that Chaplain Boyle had told Leading Aircraftman Sargeant that he was going to send help to him, had obtained his mobile number and then proceeded to action a plan to assist.

68 Once Chaplain Boyle hung up, he called the commanding officer of 462 Squadron, Wing Commander David Clyde, advising him of the conversation. Wing Commander Clyde advised Chaplain Boyle to tell Leading Aircraftman Sargeant to catch a taxi to the base, as it would be quicker than someone from base travelling to collect him and bringing him

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53 T188
54 T188
55 T197
56 T198
57 T199
58 T202-T203
59 T203

back. Chaplain Boyle gave evidence that he did not agree with this approach, but according to procedures, he was required to report a person at risk directly to their commanding officer, and then it becomes their responsibility to direct the response. He said simply that their decisions are the ones that must be followed.[60]

69 Dr Naso gave evidence about this approach.[61] She said that the only appropriate options in this scenario were to send first responders to Leading Aircraftman Sargeant, or otherwise to simply travel out to him immediately. I find that what happened was a sub-optimal way of assisting a person who had revealed acute suicidal intent. Wing Commander Clyde accepted that this may not have been an appropriate option in the circumstances.[62] However, this was not a standardised response, and I am satisfied that it simply represented two individuals trying to think of the best way of supporting Leading Aircraftman Sargeant and not falling upon the most ideal solution. As will become evident, this sub-optimal approach to the issue had no bearing on what followed and I need not discuss it further.

70 Chaplain Boyle rang Leading Aircraftman Sargeant back and he agreed to catch a taxi to Edinburgh. He said that Leading Aircraftman Sargeant appeared to be reassured that someone was going to help him. He explained that Leading Aircraftman Sargeant seemed to feel comforted when Chaplain Boyle said he would be with him 'every step of the way'.[63] They agreed to meet at the front gates in 30 minutes.

71 A short time later, after arriving at the main gates, Chaplain Boyle messaged and called to check that Leading Aircraftman Sargeant had gotten into a taxi, but he was not able to get through and got no response to the message. Having lost contact, he phoned Wing Commander Clyde again and they then agreed that Chaplain Boyle should make his way to Leading Aircraftman Sargeant's home with a member of 462 Squadron.

72 While Chaplain Boyle was on the way to Leading Aircraftman Sargeant's home, he received a text message from Leading Aircraftman Sargeant to say that he was at the health centre. It later became apparent that Leading Aircraftman Sargeant had driven himself to base rather than waiting for a taxi.

73 Upon arriving at base, Leading Aircraftman Sargeant presented to the Joint Military Police Station adjacent to the main gate.

74 Though Leading Aircraftman Sargeant's immediate supervisor, Flight Sergeant Carter, was recalled from offsite and briefed about the sequences of events leading to Leading Aircraftman Sargeant arriving to the base, Wing Commander Clyde ultimately made the decision to send Warrant Officer Rhodes to support Leading Aircraftman Sargeant instead. Flight Sergeant Carter gave evidence that he was not concerned about this change as he was aware Leading Aircraftman Sargeant and Warrant Officer Rhodes had interacted socially before.[64]

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60 T205
61 T652
62 Exhibit C43 at [6]
63 T208
64 T181

75 Sergeant Hannah Licul of the Military Police was on duty at the time. She had not dealt with Leading Aircraftman Sargeant before.[65] She took Leading Aircraftman Sargeant through to her office to speak to him. She asked Warrant Officer Rebecca Moverley to join them.[66] Sergeant Licul described Leading Aircraftman Sargeant as unpredictable but easy to convince.

76 At the outset of the discussion, Leading Aircraftman Sargeant said that he had been having trouble with alcohol and cannabis. At this point, Sergeant Licul administered a caution. She said that soon after that, she came to appreciate that Leading Aircraftman Sargeant had attended seeking help rather than for any police involvement.

77 Leading Aircraftman Sargeant told them he felt generally threatened after the UWB and felt unsupported by his Unit in his recovery from injury. He told them he was *not* considering suicide.

78 Sergeant Licul phoned Leading Aircraftman Sargeant's Unit who advised that they had been looking for him, with Warrant Officer Rhodes waiting in the carpark for him to arrive. Military Police went outside and brought Warrant Officer Rhodes into the office.

79 The Military Police formed the impression from his behaviour that Leading Aircraftman Sargeant was paranoid, unwell and distressed. Warrant Officer Rhodes had arrived and appeared to have a good rapport with Leading Aircraftman Sargeant. A plan was formed for a group to escort him to the Edinburgh Health Centre via the back entrance for privacy. The specific escorting members were chosen so that they could control Leading Aircraftman Sargeant if that were necessary. Leading Aircraftman Sargeant expressed a desire to leave base instead but did accompany the group. The group headed for the health centre at about 12:30 pm, being taken to a waiting area.

80 I pause here to note how impressed I was with the approach taken by the Military Police with Leading Aircraftman Sargeant. They were not aware why he had presented there on the day, having received no information about the emerging crisis. I am not critical of them not being told, as there were attempts underway to find Leading Aircraftsman Sargeant in the background, independently of those officers in the front office at the base. Once it was realised that Leading Aircraftman Sargeant was unwell, they formed a plan quickly and executed it gently but firmly to ensure he was taken to where he needed to be, the Edinburgh Health Centre.

81 The Edinburgh Health Centre, as all Defence health facilities are, is staffed with a blended workforce. There are members of the military who have medical qualifications, there are members of the Commonwealth public service, and there are members of staff supplied by an external contractor.

82 Leading Aircraftman Sargeant was then assessed by a mental health nurse, Amanda Smith. During this assessment he was paranoid, asking questions about being recorded by cameras in the ceiling. He mentioned that he was concerned about something that he had done on the computer that he wanted to undo and apologise for.[67] When

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65 T251
66 Exhibit C31 at [6]
67 Exhibit C35 at [9]

Nurse Smith asked him to elaborate on the issue of suicide, he refused to participate further in the assessment and walked out.

83 Nurse Smith commenced recording a note in which she wrote that Leading Aircraftman Sargeant was at 'high risk' and ordered that he have one-to-one supervision. At some point while she was making this note, Dr Adrian De Savi was watching over her shoulder. They discussed an earlier attendance which had resulted in the referral to Ms Mansfield. Dr De Savi agreed to assess Leading Aircraftman Sargeant.

84 Dr De Savi was not rostered to see patients that day and was present to tend to administrative duties. He did, however, have an interest in mental health and was otherwise available to conduct the preliminary assessment on Leading Aircraftman Sargeant. Dr De Savi formed the view that Leading Aircraftman Sargeant needed to be taken to the nearby Lyell McEwin Hospital for full assessment, and an ambulance was called. In the meantime, Dr De Savi gave Leading Aircraftman Sargeant paperwork about s 56 of the *Mental Health Act 2009*, a section under which Dr De Savi says he 'placed' Leading Aircraftman Sargeant.

85 The wait began for the ambulance. Leading Aircraftman Sargeant was placed into room 21-22, the entry to which was opposite the nurses' station.[68] The Court visited the facility on a view. While the particular room could be viewed from the nurses' station, it contained areas where visibility was obscured. I accept that this was the best room available for a patient in acute mental health crisis, however it was far from an ideal setup. The room chosen, while carrying risk, did not contribute to Leading Aircraftman Sargeant's death and so I will not discuss it further. I will consider it later only when considering recommendations to improve overall safety.

