CORONERS COURT OF SOUTH AUSTRALIA

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INQUEST INTO THE DEATH OF BENJAMIN EDWARD WARREN

[2026] SACC 44

Inquest Findings of her Honour State Coroner Kereru

1 October 2026

CORONIAL INQUEST

Examination of the cause and circumstances of the death of a member of police who took his own life after experiencing mental health issues following exposure to traumatic events at work. The Inquest explored the assistance given to him by his employer and whether there are systemic issues with the engagement by members of police with support services.

Held:

1. Benjamin Edward Warren, aged 35 years of Andrews Farm, died at Taperoo on 27 February 2022 as a result of a gunshot wound to the head.

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

Recommendations made.

Counsel Assisting: MS R SCHELL

Family: MRS R WARREN
Counsel: MR C KUMMEROW - Solicitor: TINDALL GASK BENTLEY LAWYERS

Interested Party: COMMISSIONER OF POLICE
Counsel: MS S WILSON - Solicitor: CROWN SOLICITOR

Witness: INSP W HUMPHRIS, MR S GRIGGS, C/INSP L STUBING & DR J COOPER
Counsel: MS S WILSON - Solicitor: CROWN SOLICITOR

Hearing Date/s: 14/10/2025-22/10/2025 & 03/12/2025

Inquest No: 27/2025 **File No/s: 0478/2022**

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

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INQUEST INTO THE DEATH OF BENJAMIN EDWARD WARREN [2026] SACC 44

Introduction

1 Benjamin Warren was a member of South Australia Police (SAPOL) from 2011 until his death. He loved the idea of serving the community, representing police and doing the right thing.[1] He was recognised as a hardworking member of police.

2 He had various postings throughout his career and was tasked to numerous potentially traumatic fatal incidents, including several fatal motor vehicle collisions. At the time of his death, he held the rank of Senior Constable First Class and was stationed in the Driver Training Unit at the SAPOL Academy.

3 Mr Warren died on 27 February 2022 following a single self-inflicted gunshot wound to the head. He had kept the depths of his mental health struggle largely to himself.

4 An Inquest was held to explore the cause and circumstances of his death and, in particular, whether there were indicators of the significant mental health struggle that he was dealing with and whether anything could have been done to prevent his death.

Family

5 Mr Warren had a loving and supportive family. He was raised in Adelaide, South Australia with his parents and older sister, Rebecca. Mr Kym Warren provided an affidavit to the Court which detailed Mr Warren's intelligence, strategic thought processes and his ability to think ahead in difficult situations. Mr Warren was someone his father identified as hating to show signs of weakness. Notwithstanding his hard exterior, his father recalled that he was as 'soft as a marshmallow' on the inside.[2]

6 Mr Warren met his wife, Rebecca, in 2004 when they were both working casual jobs at a shopping centre in West Lakes. They married in 2011 and had two children together. Mr Warren separated from his wife and moved out of the family home in February 2022 in the midst of the issues explored during the Inquest. However, the couple remained married and were committed to co-parenting their children. Mrs Warren provided an affidavit to the Court and was represented by Counsel at the Inquest. I also received helpful written closing submissions on her behalf.

7 I acknowledge the presence of Mr Warren's parents and wife during the Inquest and thank them for their contribution.

Content of these findings

8 In determining what factual findings to make, I have proceeded on the basis of an assessment of the evidence and what is clear on the balance of probabilities. Where I express a fact, I do so on the basis that, after consideration of the whole of the evidence, I am satisfied that that fact has been established as more likely than not.

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1 T300
2 Exhibit C4

9 I warn myself concerning a vital consideration in the assessment of the evidence and any potential criticisms of witnesses in this Inquest, namely, hindsight bias.

10 A description of 'hindsight bias' is given in the Australasian Coroners 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.

11 To assess the actions of those involved with the benefit of knowledge of the outcome would be unfair. I am very mindful of this warning when considering the evidence in this Inquest and I will assess the actions of those involved on the basis of the information and risks that presented to them at the time.

12 I do not propose to recount all the evidence I heard in this Inquest in these findings. I will focus on explaining the evidence I heard in order to determine the issues I am required to resolve, and to achieve the legislative purpose; to ascertain the cause and circumstances of the death.

13 At the time of giving evidence, a number of witnesses had either changed their ranks within SAPOL or no longer worked for SAPOL. In order to assist with the clarity of my summary of the events that led to Mr Warren's death, I will refer to these witnesses using the rank that they held at the time of the relevant events. In doing so, I mean no disrespect to any of the witnesses.

Witnesses

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

- Brevet Sergeant Julian Oliver Blackwell – South Australia Police officer, General Duties member formerly stationed at Whyalla and Roxby Downs.
- Inspector William James Humphris – Officer in Charge, District Support Section, Police Security Services Branch, South Australia Police; formerly Sergeant and General Duties Supervisor at Whyalla Police Station.
- Sergeant Matthew David Keenan – Former South Australia Police officer and former supervisor of Mr Warren in Northern District.
- Senior Sergeant Stephen John Griggs (retired) – Former Officer in Charge, Roxby Downs Police Station.
- Senior Constable First Class Matthew David Hale – South Australia Police officer and former colleague of Mr Warren.
- Dr Jane Louise Cooper – Clinical Psychologist and former SAPOL psychologist with the Employee Assistance Section (EAS).
- Helen Margaret Reed – Retired Social Worker, Employee Assistance Section (EAS), South Australia Police.

- Chief Inspector Lucas Rawdyn Stubing – Functional Lead, People and Wellbeing, South Australia Police; formerly Manager, Employee Assistance Section.
- Mr Simon Justin Brown-Greaves – Consultant Psychologist and expert witness in organisational psychology.
- Chief Inspector Astrid Gustavson – South Australia Police officer; Acting Officer in Charge, Northern District during the relevant period.