86 Having now returned to base, Chaplain Boyle attended the Edinburgh Health Centre and spoke to Leading Aircraftman Sargeant privately in the ambulance bay outside. He said that when he spoke to Leading Aircraftman Sargeant on the phone he was a calm, lost person looking for help, but that in the ambulance bay, he was hypervigilant.[69] Chaplain Boyle thought that something had changed between the phone conversation and the in-person one. He said that Leading Aircraftman Sargeant's tone had changed from the phone call earlier. He felt he had lost the strong connection with Leading Aircraftman Sargeant that had been formed quickly on the phone, and thought that this might have been the result of the change in plans that had occurred and the number of events that intervened between the call and arriving at the health centre, which included being interviewed by Military Police. Chaplain Boyle opined that perhaps because the plan that he had explained to Leading Aircraftman Sargeant over the phone had changed, Leading Aircraftman Sargeant felt that he had lost control, comfort, and trust in the process.[70] He further explained that, having learned that Leading Aircraftman Sargeant had made an attempt on his life that morning, the plan that they had made together was likely able to take Leading Aircraftman Sargeant's mind away from self-harm, and then to arrive to base and find out that the plan was not going to be executed would have hit him very hard.[71]

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68 T351
69 T189
70 T209
71 T217

87 On arrival to the health centre, Chaplain Boyle explained that he did not feel welcomed, and thought that things were clinical, sterile and heavy-handed. He felt that the medical team did not want the chaplain interfering with their processes, which was not a unique scenario to experience for him.[72]

88 Chaplain Boyle gave evidence that he told Warrant Officer Rhodes to stay with Leading Aircraftman Sargeant until the medical team had admitted him. He explained that he did not trust the medical system to do its job because he had previously observed a sterile, heavy-handed approach to people in moments of crisis, and thought it would be beneficial for somebody to help Leading Aircraftman Sargeant navigate through the process.[73]

89 The members of the Military Police who had escorted Leading Aircraftman Sargeant gave evidence that they were asked to return to their station once they were satisfied about Leading Aircraftman Sargeant's safety and others around were comfortable with them leaving. Sergeant Licul gave evidence that there was no particular rush and that those members were free to stay for as long as they considered their attendance was necessary.

90 The members gave evidence that they asked Warrant Officer Rhodes about their continued attendance and that he had said that the wellbeing of his officers was his responsibility and that he would stay with Leading Aircraftman Sargeant until the ambulance arrived. Warrant Officer Rhodes disputed their evidence and asserted that he had not said that. However, he said:

> Well, my understanding is that two police officers have already stated that's occurred so – I stand by my statement. I can't recall saying that but if two police officers have said I said that, I guess there's a likelihood that I have said that. But I can't recall saying that.

91 The assessment of evidence is not a mathematical exercise. I am not obliged to accept the evidence of multiple witnesses where it conflicts with the evidence of one witness. I am required to assess what was more likely to have occurred on the basis of my satisfaction of the manner and content of each witness' evidence. On this particular issue, I was satisfied by the evidence I heard that Warrant Officer Rhodes had said the words attributed to him and that this led to a level of comfort on the part of the police which led to their return to the station. This was entirely consistent with the approach taken by the Military Police in identifying the crisis, forming a plan, and then taking Leading Aircraftman Sargeant to the health centre. Having then left without ensuring that he was safely and securely in the care of others would be inconsistent with their earlier actions.

92 After the Military Police left, Warrant Officer Rhodes was advised that an ambulance would take some hours, and he asked Dr De Savi if he was required to stay. He was told he was not required, and so he left. He gave Leading Aircraftman Sargeant his phone number before leaving. Warrant Officer Rhodes said:

> Gary was at the safest place he could possibly be on that day so – yeah, I had information that I felt comfortable with that Gary was in a safe place.[74]

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[72] T210
[73] T214
[74] T590

93 It was unfortunate timing that the news about the delay to ambulance arrival came after Military Police had left. Had that come through when they were present, a conversation might have occurred involving Warrant Officer Rhodes and police about what supervision was required. It may be that if Warrant Officer Rhodes had identified that he was inclined to leave, police may have stayed. This is purely speculation though, as it did not occur in this sequence.

94 In the meantime, Dr De Savi gave a handover to nurses at the nursing station. He said that although Leading Aircraftman Sargeant had been deemed high risk of self-harm by Nurse Smith, he had reassessed him as medium risk. He told nurses to supervise him. He was placed in a room near to the nurses' station which was not lockable. Dr De Savi said that at this point his opinion was that Leading Aircraftman Sargeant had not been detained because he agreed with the plan for treatment.

95 Nurse Lynette Glasson was on duty. During Dr De Savi's handover, she gave evidence that she heard him say that Leading Aircraftman Sargeant was deemed low risk of suicide.[75] She gave evidence that Dr De Savi said 'I know his history, I know him, he's low risk' and that she felt relieved to hear it.[76] I am satisfied that Nurse Glasson was giving honest evidence, however I am unable to accept that she heard this conversation correctly. I am primarily moved to that position on the basis of Dr De Savi's explanation that he in fact had no prior involvement with Leading Aircraftman Sargeant at all, combined with his evidence of his views about Leading Aircraftman Sargeant at the time, and the fact that he had called for an ambulance, which would be an unlikely approach for a low risk patient. Dr De Savi's evidence was equally as compelling as Nurse Glasson's. After balancing all of the evidence, I am unable to accept that Dr De Savi said what Nurse Glasson recalled she heard.

96 In any event, Nurse Glasson formed the impression that Leading Aircraftman Sargeant was at low risk. She observed that Leading Aircraftman Sargeant did not have a picket[77] which aligned with what she heard Dr De Savi say, as she would have expected a picket if he had been deemed medium-high or high risk.[78] However, an aspect that was conflicting in Nurse Glasson's evidence is that she understood that Leading Aircraftman Sargeant had been 'sectioned', which was a reference to powers of detention being exercised. She gave evidence that she did not really think about the contrast between being low risk and being sectioned.

97 Nurse Glasson spoke to Leading Aircraftman Sargeant in relation to his apprehensiveness about going to the Lyell McEwin Hospital, as she had worked there before. She gave evidence that he was sad and had bloodshot eyes, as if he had been crying.

98 Nurse Glasson gave the following evidence about what happened next:

> [Leading Aircraftman Sargeant] sort of looked up at me and he said - he said - he said 'I'm hungry'. He said 'Have you got anything to eat?' I said 'I can get you some cheese and crackers'. And he said 'Yeah, that's great'. So I said 'Do you want a tea or coffee?' And he said 'Nah, just some cheese and crackers'. So I said 'Okay'. I walked out of the room, and

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75 T447 and T468
76 T448
77 A military health term for a 'nursing special' or one-to-one supervision
78 T441

> as soon as I stepped out of the room I noticed him behind me. And I had a thought go through my head he should actually stay in the room. I think I actually said to him 'You're probably better off just staying in your room'. He said 'Nah, I'll be right', and he followed me down to the dining room, and I gave him some cheese and crackers, like a few packets, and he opened them and he smashed them like he hadn't eaten for a month. And I said 'Okay, we'll go back to the room'. And he said 'Do you mind if I just sit here for a minute?' And I sort of thought about it, I thought: mm, okay. Then he said 'Have you got a phone charger? My phone's flat'. And I said yeah, because we had a cupboard in the nurses' station with phone chargers in it, and I said 'Yeah, I'll go and have a look'. So I went down to the nurses' station, and as soon as I opened up the cupboard I thought: I didn't even see him with a phone. And I quickly ran back there, and he was gone. [79]

99 The dining area has two doors exiting directly outside which are never locked. Nurse Glasson then immediately raised the alarm about Leading Aircraftman Sargeant's absence.

100 Going back a step, Nurse Coordinator Natalie Jackson, who had been present for Dr De Savi's handover, said she felt uncomfortable about Leading Aircraftman Sargeant being taken away and asked Dr De Savi whether it was okay. She gave evidence that he told her that Leading Aircraftman Sargeant was settled, happy with the plan and should be fine to go to the dining room.[80] Dr De Savi gave evidence that it was Nurse Glasson who asked Dr De Savi for permission to go to the dining room.[81] Nurse Glasson gave evidence that she did not ask him and she did not believe she needed permission to take Leading Aircraftman Sargeant out of the room because she believed he had not been categorised as high or medium risk.

101 Nurse Glasson gave evidence that she felt guilty about what happened, and although she was trying to help him, she felt that she let Leading Aircraftman Sargeant down.[82]

The search

102 Immediately upon Leading Aircraftman Sargeant's absence being raised by Nurse Glasson, an announcement was made over the health centre's public address system. Searches were commenced. The nurse tasked with notifying Military Police could not call through because she could not get an external line. It took 22 minutes to work out the technical issue and notify them. This was an issue with the requirements to dial out on this phone being different to other phones. It has since been remedied with signage.[83] By that time Leading Aircraftman Sargeant had already left base. However, in light of the delay of the news reaching police, it took an hour to review all the relevant cameras for the period in order to determine that he had left. The delay was compounded because no one knew what car Leading Aircraftman Sargeant might have been driving.

103 After identifying that he had left base, South Australia Police became involved and assisted with the search. In order to assist their efforts, they requested a photograph of Leading Aircraftman Sargeant.

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79 T451
80 Exhibit C33 at [18] and T358
81 T561
82 T455
83 T361

104 Sergeant Licul sought permission to release the photograph from Leading Aircraftman Sargeant's ID pass. Documentary evidence received raised a concern that this was refused because he was depicted in uniform, however oral evidence at Inquest established that there was no access to the computer system required to obtain the photograph at the time because of a coincidental system failure,[84] therefore this issue played no actual role in Leading Aircraftman Sargeant's death. While that was happening, members of South Australia Police found a photograph of Leading Aircraftman Sargeant on Facebook, but it was deemed too old to be useful. Police contacted Leading Aircraftman Sargeant's mother, however she did not have any photos from recent years.

105 Leading Aircraftman Sargeant's car was located by members of South Australia Police at the car park of the North Haven Surf Live Saving Club just before 7:30 pm. A dog patrol of the surrounding land and water patrol of the surrounding ocean were requested. Hotels in the area were checked, and hospitals were called. Throughout the night South Australia Police officers searched parks, reserves and streets.

106 At about 2 am, members of South Australia Police gained entry to Leading Aircraftman Sargeant's home. Inside they found that the manhole cover had been removed and a barbell was placed over the top of the opening. There was a small ratchet strap tied around the barbell forming a noose. It appears that Leading Aircraftman Sargeant had prepared this before he called Chaplain Boyle and left for base.

107 At about 1 pm a boater came across Leading Aircraftman Sargeant's body on breakwater rocks at Outer Harbor. Members of South Australia Police removed the body and brought it to shore. Paramedics attended and declared life extinct at 3:05 pm. They noted no signs of struggle or any signs of violence. In the left pocket of his jeans, members of South Australia Police found a green rope with a noose tied at one end.

108 Police extracted and examined Leading Aircraftman Sargeant's phone, which was found in his car. Analysis revealed that Leading Aircraftman Sargeant had told others his life was in danger from his boss who he identified as DC, which could relate to either of two people in 462 Squadron, and also revealed that he had reached out to a child abuse support group on 7 September 2020.

109 Leading Aircraftman Sargeant's internet history revealed that he had researched death by car exhaust. He had viewed numerous photographs of ropes tied into nooses on 17 August 2020. On a laptop taken from his house, Leading Aircraftman Sargeant had researched placing a bag over one's head as a means of ending life.

Post-mortem examination

110 Senior specialist forensic pathologist Dr Karen Heath conducted a post-mortem examination. Dr Heath found frothy fluid in the airways and hyperextended, oedematous lungs. These are non-specific findings which are consistent with drowning. Superficial abrasions and bruising were identified to the face, upper, and lower limbs. They had the appearance of post-mortem injuries, likely from bumping against rocks near the

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[84] T287

waterline. Dr Health was able to conclude that these injuries had made no contribution to the death.

111 There were no drugs or alcohol found in Leading Aircraftman Sargeant's system. No natural disease that could have caused or contributed to the death was identified. The presence of an elevated vitreous sodium level of 143 mmol/L was in keeping with immersion in saltwater.

112 Given the indicators found, together with the circumstances of the finding of Leading Aircraftman Sargeant's body and the absence of any significant underlying organic disease or any significant injuries, Dr Heath concluded that Leading Aircraftman Sargeant's death was attributed to drowning. No evidence was raised during the Inquest that gave rise to an alternative cause and the cause was not questioned. I therefore make a finding to that effect.

Expert assistance

113 I was assisted at Inquest by the evidence of an independent experienced psychiatrist, Dr Maria Naso. In her report, which was received into evidence, Dr Naso said that 'Leading Aircraftman Sargeant's life was marked with a lack of trust in others, which is common for those who suffer abuse in childhood'. Dr Naso considered it unsurprising that Leading Aircraftman Sargeant did not express any suicidal ideation to anyone after the UWB meeting, which appeared to trigger his paranoia against his background of mistrust of others, even though he was in fact using the internet to search for guidance about nooses around that time.

114 Dr Naso pointed out that Leading Aircraftman Sargeant's risk was rated as low by Nurse Shepherd, high by Nurse Smith and medium by Dr De Savi, all within the space of seven days which speaks to the unreliability of subjective assessments. She gave evidence that the use of stratification in managing risk of suicide is a concept that has fallen out of favour as unreliable. It is not uncommon for those at low risk, or no detected risk, to take their own lives. It is not uncommon for those considered high risk to decide against that action. Dr Naso explained that a better approach that has contemporary consensus is to identify any risk of suicide and then address it in ways that are appropriate to the patient.[85] In that way, the individual risk factors presented are addressed without the need for a label of low, medium or high risk.

Assessment of the issues arising

Appropriateness of the Unit Welfare Board

115 I was struck by the evidence of Flight Sergeant Carter, a member of the British and Australian military with more than 20 years' experience, who said that he felt intimidated to a degree when he attended the UWB meeting on the same day as Leading Aircraftman Sargeant.[86] Given that we now know that Leading Aircraftman Sargeant was researching mechanisms of suicide six days later, it concerns me that this meeting may have had a deep impact on Leading Aircraftman Sargeant, given that it appears to me he

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[85] T644
[86] T161

was likely of a more sensitive disposition than Flight Sergeant Carter. This leads me to consideration of the factors that may have produced an intimidating effect.

116 I heard evidence about the physical layout of the meeting, where the person under review sat facing a panel of officers, members and staff.[87] This physical layout itself is prone to inducing anxiety and is far from ideal. I was comforted to a degree that Warrant Officer Gawley described this layout as unusual.

117 I also heard evidence about the paperwork that is distributed in advance of these meetings. Warrant Officer Rhodes' evidence was that this process could be improved.[88] It was disappointing to hear that important aspects which might put an anxious mind at ease, such as the collaborative intent of the meeting, were left out of paperwork in favour of a member's supervisor speaking to them about it. This allows for natural variations in quality and depth of such advice. It opens the possibility for a particularly non-interventionist manager to simply not provide any advice at all. If that possibility is there without mechanisms to prevent it, then the approach is flawed.

118 I was greatly assisted by Dr Naso's expert views, having read the evidence of the earlier witnesses. It was telling that Dr Naso likened the UWB to the Parole Board, which is set up to assess criminals.[89] In his evidence, Dr Duncan accepted that the meetings might be intimidatory, but said that it was, at the end of the day, a task that needs to be set up for the commanding officer to be able to execute a specific duty. He said that the effect on a member depends on their level of comfort with hierarchy. With great respect to Dr Duncan, deference to rank at the cost of wellbeing is not unassailable and the purpose of the meeting should be achieved without intimidating any of its subjects, even if many can tolerate it.

119 I was comforted by submissions made on behalf of the Department of Defence that it is committed to making the UWB meetings less intimidatory as much as possible and that there is a desire to improve and standardise the pre-meeting information.

Adequacy of care provided by Kathleen Mansfield

120 Ms Mansfield is a psychologist with about 20 years of experience.[90] She gave evidence that the computer system used to obtain documents in relation to Defence Force clients was clunky. She gave evidence that, in accordance with her current practice, she believes she would have tried to open Leading Aircraftman Sargeant's referral document on the morning of her appointment with him, notwithstanding having received it some days earlier.[91] She encountered an issue where she realised she did not have the correct passcode to access the document, which is usually sent through separately.