Mr Simon Brown-Greaves

15 Mr Brown-Greaves has been a registered psychologist since 1982 and has held specialist endorsement as an Organisational Psychologist for more than 10 years. He is also a registered and accredited supervisor for AHPRA purposes. He holds a Bachelor of Science (Honours) in Psychology, a Master of Science in Clinical Psychology, and a Postgraduate Diploma in Criminology, all obtained from the University of Melbourne. Throughout his career, Mr Brown-Greaves has held a number of senior leadership and practitioner roles, including Senior Psychologist with the Victorian Office of Corrections from 1982 to 1985, Manager of the Victoria Police Psychology Unit from 1985 to 1990, Chief Executive Officer of Occupational Services Australia from 1997 to 2004, and Chief Executive Officer and Director of FBG Consulting Pty Ltd from 2004 to 2022.

16 Mr Brown-Greaves is currently the Chief Mental Health Officer for Australia Post and provides advice to a range of organisations on mental health strategy and risk management, including the Victorian Independent Broad-based Anti-corruption Commission (IBAC), the Independent Commission Against Corruption (NSW), and Youth Justice Victoria. He has also held teaching appointments in Criminal Justice and Forensic Psychology at both the University of Melbourne and RMIT University. In recent years, he has served as a member of the Mental Health Committees of the Coroners Court of Victoria and the Magistrates' Court of Victoria.

Hazard and Incident Reporting System

17 The Hazard and Incident Reporting System (HIRS) is an electronic system within SAPOL that provides for, among other things, the recording of exposure to distressing or traumatic events which might cause psychological injury.[3]

18 I heard that, within SAPOL, a HIRS report is now routinely lodged for any exposure to a traumatic incident.[4] Each report is also commonly referred to as a HIRS.

19 The form was originally designed to deal with the reporting of physical hazards. I heard evidence that it was not ideally structured to deal with psychological issues, but that it was the only mechanism available for formally reporting psychological injury in 2015.[5] The oral evidence established that the use of HIRS to report issues has increased over time.[6]

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3 See, for example, Exhibit C21 at 30-39 (35 and 36 provide for Psychological Details for an incident)
4 T136
5 T140 and T194
6 T378

EAS and EAP

20 There is an important distinction between the Employee Assistance Section (EAS) and the Employee Assistance Program (EAP), particularly in the context of issues explored in this Inquest.

21 The Employee Assistance Section (EAS) sits within the Health Safety and Welfare Branch of SAPOL.[7] The section comprises psychologists and social workers and other allied health professionals.[8]

22 Unlike the EAS which is within a branch of SAPOL and is staffed by employees of SAPOL, the EAP is independent of SAPOL. It provides counselling services to members who are referred to it and the allied health professionals who provide this service are not employed by SAPOL. It is available to members of SAPOL for a specific number of sessions.[9] The sessions are paid by SAPOL.

23 Focusing on the EAS (to which Mr Warren was referred on a number of occasions) the service is provided to monitor and maintain the physical and psychosocial wellbeing of all SAPOL employees. Chief Inspector Stubing, who managed the section in 2022, explained:

> The Employee Assistance Section provides a range of people-related functions for the organisation. In the wellbeing space, there is an in-house psychosocial team, which consists of social workers and psychologists. And within the psychosocial team, they provide a service to all SAPOL employees, to provide a point of contact, to provide brief intervention counselling, wellbeing reviews, annual reviews, and a range of other services including psychoeducation, critical incident response, and a broader range of services to respond to issues that impact the workforce. Separately to that we have a medical team, which consists of nurses and two police medical officers, and the medical team equally look after - they have a responsibility for wellbeing as well, across the organisation, but they also have a key role in the recruitment of new employees to SAPOL, and also managing and providing assistance to the police medical officer for work capacity assessments and other related issues in relation to potential impacts that employees are experiencing through their work.[10]

24 Chief Inspector Stubing gave evidence of a number of particular programs or initiatives run by the EAS. These included Critical Incident Response to members who are exposed to significant trauma during duties,[11] a metropolitan outreach program,[12] a regional outreach model[13] as well as the introduction of a Suicide Prevention Action Plan.[14] He said there were partnerships with various external providers to ensure access and support to members.[15] He said that education and support of recruits through their training is a

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7 Exhibit C32 at [1]
8 T354 and Exhibit C20ai
9 T188
10 T352-T353
11 T361
12 Exhibit C32a at [14]
13 Exhibit C32a at [16]
14 Exhibit C32a at [25] and Exhibit C37
15 Exhibit C32a at [29]

particular focus[16] as well as psychoeducation training[17] and health and wellbeing programs.[18]

25 I heard evidence that various changes within EAS are currently being implemented, including a new Standard Operating Procedure (SOP). The SOP will provide guidance around when EAS will provide a Critical Incident Response following a traumatic event, including the types of circumstances which will warrant that intervention.[19]

26 All HIRS are automatically provided to the EAS.[20] Upon a HIRS being uploaded by a person who nominates the member(s) involved, the document goes into each member's file on the CareRight system operated by EAS.[21]

27 One of the roles of EAS is to consider all incoming HIRS and to assess whether further support is needed for an individual or team and to contact the individuals involved to remind them of the services available, including the EAP.[22] These assessments of incoming HIRS are conducted by allied health professionals.[23] Someone within EAS speaks to the member(s) the subject of the HIRS about their experience and talks about the normal responses to trauma. The member is encouraged to seek help if their symptoms do not resolve. If the member raises any concerns during this initial contact, EAS follows up with the member at a later stage.[24] If a member is deemed to require additional support or treatment, the member would be referred elsewhere, either to a GP or an external healthcare provider.[25] If the member indicates that he or she does not want support, the clinician would still check the member's history and review recent exposure to trauma to make a decision as to whether further contact is required, despite the member having declined assistance.[26]

28 I heard that EAS also conducts a process similar to a multidisciplinary team meeting familiar in the medical setting. This is a forum that takes place fortnightly where EAS staff are required to provide a synopsis on complex clients.[27] Chief Inspector Stubing was not aware whether this existed in 2022, noting that he is not a clinician.[28]

29 Evidence was heard during the Inquest that EAS often encounter members who are reluctant to engage with the service, notwithstanding that they present with a potential need for mental health intervention. There were a number of reasons raised as to why this reluctance existed, but at its core, the issue appeared to be the internal nature of the service as well as the requirements imposed on EAS staff to disclose certain information.

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16 Exhibit C32 at [8]
17 T370-T374
18 For example, Reconditioning Program, My Health My Wellbeing Internet Site, Be Well Program: Exhibit C32 at [8h]
19 T363
20 T141
21 T551
22 Exhibit C34 at [6]
23 Exhibit C32a at [9]
24 T476
25 Exhibit C34 at [7]
26 T381
27 T355
28 T355

30 The obligations of internal and external mental health providers are materially different insofar as confidentiality is concerned, with external providers generally only required to disclose information where there is a risk of self-harm or harm to others.[29]

31 The social workers and psychologists within the EAS are bound by the usual laws relating to confidentiality, which include the obligation to disclose if there is a risk of harm to self or another. However, members who engage with EAS sign a consent form acknowledging limits to confidentiality prior to any discussion.[30]

32 Unlike the external providers, the EAS has additional obligations of compliance with General Orders, employment agreements, and policies. There is therefore a greater range of circumstances in which confidentiality is not retained,[31] although I accept that informed consent is required for EAS clinicians to comply with a General Order that undermines patient confidentiality. As I have observed, members are routinely asked to sign consent forms. The EAP is not subject to the General Orders.[32]

33 If there was a risk identified by the EAS, restrictions could be placed on an officer's ability to carry out certain duties. I heard evidence during the Inquest that there was a perception that this in turn could impede advancement and career opportunities. Dr Cooper agreed that the existence and obligations under the General Order might cause members to present a more guarded approach when it comes to interactions with EAS.[33]

34 This issue became a focus for the Inquest as Mr Warren was noted to comment on more than one occasion to different people that disclosing any vulnerabilities to EAS was 'career suicide' or words to that effect.[34]

35 The other issue relating to EAS was the role and prescribed function of EAS. I was surprised to hear during the oral evidence that while the allied health professionals employed within EAS were tasked with the role of assessing the member for mental health symptoms, if they were detected, there was no ongoing counselling or therapy available from within. A referral would be necessary to an external service like EAP.

36 Chief Inspector Stubing was very clear that the EAS do not provide a counselling service.[35] He said:

> We often use the narrative that 'We don't provide treatment', although that's not entirely true. We do provide brief intervention counselling, and then we also provide ongoing support for people that we are struggling to connect with support or treatment within the community. But yes, … the treatment that we provide is very brief - brief intervention counselling - and then our objective is to, if it's required, refer that employee into the community for treatment and professional mental health intervention, if it's required.[36]

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29 T667
30 T478
31 T668
32 T544
33 T544
34 T160, T206, T331
35 Exhibit C34 at [4]
36 T354

37 SAPOL's General Order 8540, 'Psychological Health Management', lists the provision of counselling as a role of the EAS.[37] However Dr Jane Cooper, a police psychologist at the time of Mr Warren's death, gave evidence clarifying that this is taken as a reference to brief intervention in the form of basic strategies after being referred to an external professional for treatment.[38] Chief Inspector Stubing agreed and said that this interim counselling is unlikely to span more than one session.[39]

38 The main role of EAS practitioners is therefore to provide mental health support by conducting assessments and referrals to third parties, including the EAP. There is no ongoing allied health support if a mental health condition is identified.

39 If the EAS is a gatekeeper to external services (as it was before Mr Warren's death), and members are reluctant to speak openly about their mental health due to limitations on confidentiality, potential career ramifications and the limit of the service, the appropriate external supports cannot be identified. It logically follows that the more reluctant individual will not engage adequately and therefore not receive the assistance that they require.

40 Dr Brown-Greaves opined that there is a tension between the role and prescribed function of EAS and the ability to establish trust in a mental health setting. He gave the following evidence:

> And indeed, by the way, every bit of evidence tells us that the likelihood of opening up is based on relationship with the potential therapist. So rapport and relationship is critical. And this is the really sad part, as many parts of Mr Warren's death is terribly sad, one of them is that the role and the prescribed function of an internal EAS person meant that that, you know, was not going to happen. And this goes to my earlier point about where should treatment be done and how does that, you know, happen in a practical way? I am seeing more broadly, by the way, in police forces not just in Australia, more broadly, that that role of the treatment side of looking after mental health of officers is outsourced, is taken outside the organisation, and what is retained internally is essentially risk management but also the preparation, the training, you know, the pre-mental-health-condition readiness tends to be managed internally. So that is certainly, you know, the treatment that I am seeing. So Dr Cooper's description of that role conflict was, you know, unfortunate, is the common reality in such circumstances.[40]

41 I will return to this issue later in the finding.

Mr Warren's policing career

Whyalla Police Station – 2013 to 2015

42 In 2013, the Whyalla Police Station had approximately five teams and at least 50 members of police stationed there.[41] All members were assigned general duties.[42] All teams worked

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37 Exhibit C35 at 8
38 T542
39 T354
40 T667
41 T51
42 T52

on a five-week rotating roster. Mr Warren held the rank of Constable when he commenced in Whyalla in 2013.[43]

43 During the period 2013 to 2015, Whyalla was an extremely busy town with a high volume of taskings each shift.[44] Members routinely attended taskings which were variously related to domestic violence, mental health issues, illicit drugs, break-ins and road fatalities, among other taskings.[45] In circumstances involving a fatality, the general duties members were first on scene.[46]

44 Inspector William Humphris was, at the time, promoted to Sergeant and posted to the Whyalla Police Station, commencing on 15 January 2015. He was responsible for supervising Mr Warren as the Sergeant for his team. As I have said, with no disrespect intended, I will refer to him in this narrative as Sergeant Humphris.