121 Ms Mansfield proceeded with her appointment. There were a number of risks inherent in that approach. For example, such a document might reveal a risk to the psychologist themselves of which they ought to be aware before meeting with a client. Another potential risk is what turned out to be the case in relation to Leading

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87 T122-T124 and T159
88 T584
89 T604
90 T22
91 T62

Aircraftman Sargeant; that the document contained extremely important information about his clinical picture which I consider likely affected the course of the appointment.

122 I consider it important to recall the evidence of Chaplain Boyle at this point. He said that upon directly questioning Leading Aircraftman Sargeant on the topic of suicide, Leading Aircraftman Sargeant revealed intent and then his tone completely changed. As I have detailed, Chaplain Boyle gave evidence that he formed the impression that Leading Aircraftman Sargeant was waiting for that to be asked and when it was, it quickly sparked what appeared to be a trusting relationship.[92]

123 Another important reason for opening and reading the referral document that also played out is that once she had read it, Ms Mansfield realised that the referral was for a type of therapy that she did not provide. That is, she might have passed the urgent referral to another provider had she read it earlier.[93]

124 Ms Mansfield was somewhat open to the criticism she faced during questioning for not having opened and read the referral document, expressing that she regrets not having done so.[94] She faintly suggested that she might want to keep an open mind, but then quickly conceded that she could read the information and take a professional approach of having an open mind during the consultation.[95]

125 The referral recorded:

> Gary reported a long history of low mood and social isolation.
>
> Stated he grew up in a highly dysfunctional family. His mother met an alcoholic partner when Gary was 18 months old who disowned him and continually asked his mother to 'get rid' of him. Gary stated that he grew up unloved and unwanted with his mother choosing her partner over him. He stated from a young age he experienced suicidal ideation where he fantasized about taking all of his bedding to the train tracks, falling asleep and being killed by a train while sleeping. He stated he never acted on these thoughts but would cry himself to sleep nightly and promise himself things would get better.
>
> When he was 18 years old he stated that his mother packed his belongings and asked him to leave, he stated he had nowhere to go but a friend allowed him to stay with her.
>
> This abandonment has reportedly followed him throughout his life with him reporting that he had never had a relationship and has no friends. Nil meaningful contact with his mother stating he attempts to keep in touch but the contact is rarely reciprocated.
>
> A further stressors [*sic*] was the death of the one close ADF friend he had a couple years ago. He stated he lived close by with this friend and often caught up with him. He was unfortunately killed in an MVA on the way to a course. Gary stated he has not dealt with the grief surrounding this loss.[96]

126 One can immediately appreciate how significant that information would have been in the context of a psychological assessment requested in urgent circumstances. The fact that Nurse Shepherd was able to extract all of that information once again speaks to Leading Aircraftman Sargeant's willingness to discuss his issues when prompted and the failure

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92 T198-T199
93 T85
94 T68
95 T68
96 Exhibit C24 at Annexure A

to read this information highlights a lost opportunity to provide a perfectly timed intervention at this point.

127 When Ms Mansfield read the referral after the appointment with Leading Aircraftman Sargeant, she said she knew some of the information contained within the referral, based on her appointment with him, and some of it was new information to her.[97]

128 When asked if she would have approached her appointment with Leading Aircraftman Sargeant differently had she read the referral document before the appointment, Ms Mansfield said:

> That requires a degree of speculation but I would say, as a general no, not specifically. The one slight exception is that I may have been less prepared to accept at face validity or face value what he was saying in regards to not having suicidal ideation. So I may have been a little bit more cautious around what he was saying rather than just taking his word for it.[98]

129 While I accept that it was not certain that Ms Mansfield would have got more information than she did from Leading Aircraftman Sargeant, nor that she would certainly have been able to intervene to prevent his death, I am satisfied on the basis of his behaviour of becoming forthcoming when prompted on real issues, that this was more likely than not what would have happened.

130 Ms Mansfield disagreed that the referral disclosed chronic suicidal ideation and instead said that it revealed distal suicidal ideation. Dr Naso said that any reference to suicide is a matter of concern to clinicians, regardless of the context within which it arises.[99] In any event, I am satisfied that Ms Mansfield's distinction is not based on a proper reading of the referral which speaks of suicide concerns 'from a young age'. This provides no indication that such thoughts have ended. This accords with what I expect to have been the case; that such thoughts never did in fact end. In my assessment, Ms Mansfield was attempting to distance herself from the importance of the information in the referral, in the light of her not having read the document prior to her consultation.

131 The issue of suicide was squarely raised in the referral in quite descriptive and serious terms, albeit 'distal'. I am satisfied that any reasonable psychologist would have discussed suicide in detail having read that referral. If suicide was front and centre and explored, Leading Aircraftman Sargeant might have benefited from counselling on the actual issue of concern. It might also have put the confidentiality fixation into context.

132 Dr Naso gave evidence that reading referral documentation is a 'non-negotiable' for clinicians. She described circumstances of not being able to read it in advance, and having read it in the presence of the patient, to ensure that she had awareness of the contents before consulting with the patient.

133 In light of the significance of the information that such documents potentially contain and that Dr Naso's evidence is that it is a fundamental part of the process, I find that Ms Mansfield not reading the referral prior to the meeting with Leading Aircraftman Sargeant was inappropriate.

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97 T54
98 T53
99 T611

134 As I have described, Leading Aircraftman Sargeant also demonstrated a fixation on confidentiality which, with the benefit of hindsight, was part of his presentation when in crisis. Ms Mansfield was not necessarily required to detect that it indicated such a serious issue, however Dr Naso was critical of Ms Mansfield for not having adequately explored the fixation on confidentiality.[100]

135 Ms Mansfield explained that she had not explored the issue deeper because it was not unheard of in her experience, this was her first session,[101] and because she was beginning to document things that she might be on the lookout for in subsequent appointments. While she accepted that she could have enquired more about the confidentiality concerns that were raised twice, she did not accept that she should have.[102] She did, however, acknowledge that it might have been clinically relevant[103] and objectively, she considered it significant enough to record in her session notes as well as her letter to Nurse Shepherd.

136 Ms Mansfield said there were two broad aims for a first session with any client; building rapport, and for the clinician to start gathering information.[104] Dr Naso agreed that it is important for clinicians when interacting with patients to build rapport. She said without rapport, there may not be trust and it can be difficult to implement future plans.[105]

137 Dr Naso was asked about the tension between exploring deep issues and building rapport during a first appointment. Dr Naso resolved this in favour of exploring the issue. She said that irrespective of whether it is a first appointment or not, issues alluding to paranoia must be explored.[106] Ms Mansfield conceded that if she did press the issue more, she might have drawn out that it was a symptom of paranoia.[107] In line with Dr Naso's expert advice, I find that Ms Mansfield should have explored Leading Aircraftman Sargeant's focus on confidentiality more than she did. While I am certain that discussion of suicidal ideation would more likely than not have changed the course of Leading Aircraftman Sargeant's treatment, I am less certain that the pressing of the paranoia issue would have materially altered what happened.

138 With that analysis, I find that Ms Mansfield's approach to Leading Aircraftman Sargeant's case was lacking. This finding bears cogency with the outcome; Leading Aircraftman Sargeant expressed a desire not to have another appointment with Ms Mansfield. In the course of chasing rapport, Ms Mansfield failed to provide the real engagement Leading Aircraftman Sargeant was seeking.

Powers under the Mental Health Act 2009

139 Before turning to assess the actions of those involved on 9 September 2020, it is important to understand the regime that exists under South Australian law which empowers doctors and police (and other people) to take action to protect people with mental health issues. The *Mental Health Act 2009* (SA) provides a suite of powers to both medical staff and members of police to allow them to act when necessary.