45 Sergeant Humphris described the Whyalla Police Station as a 'busy posting' with a 'young workforce' during his time there.[47] Mr Warren was initially abrupt with Sergeant Humphris but the two became friends over time.[48] He observed Mr Warren to be an exceptionally hard worker who would often stay back after-hours, even where there was not an operational need to do so.[49]

46 With a small team and many taskings per day, each team would be assigned to a tasking and back-up assistance would not necessarily be available.[50] Senior Constable Matthew Hale said that resources would sometimes be stretched 'quite thin' in that it would not be unusual for a night shift to have just a Sergeant, one person on the road and another covering the station.[51]

47 During busy periods it was normal for each team to be recalled to duty once a fortnight or otherwise be often asked to work overtime.[52] This included circumstances when an investigation was underway and the team would be required to stay until the job was finished. This was part of policing in Whyalla. Senior Constable Hale recalled that members of his team would be held on for additional hours in most weeks.[53] Most of the time there were things that needed to be undertaken before completion of the shift and he highlighted that Mr Warren would always make sure that everything was done thoroughly.[54]

48 Brevet Sergeant Julian Blackwell worked with Mr Warren from early 2013 at the Whyalla Police Station. The two became close as they worked in the same team and also spent

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43 Exhibit C21 at 1
44 T56
45 T52 and T57
46 T53
47 T193
48 T146 and Exhibit C30 at [4]
49 Exhibit C30 at [4] and T146
50 T55
51 T295
52 T94
53 T294
54 T292

time together socially.[55] Brevet Sergeant Blackwell said that while Mr Warren was initially guarded,[56] he opened up as the two became friends.

49 Brevet Sergeant Blackwell observed that the frequency with which Mr Warren would spend time beyond his shift increased from around 2014 until the end of his time in Whyalla.[57] This progressed to the point that he sometimes needed to be sent home by the oncoming Sergeant.[58]

50 When Senior Constable Hale was posted to Whyalla in early 2014, he was often partnered with Mr Warren. He immediately observed Mr Warren to be an instinctive member of police with an incredibly strong sense of justice and a strong work ethic. He said that Mr Warren had an ability to 'find crime'.[59]

51 Senior Sergeant Stewart Green, Mr Warren's supervisor in 2014, also observed him to be a very conscientious and hardworking member of the team. He said that, at times, Mr Warren had difficulty letting go of things he was passionate about.[60] He observed that when given a task or someone to investigate, Mr Warren would not let it go until it was finished.[61] Sergeant Humphris also told the Court that Mr Warren would not let things go easily and would frequently stay back to do work when it was not operationally imperative for him to do so.[62] On several occasions, Sergeant Humphris told Mr Warren to 'pack up' in a friendly manner. Sergeant Humphris said he had to make this request of Mr Warren repeatedly and would have to ascertain exactly what he was working on.[63] While Sergeant Humphris described needing to do this on a semi-regular basis, it was not a cause for significant concern for Sergeant Humphris other than that he thought it was important for members to spend time with family or other pursuits and have separation from the role.[64]

52 Brevet Sergeant Blackwell observed Mr Warren's demeanour to change over his time at Whyalla. He became less jovial. He had an unhealthy obsession with specific jobs and an increased relentlessness to his approach.[65] If people got away, Mr Warren was said to become more frustrated and would speak of it more often.[66]

53 Brevet Sergeant Blackwell described his time at the Whyalla Police Station as 'extremely taxing' and that the team attended to 'extremely emotional and challenging jobs on a daily basis'.[67] Senior Constable Hale described Whyalla as a 'difficult' posting, with a high amount of work and exposure to different jobs.[68] I was grateful for the candid evidence I heard about the work at this posting at that time. It has greatly assisted me to understand the course of events that followed.

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55 T43 and Exhibit C29 at [5]-[9] and [11]
56 Exhibit C29 at [3]
57 T47-T49
58 T49
59 T291
60 Exhibit C15 at [21] and [22]
61 T45
62 T146
63 T147 and T174
64 T174
65 Exhibit C29 at [35]
66 T72
67 Exhibit C29 at [30]
68 T293

54 Due to unfortunate timing or simply bad luck, Mr Warren and his team in Whyalla were exposed to a higher-than-normal amount of road fatalities.[69] This included a double fatality at Cowell, a triple fatality north of Whyalla, a single fatality at the Whyalla Speedway and another single fatality at the Whyalla Auto Wreckers.[70]

55 Given the resourcing at the time, in circumstances involving a motor vehicle collision, the first on scene general duties member would deal with the accident itself, any death or related injuries, and the traffic requirements in closing off the road or highway.[71] That is, members attending were not only confronted with the traumatic nature of the scene, but also with a great burden of responsibility to manage everything happening. Members would formally debrief after difficult jobs and also do their best to be around each other and talk about the jobs informally during this time.[72]

The Knowles incident – 29 December 2014

56 On 28 December 2014, Mr Warren attended at a domestic violence tasking in relation to a person called Michael Knowles. His estranged partner had expressed concerns to police that Knowles had left home in an intoxicated state and had made threats to harm himself. Senior Sergeant Green and Mr Warren were the only two members available at the time and Mr Warren was tasked to make enquiries to locate Mr Knowles.[73]

57 Mr Warren was making enquiries when he received information from police communications that a serious motor vehicle collision had occurred on the Lincoln Highway at Middleback Range, approximately 30 kilometres west of Whyalla. Mr Warren was the first on scene, arriving at 12:39 am on 29 December 2014.[74]

58 Mr Warren observed two deceased people within a vehicle at the scene and another two injured. He located and identified Mr Knowles next to his vehicle.[75] The collision had been head-on and was later determined to have been deliberate.

59 Senior Sergeant Green arrived at the scene at 12:54 am. He described the scene as horrific. He said that it was clear that Mr Warren was shaken by the circumstances of the scene as he had a heightened level of anxiousness in his voice while he was relaying important information.[76]

60 Senior Sergeant Green and Whyalla Operations Manager, Senior Sergeant Peter Murray, were concerned for Mr Warren's welfare and also other junior members who were on scene given the 'graphic nature' of the crash scene. They determined to engage the EAS by lodging a HIRS.[77] The HIRS identified Mr Warren as one of the witnesses on scene and further noted that it was an 'horrific scene with serious trauma'. The HIRS was submitted with a request for an EAS psychological debrief to be conducted.[78]

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69 T139
70 T60 and Exhibit C29 at [34]
71 T55
72 T124
73 Exhibit C15 at [6]-[8]
74 Exhibit C20o
75 Exhibit C20o
76 Exhibit C15 at [13]
77 Exhibit C15 at [16]
78 Exhibit C21 at 30 (38-39 contain the specific request for EAS involvement)

61 Over the following days, Senior Sergeant Green identified that Mr Warren appeared to have adopted a position where he felt personally responsible for the deaths of the two people involved due to not being able to locate Mr Knowles prior to the crash, a task he had been assigned and was working on. He further observed that Mr Warren would discuss the crash at every opportunity.[79]

62 Senior Sergeant Green gave evidence that it appeared the event had a strong impact on Mr Warren and so he encouraged him to speak with EAS. However, Mr Warren continually declined to do so.[80]

63 Major Crash Unit member Senior Sergeant David Kuchenmeister arrived on scene at 5:35 am that morning. Sergeant Kuchenmeister made a note of a conversation on 29 December 2014 between himself and a member of EAS. The notation reads 'blamming (*sic*) himself the 1st General duties' and 'Ben Warren' with an arrow pointed to the words 'If I had found the car'.[81] I find that this conversation was in relation to Mr Warren's concern that he did not find Mr Knowles before the collision.

64 Brevet Sergeant Blackwell was also aware that Mr Warren took the deaths of the victims personally and blamed himself for not finding Mr Knowles. He told the Court that he spoke to Mr Warren about the event on more than one occasion over a period of weeks after the incident, and that the two spent hours discussing it in the car, in the gym and over drinks. Mr Warren would instigate conversation about not being able to catch Mr Knowles before the collision and was frustrated at his attempts. To Brevet Sergeant Blackwell, it was apparent that the event had a huge impact on Mr Warren, which concerned him. Ultimately, Brevet Sergeant Blackwell told the Court that every member of police has a job that sticks with them, and he believed this was Mr Warren's.[82]

65 Brevet Sergeant Blackwell observed this job to be a turning point for Mr Warren and said that it was followed by an apparent decline in his mental wellbeing.[83] Following this event, Mr Warren appeared more uptight and sensitive and seemed to be on a mission to immerse himself into work, 'almost as though he was trying to make it right (that he didn't find the offender that night)'.[84]

66 As I will detail later, on the evening of his death some seven years later, Mr Warren uploaded a post onto Facebook in relation to the Knowles incident.[85] The post read 'I didn't find him and it has never left me. Michael Frank KNOWLES may you rot in hell'. The post attached a link to a news article in relation to the sentencing of Knowles.[86]

67 I heard evidence that there are a range of normal symptoms that might be experienced in the short-term following a traumatic event, so the idea of preoccupation or disappointment with the outcome would be relatively normal. Persistent symptoms of this nature after a passage of time, if unmanaged, may transition into PTSD.[87] In my view,

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79 Exhibit C15 at [187] and [18]
80 Exhibit C15 at [19]
81 Exhibit C21 at 27
82 T75-T76
83 Exhibit C29
84 Exhibit C29 at [43]
85 Exhibit C8
86 Exhibit C10 at [28]
87 T634

these symptoms did persist for Mr Warren and ultimately contributed to the PTSD that he developed.

68 Sergeant Humphris was briefed by Senior Sergeant Peter Murray on his arrival in mid-January 2015. This briefing included information about the team's recent involvement in a number of motor vehicle fatalities, and specifically the incident involving Michael Knowles.[88] Senior Sergeant Murray conveyed concerns to Sergeant Humphris, specifically about Mr Warren in relation to this incident, and suggested that he direct Mr Warren to attend a debriefing session for this incident due to his reluctance to engage in the process.[89]

69 Sergeant Humphris said that he understood Senior Sergeant Murray's concerns to be that Mr Warren maintained a stoic façade but that this was potentially masking turmoil and distress.[90] Sergeant Humphris told the Court that, looking back, he agrees with this assessment by Senior Sergeant Murray in relation to Mr Warren generally, namely that Mr Warren portrayed a tough and stoic demeanour but that he was more sensitive than he let on.[91]