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100 T681
101 T61, T64, T76 and T78
102 T82
103 T64
104 T57
105 T672
106 T619
107 T73

140 Section 1 provides, *inter alia*:

> ***authorised officer*** means—
>
> (a) a mental health clinician; or
>
> (b) an ambulance officer; or
>
> (c) a person employed as a medical officer or flight nurse by the Royal Flying Doctor Service of Australia (Central Operations) Incorporated or the Royal Flying Doctor Service of Australia (South Eastern Section); or
>
> (d) a person, or a person of a class, approved by the Chief Psychiatrist, by notice in the Gazette, for the purposes of this definition; or
>
> (e) any other person, or person of a class, prescribed by the regulations for the purposes of this definition;

141 The *Mental Health Regulations 2025* prescribe no other person or class of person for the purposes of that definition. The Chief Psychiatrist has approved additional classes of clinicians for the purposes of the definition.[108]

142 Section 56 then provides the following relevant powers directed to health professionals:

> (1) This section applies to a person if—
>
> …
>
> (c) it appears to an authorised officer that—
>
> (i) the person has a mental illness; and
>
> (ii) the person has caused, or there is a significant risk of the person causing, harm to himself or herself or others or property or the person otherwise requires medical examination.
>
> (2) An authorised officer may form an opinion about a person under subsection (1)(c) based on the officer's observations of the person's behaviour or appearance or reports about the person's behaviour, appearance or history (which may include reports about matters occurring outside the State).
>
> (3) An authorised officer may, subject to this section, exercise the following powers in relation to a person to whom this section applies:
>
> (a) the authorised officer may take the person into his or her care and control;
>
> (b) the authorised officer may transport the person from place to place;
>
> (c) the authorised officer may restrain the person and otherwise use force in relation to the person as reasonably required in the circumstances;
>
> (d) the authorised officer may restrain the person by means of the administration of a drug when that is reasonably required in the circumstances;
>
> (e) the authorised officer may enter and remain in a place where the authorised officer reasonably suspects the person may be found;
>
> (f) the authorised officer may search the person's clothing or possessions and take possession of anything in the person's possession that the person may use to cause harm to himself or herself or others or property.

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[108] See, for example, South Australia, *Government Gazette*, No 25, 10 April 2018, 1356

(4) An authorised officer who takes the person into his or her care and control must, as soon as practicable—

…

(c) in the case of a person referred to in subsection (1)(c)—

(i) transport the person, or arrange for the person to be transported by some other authorised officer or by a police officer, to a treatment centre or other place for medical examination; and

(ii) give the person a copy of a written statement in the form approved by the Chief Psychiatrist (a statement of rights)—

(A) informing the patient of his or her legal rights; and

(B) containing any other information prescribed by the regulations.

(5) The powers conferred by this section continue to be exercisable as reasonably required for the purpose of enabling or facilitating the medical examination or treatment of the person.

(6) An authorised officer may not administer a drug to restrain a person under this section unless the officer is authorised to do so under the Controlled Substances Act 1984.

(7) A search of a person must be carried out expeditiously and in a manner that avoids, as far as reasonably practicable, causing the person any humiliation or offence.

(8) Anything taken into the possession of an authorised officer under this section may be held for as long as is necessary for reasons of safety, but must otherwise be returned to the person from whom it was taken or dealt with according to law.

143 Section 57 provides the following relevant powers directed to police:

(1) This section applies to a person if—

…

(c) it appears to a police officer that—

(i) the person has a mental illness; and

(ii) the person has caused, or there is a significant risk of the person causing, harm to himself or herself or others or property; and

(iii) the person requires medical examination.

…

(3) A police officer is not required to exercise any medical expertise in order to form an opinion about a person under subsection (1)(c) and may form such an opinion based on the officer's observations of the person's behaviour or appearance or reports about the person's behaviour, appearance or history (which may include reports about matters occurring outside the State).

(4) A police officer may, subject to this section, exercise the following powers in relation to a person to whom this section applies:

(a) the police officer may take the person into his or her care and control;

(b) the police officer may transport the person from place to place;

(c) the police officer may restrain the person and otherwise use force in relation to the person as reasonably required in the circumstances;

(d) the police officer may enter and remain in a place where the officer reasonably suspects the person may be found;

(e) the police officer may use reasonable force to break into a place when that is reasonably required in order to take the person into his or her care and control;

(f) the police officer may search the person's clothing or possessions and take possession of anything in the person's possession that the person may use to cause harm to himself or herself or others or property.

(5) A police officer who takes the person into his or her care and control must, as soon as practicable—

…

(c) in the case of a person referred to in subsection (1)(c)—transport the person, or arrange for the person to be transported by some other police officer or by an authorised officer, to a treatment centre or other place for medical examination.

(6) The powers conferred by this section continue to be exercisable as reasonably required for the purpose of enabling or facilitating the medical examination or treatment of the person.

(7) A search of a person must be carried out expeditiously and in a manner that avoids, as far as reasonably practicable, causing the person any humiliation or offence.

(8) Anything taken into the possession of a police officer under this section may be held for as long as is necessary for reasons of safety, but must otherwise be returned to the person from whom it was taken or dealt with according to law.

(9) If a police officer has arrested a person for an offence or apprehended a person under some other law, the person may, despite any other law, be released from police custody for the purpose of medical examination or treatment under this Act.

(10) If a person who has been arrested for an offence is released from police custody for the purpose of medical examination or treatment under this Act—

(a) the Commissioner of Police must be notified in accordance with the regulations of the action taken under this Act in relation to the person; and

(b) the person must, at the request of the Commissioner of Police, be held and returned to police custody in the event that an inpatient treatment order is not made in respect of the person or ceases to apply to the person.

144 Section 58 provides:

> Authorised officers and police officers may assist each other in the exercise of powers under this Act.

145 The regime therefore envisages a collaborative approach between health professionals and police in order to ensure that those in circumstances of risk can be looked after until delivered into the care of experts.

146 Dr Naso gave evidence that these are powers that are available to be exercised, as opposed to other provisions in Part 5 of the *Mental Health Act* which permit detention orders, known as Inpatient Treatment Orders (ITOs) to be made.[109] I consider that language such as 'placing under' or 'sectioning' might reflect a misunderstanding of the nature of the regime and that the provisions set out above do not require 'orders' to be made. The adoption of such language has the capacity, to some degree, to give the impression that more is required than the regime actually requires before the powers can be exercised.

Adequacy of care provided by Military Police

147 Leading Aircraftman Sargeant attended the Joint Military Police Station unexpectedly and in mental health crisis. He was taken to a relatively private area and spoken to. When

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[109] Exhibit C25 at 19

he raised potential offences, he was cautioned, but the focus quickly changed when it was appreciated that he actually needed help. As touched on above, this was a sensitive and appropriate approach.

148 A plan was then formed to escort Leading Aircraftman Sargeant to the health centre. Arrangements were made to escort him through a more private entrance and to have him wait in a more private waiting area than the main area. This was also appropriate and sensitive care. Putting aside for a moment as to whether there was any lawful authority to exercise care and control over Leading Aircraftman Sargeant, and assuming that there was, the circumstances at this point did not call for compulsion as he was willing, with slight reluctance, to attend for assessment. This is consistent with him having attended seeking help in the first place.

149 It might have been useful at this point for Leading Aircraftman Sargeant to have been searched and his keys removed. However, given that he was dealing with police who are not medical professionals and who were not trained in dealing with acute mental health crises, I find that there is no criticism to be made for not doing so, assuming for the purposes of the consideration that there was power to take such action.

150 Sergeant Licul gave evidence that there was no rush for her members to return to the station, although she did check on their progress. The unfortunate part of this was that Warrant Officer Rhodes left the members with the impression that he was committed to the task of caring for Leading Aircraftman Sargeant until he was in the care of paramedics. That did not eventuate. The fact that that did not eventuate was in no part due to the actions of the Military Police.

151 I am unable to find any criticism in the approach of Military Police to Leading Aircraftman Sargeant's care on 9 September 2020. I will return to the question of whether they might have been assisted by State powers, and whether I should recommend that, later.

Adequacy of care provided at the Edinburgh Health Centre

152 Dr Naso considered that Leading Aircraftman Sargeant presented on 9 September 2020 with symptoms consistent with psychotic depression. He was assessed by two clinicians and planned for transport to hospital before he absconded.