Cowell double fatality – 24 January 2015

70 On 24 January 2015, Mr Warren was first on scene at another motor vehicle fatality, this time occurring on the Lincoln Highway at Cowell. There had been a collision between a car and a truck in which two people were killed. Sergeant Humphris submitted a HIRS for this event and identified in it that Mr Warren had been first on scene to a fatal vehicle collision in a similar area approximately one month prior; a reference to the Knowles incident. Sergeant Humphris said that he was concerned about repeated exposures to traumatic incidents.[92]

71 Subsequently, Senior Sergeant Murray engaged with EAS specifically in relation to Mr Warren noting that he had held concerns about him since the Knowles incident. This was done by way of email dated 24 January 2015 at 4:42 pm.[93] Senior Sergeant Murray identified that Mr Warren 'plays tough, and basically, he isn't' and would be likely to resist EAS involvement.[94]

Off-duty incident – 18 February 2015

72 On 18 February 2015, Mr Warren was off-duty during the day and was scheduled to commence on the afternoon shift. Mr Warren called the station seeking patrol assistance in relation to an incident involving a car that had cut him off at an intersection. At the time of the call to the station, Mr Warren said he was still actively following the car in his own personal car. Sergeant Humphris determined that it was not possible to send anyone nor would it have been logistically possible to catch up with the vehicle. He requested that Mr Warren come back to base and for inquiries to be made at a later stage. Instead, Mr Warren continued to follow the car and repeated his request for assistance. Sergeant Humphris called Mr Warren directly to ask him to return to base. While on that

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88 Exhibit C30 at [3] and T134
89 T135
90 T196
91 T197
92 Exhibit C21 at 40-48 and T136
93 Exhibit C21 at 49
94 Exhibit C21 at 49

phone call, Sergeant Humphris described Mr Warren as sounding 'quite heightened', and he was adamant that the vehicle was going to kill someone. Sergeant Humphris told the Court that there was emotion present in his voice and that it was elevated. Sergeant Humphris' assessment, based on the information he had been provided with by that stage, was that the incident involved a failure to give way, but that Mr Warren did believe that the car posed a significant risk to the public. Sergeant Humphris was concerned that Mr Warren was travelling away from Whyalla, he was in his own car, he had no access to police equipment and that Mr Warren had already made an attempt to stop the car by displaying his badge which was unsuccessful. Sergeant Humphris was concerned that Mr Warren was effectively engaging in a pursuit off duty which posed a risk to both Mr Warren and the public. He gave Mr Warren a formal direction to terminate the pursuit which appears to have been effective.[95]

73 Mr Warren was then asked to prepare a statement to enable Port Augusta police to follow up with the driver for any offences.[96] Mr Warren's affidavit was received into evidence at the Inquest.[97] In it, Mr Warren outlined that he had observed a van to pass through an intersection and rapidly turn right causing himself and another vehicle to brake severely to avoid collision. He said that the van posed a significant risk to other road users and identified that the Lincoln Highway had experienced many fatalities in past months due to driver inattention, among other causes. He presented his police identification to the driver's side mirror of the van, flashed his headlights to stop the vehicle and announced to the driver through an open window to pull the vehicle over. The driver was not compliant.

74 In my view, it is quite clear that Mr Warren's reaction to this incident was coloured by his recent experiences of fatalities. That is especially clear given that his affidavit dealt with the issue of risk to other road users by reference to fatalities on the Lincoln Highway.

75 The driver was ultimately located and issued an expiation notice on 14 May 2015.[98] No more serious offences were detected.

76 At the Whyalla Police Station on the afternoon of the incident, Mr Warren approached Sergeant Humphris to speak with him, emotionally charged. Sergeant Humphris observed Mr Warren to be red in the face and sweating. Mr Warren was upset and angry that a patrol was not sent to support him and was worried of the potential harm that the vehicle could have caused to the public.[99] The two moved the conversation to an interview room for privacy and, after some time, Mr Warren calmed down.

77 Sergeant Humphris said that he was concerned about Mr Warren in the context of the information he had received regarding his recent exposure to collisions.[100] Sergeant Humphris told the Court that he made a link between this incident and what he understood to be repeated exposure to serious vehicle collisions, including the Knowles incident. His concern was related to the heightened emotional reaction and Mr Warren's decision to attempt to intercept the vehicle while off-duty and away from support.[101]

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95 Exhibit C30 at [5]–[7] and T148-T151
96 T151
97 Exhibit C38
98 Exhibit C38b
99 Exhibit C30 at [9] and T151
100 Exhibit C30 at [10] and T154
101 T157

Essentially, he was concerned that Mr Warren may be exhibiting signs of post-traumatic stress.[102]

78 Sergeant Humphris contacted EAS and spoke with a welfare officer, Ms Helen Reed. He told her that Mr Warren had been to several serious fatal collisions and then provided information about the attempted interception of a vehicle in his own car while off-duty.[103] Sergeant Humphris told the Court that he described the incident in detail.[104] He told Ms Reed that he was worried that Mr Warren's decision-making had been impacted by his previous experiences to the extent that he may have placed himself at risk. Sergeant Humphris said that, at the time of contacting the EAS, he was concerned about post-traumatic stress symptoms impacting Mr Warren's decision-making at work but that he did not consider that he posed a risk to himself.[105]

79 Sergeant Humphris reviewed Ms Reed's notes of this conversation. He agreed that they were correct, but said that they did not record the true level of concern he was trying to impart and in that respect, were not sufficient.[106] Ms Reed said her standard practice was to make notes contemporaneously and to record what was important, but that her notes only reflect a *summary* of the conversation.[107] She said that it was her standard practice to listen seriously and write down the manager's concerns.[108] She said she would endeavour to understand the issues, not only from a mental health perspective but also in relation to SAPOL procedures.[109]

80 The notes were made contemporaneously by Ms Reed and when she gave evidence, she did not have any independent recollection of the conversation with Sergeant Humphris or the conversation she had with Mr Warren the following day.[110] It was not common at that time for members to contact EAS staff with concerns about mental health.

81 Sergeant Humphris told the Court that he had said his engagement of the EAS was conditional on him having the opportunity to forewarn Mr Warren of his concerns.[111] Sergeant Humphris did relay those concerns at the next shift. He told Mr Warren that he considered that his reaction was over the top and that he had potentially put himself at risk. He said that Mr Warren was dismissive[112] and then angry when he was told he had been referred to EAS.[113] While Sergeant Humphris was not able to recall the specifics of the conversation, he said the gist of it was that Mr Warren considered that a notification to EAS was 'career suicide', and that a suggestion of psychological weakness would be detrimental to his future career aspirations. Sergeant Humphris tried to reassure Mr Warren of the confidentiality of the service, but he did not think that Mr Warren believed him, with the two 'agreeing to disagree' on that issue.[114]

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[102] T154 and Exhibit C30 at [10]
[103] T159
[104] T180
[105] T159
[106] T203, the file note of the conversation to which Inspector Humphris considered is Exhibit C22 at 48
[107] T592 and T605
[108] T591
[109] T593
[110] T589
[111] T205
[112] Exhibit C30 at [12] and T159
[113] T160 and Exhibit C30 at [12]
[114] T160 and Exhibit C30 at [12]

82 When Ms Reed subsequently spoke to Mr Warren on 20 February 2015, she recorded her assessment of Mr Warren which indicated that he presented in a logical manner with an ability to explain his actions and thought processes. She further identified that he appeared to have a work/life balance and an ability to switch off.[115] She did not record any concerns and told the Court that if she did have concerns, she would have written it down and taken him through the various supports available, including the prospect of a face-to-face meeting.[116] In the event that Mr Warren had divulged information that he was struggling but did not want to engage further, she said she would have made further enquiries.[117]

83 Sergeant Humphris followed up with EAS by email to Ms Reed on 20 February 2015 at 3:15 pm. Ms Reed indicated that she had spoken to Mr Warren and had no concerns.[118] She said that, if there had been concerns, these would have been reported back to the member's supervisor in a limited capacity due to confidentiality.[119] Sergeant Humphris told the Court that he was sceptical of Ms Reed's response and he struggled to rationalise the observations he had made with the response he received.[120] However, he was mindful that the service was confidential and that only certain things could be disclosed to him.[121]

84 During her evidence, Ms Reed was told that Sergeant Humphris had been sceptical about her response. She said that if he was not satisfied, he could have picked up the phone and called to ask further questions. While the information that she could disclose would be limited, she could have reiterated her assessment and reassured him.[122] While Sergeant Humphris accepted that the response did not align with his observations, he did not consider he had an avenue to contest it unless there was a further incident. Ultimately, Sergeant Humphris considered that he needed to trust the expertise and the assessment undertaken by the EAS in relation to Mr Warren.[123] I accept Sergeant Humphris' position. He had referred a matter to a Section specifically set up to deal with issues of this nature and was entitled to assume that they had properly dealt with those issues.

85 Sergeant Humphris' observations of Mr Warren during this incident were perceptive and well-informed. They were properly reported to EAS. However, I find that, likely due to the career impacts he spoke about, Mr Warren did not make any meaningful disclosures about the true nature of his struggles. I find that EAS, and in particular Ms Reed, did not account for that and merely took Mr Warren's position on face value.

86 I note that Senior Constable Hale's assessment was that Mr Warren seemed to process the road trauma 'well'.[124] He said that he could not recall any conversation about the Knowles incident with Mr Warren, nor did he make any observations of a change in his behaviours or demeanour. The first that Senior Constable Hale knew about the impact of the Knowles incident on Mr Warren was in a conversation sometime later, in early 2022. When Senior Constable Hale was asked to explain why he considered that Mr Warren

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115 Exhibit C21 at 61
116 T597
117 T604
118 Exhibit C21 at 63
119 T603
120 T189
121 Exhibit C30 at [13] and T167
122 T613
123 T191
124 Exhibit C31 at [11]

dealt with trauma well, he told me that Mr Warren presented as a very professional member of police, he was the first person on duty and the last to leave and was always well-dressed. He considered the signs of a person who was not coping might be that the person was late for work, dishevelled or low, which Mr Warren did not present with.[125] While Senior Constable Hale's evidence is that Mr Warren appeared to be coping well based on his physical appearance and diligent work habits, the evidence of Sergeant Humphris and Brevet Sergeant Blackwell provided greater insight as to Mr Warren's internal struggles and were a better reflection of the factors that one might look for in identifying such issues.

87 The evidence suggested that Mr Warren had the capacity to mask his potential internal challenges with a strong exterior. As I have explained, this behaviour was identified explicitly by Senior Sergeant Murray in correspondence to the EAS in which he stated that Mr Warren 'plays tough, and basically, he isn't'.[126] This information ought to have been used by EAS in assessing their interactions with Mr Warren.

88 Mr Warren continued to perform his duties in a diligent and professional manner beyond this incident and to a high level. Sergeant Humphris' observations of Mr Warren's interactions both at work and in social settings following these events provided no further grounds for concern.[127] Mr Warren left the team after successfully winning a position at the Driver Training Unit.