Risk assessments

153 Assessing the actions of those involved against the prevailing approach to suicide risk at the time, Dr Naso said that it was reasonable for Nurse Smith to make a determination that Leading Aircraftman Sargeant was at high risk of suicide or self-harm. However, she also considered that it was reasonable for Dr De Savi to downgrade that to medium risk once Leading Aircraftman Sargeant indicated agreeableness to being transferred to the Lyell McEwin Hospital for assessment.

154 I heard evidence that, in line with the approach of the general medical community, Joint Military Health has moved away from risk stratification in cases of concern about suicide or self-harm. Instead, the SafeSide model has been adopted. I received into evidence a copy of the SafeSide training module and this was assessed by Dr Naso.

Dr Naso considered that it was a good approach[110] to this issue and I am satisfied that the improvement in approach is a positive step. Removing the language of 'low risk' might have seen more caution taken in relation to Leading Aircraftman Sargeant, so it is pleasing to see that occur.

Dr De Savi

155 Dr De Savi gave evidence that, at the time of the events and Inquest, he predominantly worked at Woodside base. His role was effectively to provide general practitioner services. While the Edinburgh Health Centre impresses as a small hospital, it does in fact remain as a high-level general practitioner clinic. While Dr De Savi had an interest in mental health, he did not have significant experience in dealing with mental health patients. This was in fact the first time that he had ever exercised any powers under the *Mental Health Act*.

156 It was unfortunate that Dr De Savi did not read Nurse Smith's completed note of her abandoned interaction with Leading Aircraftman Sargeant.[111] If he had, even if it was after his own assessment, he would potentially have picked up the depth of the paranoia aspect, which Nurse Smith had described in the note,[112] and that the paranoia specifically related to equipment inside of the health centre. This is a concerning aspect which might have provoked thought about whether Leading Aircraftman Sargeant was at risk of absconding from this particular location, notwithstanding his overall compliance. This knowledge might have guided Dr De Savi's decision-making, particularly in respect of Leading Aircraftman Sargeant visiting the patient lounge when it was raised with him by Nurse Jackson. He acknowledged that it could have changed his approach.[113]

157 To be clear, Dr De Savi did detect paranoia,[114] but he had not appreciated that Leading Aircraftman Sargeant had experienced paranoia about the health centre equipment specifically.[115] He could not recall being told that aspect by Nurse Smith, even though it was in her note. Dr Naso provided useful clinical context. She explained that it would not have taken much to provoke a paranoid response if Dr De Savi had known what had happened with Nurse Smith.[116] Had Dr De Savi provoked a paranoid response and observed it personally, it might have revealed the severity of the situation Leading Aircraftman Sargeant was in at that time.

158 In psychiatric assessments, as with any medical assessments, the more information available, the better. As occurred when Ms Mansfield failed to read the referral documents, significant information that had the capacity to change the course of events was lost due to a lack of comprehensiveness. Notwithstanding that Dr De Savi spoke to Nurse Smith, I find that he should have read her formal note after it was completed. Whether that was before or after his assessment of Leading Aircraftman Sargeant is of less importance than that he read it at all. I place little weight on the fact that Dr De Savi

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110 T649-T650
111 T490, T491 and T540
112 Exhibit C21f at 36, T500 and T538
113 T541 and T552
114 T498
115 T542
116 T628

thought there would be a quick transfer, as in my view that would not alleviate the importance of reading the note before making his own.

159 Dr De Savi found no evidence of psychomotor agitation, although he found Leading Aircraftman Sargeant's affect was flat and his speech disconnected. He said there was some paranoia evident and he referred to Leading Aircraftman Sargeant making comments about there being noises outside of his home that would wake him up. However, there were no delusions, hallucinations, or obvious psychotic indicators. He found no evidence of thought disorder and he made a diagnosis predominantly of depression or major depressive disorder. Dr De Savi thought that Leading Aircraftman Sargeant was not overly psychotic, but he did not completely rule it out. Dr Naso was not critical of that diagnosis. Dr Naso's overall assessment of Dr De Savi's approach was:

> Once he was in the medical centre, the psychosis was obvious, the major depressive episode was obvious and Dr De Savi had appropriately diagnosed that. He also adequately identified that there was guarding, he was also aware that that morning there had been an attempt at hanging. He appropriately put him on s 56. All we needed to do then was to constantly watch him, search him and get him to the Lyell McEwin Hospital.[117]

160 Dr De Savi's plan for treatment was therefore sound. He identified an acute mental health issue and determined that transport to hospital for expert intervention was indicated. This was itself appropriate. He gave evidence that he expected a transfer might take around 30 minutes, which was unfortunately overly optimistic for a mental health transfer, but not unreasonably so.

161 Dr De Savi clearly considered that Leading Aircraftman Sargeant needed observation. He recorded that specifically in his medical record. I am satisfied that Dr De Savi made this expectation plain to Nurse Jackson, but that it did not filter down to Nurse Glasson. Dr Naso said that 'absolute clarity is required when giving instructions about the implementation of the use of powers under the *Mental Health Act*'.[118] During his evidence, Dr De Savi accepted that his communication must have been insufficient given the confusion that resulted. I also observe that Dr De Savi agreed that he approved Nurse Glasson's request to take Leading Aircraftman Sargeant away from the room near the nurses' station. In any event, this approval undoubtedly further muddied the strength of his expectation and required a clear discussion about what was going to happen prior to approval.

162 Dr De Savi said that he took some comfort from the fact that they were inside a health centre within a military base and that members of the military can generally be expected to be compliant. I accept that those factors do offer some level of security, although as it was in this case, it might be falsely reassuring where the extent of the mental health crisis outweighs those factors, or as occurred with Leading Aircraftman Sargeant, part of the mental health crisis related to the health centre equipment.

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[117] T659
[118] T634

Choice of powers

163 Dr Naso's opinion was that the use of s 56 powers was appropriate as it was the least restrictive way of dealing with Leading Aircraftman Sargeant.[119] He certainly had not reached the level of presentation where orders of detention needed to be considered. I accept Dr Naso's opinion.

Search

164 Dr De Savi wrote in his affidavit that Leading Aircraftman Sargeant would only have been physically searched if he were placed under an ITO but then conceded in his oral evidence that what he had written was wrong.

165 The evidence from nurses was effectively that a search would usually be conducted at the point of admission to the health centre. Leading Aircraftman Sargeant was, of course, never admitted to the Edinburgh Health Centre and was always intended to simply pass through. I find that there was no genuine occasion for admitting Leading Aircraftman Sargeant as it was the intention to refer him on for hospital care. This was not, therefore, a mechanism genuinely open that should have been used to search him. To be clear, I consider that he should have been searched, but in a manner unrelated to admission.

166 Dr Naso was critical of Dr De Savi's statement that Leading Aircraftman Sargeant would only have been searched if he were placed under an ITO, which likely reflected his understanding on 9 September 2020. As I have set out above, the powers available to authorised officers and to police both include a specific power to search and remove anything that may be used to cause harm. The same power is available upon imposing an ITO. Given there is power to search under both regimes, the decision to search is therefore risk based as opposed to being based on what suite of powers is chosen. Dr Naso's clear view was that all patients with suicidal ideation should be searched when dealt with under either regime, that is, made the subject of the exercise of s 56 powers or placed under an ITO.[120]

167 As a result of that, I find that Dr De Savi's understanding of the power to search a mental health patient was flawed and that this was a lost opportunity to remove Leading Aircraftman Sargeant's keys, which he later used to further his plan of harming himself.

Warrant Officer Rhodes

168 As I have discussed earlier in this Finding, I consider that Warrant Officer Rhodes should either not have indicated to Military Police that he was going to stay with Leading Aircraftman Sargeant until the ambulance arrived or otherwise commit to that task. What occurred was the worst combination of circumstances possible; he indicated that he would remain there, which gave Military Police a false sense of ease, and then decided that he did not wish to wait. As the circumstances of 9 September 2020 were unusual and outside of what could reasonably be trained, I consider that this was an individual error made by Warrant Officer Rhodes and did not reflect a systemic issue.

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[119] T633
[120] T664

Nurse Glasson and the decision to move around the health centre

169 Nurse Glasson gave a detailed explanation about her approach to Leading Aircraftman Sargeant throughout her evidence. She did not have any awareness of his specific presentation. She did not see any pickets outside his room, which she would expect for a patient at high risk.[121] She had overheard a conversation where she understood that he had been deemed 'low risk', which she was relieved to hear.[122] Leading Aircraftman Sargeant said he was hungry and followed her to the patient lounge. Even though she adamantly denied it, the evidence is clear that Nurse Glasson asked Dr De Savi whether it was acceptable to take him to the patient lounge and he consented.[123]

170 Dr Naso assessed the approach of Nurse Glasson and reviewed her evidence about mental health patients generally. Dr Naso said that Nurse Glasson's knowledge of the *Mental Health Act* was inadequate and pointed out that her decision to leave Leading Aircraftman Sargeant alone because she thought he was low risk, is incongruent with her understanding that he was 'under' s 56 or 'sectioned'.[124] Having listened carefully to Nurse Glasson's evidence and comparing it to the structure of the *Mental Health Act*, I agree with Dr Naso's criticism. It was clear to me that Nurse Glasson took a lot of the weight of Leading Aircraftman Sargeant's death personally. Rather than an individual failing, I view the events as representative of an environment in which there were inadequate systems and overall understanding of all staff about the best practice approach to those in acute mental health crisis. While I have found Nurse Glasson's approach flawed, this is not intended to be a personal criticism of her, or to imply that she was not acting with the best intentions and acting on the signs she observed that provided her comfort about risk.

Standard Operating Procedures

171 I heard evidence that while Standard Operating Procedures existed at the Edinburgh Health Centre, they were not accessible in a way that one would expect such important documents to be.[125]

172 Dr Naso was critical of the Standard Operating Procedures insofar as they were not easily accessible, not widely known, were difficult to understand and did not address the question of search for mental health patients.[126] I observe that many clinicians that work within the military health system are external to the military and much more like Dr Naso. Where Dr Naso described the documents as difficult to understand, I consider this representative of how many of the clinicians that were expected to use them would find them. Dr Naso was also critical of the over reliance on the level of risk assessment in determining how to deal with a patient, which is not an approach that is adopted in the industry generally, nor in the military health system.

173 I will not make any recommendations about the general confusing state of the policies because there are no specific items that I can usefully draw out for improvement. I would

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[121] T440, T448 and T452
[122] T448
[123] T466 and T561
[124] Exhibit C25 at 16
[125] For example, T364
[126] T647-T648

instead encourage the Joint Health Command to review the policies with a view to simplifying them. This is no doubt a large task and one that requires considerable skill to keep complex policies clear, however the benefits of doing so are immense.

Preventability

174 In line with my assessment of the evidence, in particular in light of Dr Naso's evidence, there were a number of occasions where Leading Aircraftman Sargeant's death could have been prevented. The two most obvious were:

a. the opportunity to search him and remove his keys at the health centre when powers under the *Mental Health Act* were exercised, and

b. having a picket remain with him constantly at the health centre.

175 In line with Dr Naso's opinion,[127] I find that had either or both of those things occurred, Leading Aircraftman Sargeant's death would have been prevented.

Recommendations

176 Under s 25 of the *Coroners Act 2003* (SA), I am required to consider whether there are any recommendations that should be made that might prevent a recurrence of the same or similar circumstances that led to Leading Aircraftman Sargeant's death, or that might contribute to an improvement in public health and safety. An obligation to respond to my recommendations exists in State law. There is therefore no obligation on a Commonwealth agency, such as the Department of Defence, to respond to my recommendations.

177 However, there is, at this time, no Commonwealth Coroner. It is necessary therefore for Commonwealth agencies to participate fully in the coronial processes of the States and Territories in order to realise the benefits of a robust safeguarding mechanism as important as the Coroners Court, which is only enlivened upon loss of life. I was pleased to receive a level of engagement during the Inquest that meets that description.

178 It is my sincere hope that the Department of Defence continue this engagement and take my recommendations with the genuineness they are intended. I encourage the Department of Defence to consider and action the recommendations, where appropriate, and to otherwise explain why they are not appropriate. I would encourage the Department of Defence to provide a report to the South Australian Attorney-General to allow our Honourable Parliament to be informed about the improvements made in response to the death of Leading Aircraftman Sargeant, a resident of South Australia, in order to protect the lives of other South Australian soldiers.

179 I now turn my attention to a number of topics that arose in the course of the Inquest that require consideration.

Unit Welfare Board

180 In light of the evidence I heard about the UWB meetings, in particular the potential for intimidation that UWB meetings have, and likely had on Leading Aircraftman Sargeant,

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[127] T658

I make the following recommendations to the Chief of Joint Capabilities of the Australian Defence Force:

One That the Australian Defence Force review and set guidelines for the physical layout of the Unit Welfare Board meetings so that they are conducted in a manner which minimises the intimidatory effect that those meetings may potentially have, including allowing a support person of the member's choosing to sit near them.

Two That the Australian Defence Force review and develop a standard set of documentation to be distributed to members presenting to the Unit Welfare Board meetings to ensure that it is made abundantly clear that the focus of the meeting is on assisting the member to progress through their recovery, and that it is not aimed at criticising them. This should ideally be accompanied by a face-to-face meeting.

Three That commanding officers receive training on the purpose of the meetings, and how they might approach them in a more appropriate way.

181 I observe that it would be helpful for these recommendations to be implemented with advice from a psychologist to ensure they achieve a best practice approach to dealing with injured members.

Incorporation of military members into State law

182 Special Counsel Assisting suggested a recommendation that s 57 of the *Mental Health Act 2009* (SA) be amended to authorise Military Police to conduct a search of a person who they consider, without medical training, to be in need of mental health assessment.

183 The approach of the Military Police who engaged with Leading Aircraftman Sargeant on 9 September 2020 was caring and considered, with an eye appropriately on their own safety. Their knowledge of South Australian mental health processes was extremely limited, but that is of course in the context of them having no direct power under South Australian legislation. The clearest example of this was the evidence of Corporal Gwinnett that he would have called his superior for advice even if a doctor asked him to assist with a search under the *Mental Health Act*.[128]

184 As I have set out above, under s 57 of the *Mental Health Act 2009*, South Australian police officers have power to detain and search a person they believe has a mental illness and requires medical assessment. They are specifically not required to exercise any medical training in making their evaluation. This provision has obvious utility in dealing with someone who is suicidal, and there can be no genuine doubt that it is a helpful tool in the arsenal of police tools in protecting the safety of the public.

185 What amounts to a 'police officer' for the purposes of s 57 is not defined in s 57, but is defined in the *Legislation Interpretation Act 2021* (SA) as a member of the South Australia Police. For that reason, it would be unwise for Military Police to exercise these powers as they currently stand.

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[128] T324

186 After hearing the evidence, I consider that the power to search a person at risk of suicide, and to transport them for medical assessment, is a suitable power for members of Military Police. Dr Naso agreed with this,[129] as did Corporal Metcafe,[130] Sergeant Licul,[131] and Corporal Gwinnett.[132]

187 I received evidence that there are very few searches conducted in the military health system.[133] While that is attractive evidence on its face, it is very difficult in light of the overall evidence I heard to be confident that this is not the product of a lack of awareness of search powers and a lack of training on when they ought to be exercised by clinicians, together with the concepts that Dr De Savi spoke of, including the comfort one feels about patient safety while inside a military facility. Given the contents of the report of the Royal Commission into Defence and Veteran Suicide, I am not prepared to place any weight on the suggestion that acute mental health crises are rare in the military and that that should govern what appropriate recommendations may be.

188 Ms Robertson-Clark on behalf of the Department of Defence raised a number of concerns about a recommendation of this nature. She raised a fundamental concern that dealing with military members in a mental health crisis is a health issue, not a police issue and that members may consider themselves as being in trouble if police are involved. Of course, in Leading Aircraftman Sargeant's case, he presented to police inadvertently while looking for an old acquaintance. He did not specifically seek out the assistance of police. He was even cautioned at one point, but that was able to be managed. Contrary to the submissions made, I observe that it is often police who are called when there is a mental health crisis. In fact, this is what Ms Robertson-Clark suggested was appropriate here, however she proposed that it was only appropriate to call State police rather than Military Police. Dr Duncan gave evidence about risks involved in searching and assessments being made about weight and height in order to determine safety. Those are valid concerns. They further highlight the potential appropriateness of police involvement, depending on the situation. I also observe that Military Police, at least at Edinburgh, are stationed in very close proximity to the health centre, another reason why they are likely to be among first responders to some mental health patient crises.

189 Ms Robertson-Clark suggested that health clinicians should be left to conduct any necessary searches. I am concerned that such an approach is insufficient, given that it brought about circumstances in Leading Aircraftman Sargeant's case where clinicians did not even think of searching him. I am concerned about the circumstances described by Dr Duncan where a clinician may not feel comfortable and confident in searching due to the physical attributes of a military member. It may also assist to have a member of the military searching another member of the military rather than a civilian doctor searching a member. I am also concerned that health clinicians may prefer the use of a third party, such as Military Police, in order to preserve their fundamentally important clinical relationship in these situations.

190 Another concern that Ms Robertson-Clark raised was that a specific power in South Australia would result in a regime which differs across the country. She identified the

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[129] T642
[130] T243
[131] T292
[132] T332
[133] Exhibit C44 at [36]-[38]

potential for confusion about what can be done in South Australia by members who move around jurisdictions as directed. She did not address the extent to which that could be mitigated by training and, in any event, a safer situation in South Australia should not yield to a poorer situation in other States and Territories. I am certain that there will be many nuances for staff crossing jurisdictions and that this can be managed by an agency as well organised as the Department of Defence.

191 The other concern that Ms Robertson-Clark raised was a Constitutional point. She indicated that because the Australian Defence Force is governed in the Commonwealth regime, there may be legality issues with State legislation empowering a Commonwealth official. Counsel Assisting had raised this point and had suggested that the High Court had published a judgment that indicated circumstances where the State can legislate in the same area as the Commonwealth where the State removes no privilege of the Commonwealth and imposes no disability on it.[134] Ms Robertson-Clark said that where the State attempts to supervise Commonwealth officials, the State's law would be invalid. In my view, providing an authorisation for a Commonwealth official to do a certain act is unlikely to involve any supervision over them. There was also some discussion about the appropriateness of amending the *Defence Force Discipline Act 1982* which governs Military Police officers.

192 In any event, I am satisfied that members of the Military Police are likely to be involved in circumstances similar to Leading Aircraftman Sargeant's presentation in the future. I am satisfied that safety must come first. I am satisfied that it is appropriate for members of Military Police officers to hold a power to search and detain a member of the public who they consider, without medical training, may need medical assistance.

193 In respect of the practical achievement of that recommendation, I have considered whether to make the recommendation proposed by Counsel, or to make a more general recommendation for the issue to be carefully considered. In the end, I consider that it is not appropriate to specify a mechanism where there is a risk of invalidity and/or confusion and that it is not appropriate to address a recommendation to a state agency to try to deal with what is squarely a Commonwealth issue. Instead, I make the following recommendation to the Commonwealth Minister for Health and Ageing:

> *Four* That the Minister introduce a power, applicable across the country, for members of the Military Police and Australian Federal Police to detain and search a person they consider (without being required to apply any medical training) may be suffering from a mental illness and may need assessment by a health professional.

194 Framed in this way, a new law would empower Commonwealth officers in the same manner as members of South Australia Police are empowered under s 57. The use of these powers is not mandated, it simply provides a tool in the arsenal of tools available to these police in dealing with people who are at serious risk of harm. Where appropriate, they will continue to call State police, however they will be empowered to act immediately while that response arrives.

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[134] *Re Residential Tenancies Tribunal (NSW); Ex parte Defence Housing Authority* (1997) 190 CLR 410

195 The Australian Defence Force would need to implement training once the power is widened. To deal with the risk in the meantime, I make the following recommendation to the Chief of Joint Capabilities of the Australian Defence Force:

Five That members of the Military Police be trained to seek consent for voluntary searches of members who are suicidal or suspected of being in acute mental health crisis. This training should be conducted on advice from, or involving, mental health clinicians who conduct these types of voluntary searches every day, in a caring way.

Training on dealing with acute mental health crises

196 I make the following recommendations to the Chief of Joint Capabilities of the Australian Defence Force:

Six That specific training be delivered at all Defence health facilities on the topic of local mental health legislation and, in particular, powers that can be exercised to deal with members presenting in mental health crises.

Seven That knowledge of local mental health procedures be included as a 'required skillset' for mental health practitioners supplied for use in Defence health facilities by external providers. What this involves is by no means onerous, achieved in as little as two hours online.

197 I do not view the existence of different regimes across the country as a barrier to such training, although I accept it makes it a more complex task. It simply cannot be that this training is unachievable. That is especially so when the benefit trying to be realised is achieved. If the Australian Defence Force considers themselves unable to train staff who provide health services within their network of facilities on powers they have across six States and two Territories, then this should be outsourced to local clinicians to provide. I observe that training packages are provided by the South Australian Chief Psychiatrist and I would expect similar services to be offered around the country.

Management of patients in acute mental health crises in health facilities

198 Given the confusion about the way Leading Aircraftman Sargeant should have been dealt with, I consider that an additional safeguard would be appropriate. I therefore recommend to the Chief of Joint Capabilities of the Australian Defence Force:

Eight That all significant military health facilities such as the Edinburgh Health Centre be fitted with a secure treatment space, free of ligature points and with full visibility to safely house mental health patients waiting for transport to definitive care.

Nine That consideration be given to a formal policy allowing transport to hospital by military members or civilians where transport by ambulance is likely to be delayed.

199 I also recommend to the Chief of Joint Capabilities of the Australian Defence Force:

Ten That a policy be developed that a person in a mental health crisis is to be chaperoned by a person nominated to carry out the task until relieved by another person to carry out the task.

200 If there was such a policy on 9 September 2020, either Warrant Officer Rhodes or the members of the Military Police would not have left and Leading Aircraftman Sargeant would have found it difficult to abscond.

Encouragement of chaplains in the health system

201 As I have described earlier, Chaplain Boyle gave evidence that he felt unwelcomed at the health centre.[135] Dr Naso explained the great benefit that can be realised with the use of pastoral care for those dealing with mental health issues in a sterile facility.[136] Their role is different than a usual hospital chaplain who has less involvement in patients' lives. For that reason, I make the following recommendation to the Joint Health Command:

Eleven That the Joint Health Command train all staff who work in its facilities on the usefulness of chaplains in the health care setting and that they should be made to feel welcome. After initial training, ongoing training could be as straightforward as an induction process where a chaplain attends and speaks to new nurses and doctors.

Condolences

202 Leading Aircraftman Sargeant was a valued and loyal member of the Royal Australian Air Force. He had served his country overseas, putting his own life at risk for the benefit of all Australians. He excelled in his role, demonstrating a natural ability and passion in his field. He did this against a background of childhood trauma which he struggled to overcome.

203 I received a number of impact statements from family members and family friends following the death of Leading Aircraftman Sargeant. It is clear that Leading Aircraftman Sargeant's death has had an impact on his family. He is described as someone who always had time for everyone and would always try to help in any way he could. He longed to reconnect with his distant family, and it is especially unfortunate that he never had the opportunity to realise that deep desire.

204 I convey my condolences to Leading Aircraftman Sargeant's family and to the colleagues who supported him throughout his time in the Air Force.

Acknowledgements

205 I wish to acknowledge the valuable assistance of all counsel in this matter.

Keywords: *Australian Defence Force; Suicide; Mental Health*

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