Roxby Downs Police Station – 2017-2019

89 After an uneventful period at the Driver Training Unit in Adelaide, on 21 December 2017 Mr Warren transferred to the Roxby Downs Police Station.[128]

90 The Roxby Downs Police Station had a different pace to Whyalla in that it was a quieter station.[129] There are different types of crimes committed and there is a lower crime rate generally.[130] Brevet Sergeant Blackwell had encouraged Mr Warren to join him in Roxby Downs, identifying it as a good place to raise his young family and to unwind and reset.[131] The two worked together at the station, but on opposite teams in Roxby Downs.

91 Senior Sergeant Stephen Griggs was the officer in charge of the Roxby Downs Police Station from September 2017 to May 2020.[132] Senior Sergeant Griggs estimated that there were up to 12 members within the team, including Mr Warren.[133] He told the Court that the team were understaffed nearly the whole time that he was there[134] but there was not a high frequency of taskings or jobs.[135]

92 Senior Sergeant Griggs was aware through a mutual colleague that Mr Warren had previously been at Whyalla and at Driver Training, but otherwise had limited information

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125 T298
126 Exhibit C21 at 49
127 Exhibit C30 at [14] and T168
128 Exhibit C21 at 1
129 T102
130 T279
131 Exhibit C29 at [54]
132 T251
133 T252
134 T264
135 T279

about him.[136] After having worked with him, Senior Sergeant Griggs told the Court that Mr Warren was 'one of the best', in that he had a very strong work ethic and was passionate about his job. He described Mr Warren as an 'all-round good worker'.[137]

93 Brevet Sergeant Blackwell observed that Mr Warren was less jovial than he had been in the past and that he appeared not as happy as he was when the two first met in Whyalla.[138] He described Mr Warren as more withdrawn and not engaging.[139] Being in different teams, the two slowly spent less time together socially.[140] Mr Warren did not engage in the community, which is the usual expectation of members stationed in the country.[141] Brevet Sergeant Blackwell recalled Mr Warren being concerned by being followed home by a vehicle after his first shift. This paranoid and 'on-edge state', as he described it, was not something he had observed in Mr Warren previously.[142]

94 One night while working with Constable Aimee Rochea in Roxby Downs, Mr Warren told her about the Knowles incident and said he had always regretted not finding Mr Knowles and blamed himself for the deaths.[143]

95 Mr Warren encouraged Senior Constable Hale to transfer to Roxby Downs. He was positive about his experience and told Senior Constable Hale that it was a busy place. After Senior Constable Hale arrived, the two were partnered together for much of the time.[144] Senior Constable Hale agreed that Roxby Downs was a busy place, particularly when working with Mr Warren. When asked to explain that he said:[145]

> … Ben had this knack of - and he was beginning to shine a light on drug use and drug trafficking in Roxby Downs, which until, to be fair, Ben arrived in Roxby, no-one thought that was an issue.

96 When compared to Whyalla, Senior Constable Hale described policing in Roxby Downs as comprising 'self-generated police work' with more time to be proactive and build intelligence.[146]

97 In Roxby Downs, members were required to meet certain benchmarks or quotas. Brevet Sergeant Blackwell told the Court that Senior Sergeant Griggs was a former traffic Sergeant. He based what he required around traffic statistics, including fines, cautions, defects and mobile radar hours.[147] Senior Constable Hale did not recall any *demands* from Senior Sergeant Griggs but conceded it was a long time ago and things 'may have been put that way'.[148] In this regard, Senior Sergeant Griggs agreed that there were corporate benchmarks and the main one related to road safety contacts.

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136 T254
137 T255
138 T84
139 Exhibit C29 at [58]
140 T85
141 T85
142 Exhibit C29 at [59] and T85
143 Exhibit C9 at [4]
144 Exhibit C31 at [17]
145 T303
146 T304
147 T87 and T89
148 T304

98 Brevet Sergeant Blackwell told me that you had to work hard to achieve the benchmarks, including driving up and down the highway to Coober Pedy, up to 88 kilometres away. Notwithstanding the difficulty of the task, Mr Warren would surpass the benchmarks.[149]

99 Senior Sergeant Griggs described Mr Warren as a 'high performer' but also identified that most of the members did achieve the benchmarks.[150] In Senior Sergeant Griggs' view, while the benchmarks might require members to go to the main highway, he considered that it was relatively easy to achieve them given it included everything from fines to cautions and defects.[151] There was also traffic in town which could be used to achieve the benchmarks.[152]

100 Notwithstanding the general consensus of the Roxby Downs Police Station was that it was not a busy station, Brevet Sergeant Blackwell told the Court that Mr Warren was always able to find work to do.[153] While Senior Constable Hale observed what he described as a growing work ethic in Mr Warren at this time, he also told the Court that Mr Warren was becoming a more effective member of police in that he was able to be proactive in his police work. Consistent with Brevet Sergeant Blackwell, he observed that it was common for Mr Warren to stay beyond shift time for reasons that were not operational.[154]

101 Brevet Sergeant Blackwell became concerned about what he observed in Mr Warren; an overcommitment to his role as a member of police which appeared to be having an impact on his marriage. Senior Constable Hale did not detect any strain in Mr Warren's marriage.[155] However, Brevet Sergeant Blackwell understood Mr Warren to be having difficulties in his marriage through information being relayed to him by his own wife.[156]

102 Brevet Sergeant Blackwell says he discussed the topic of Mr Warren with Senior Sergeant Griggs in person on at least three occasions. He told Senior Sergeant Griggs of the circumstances that led to Mr Warren often being told to go home at Whyalla. He said that, although Mr Warren came to Roxby Downs looking for a good place for he and his wife to reconnect and to focus on his family, he observed him staying back at work again. Senior Sergeant Griggs agreed that it was possible that Brevet Sergeant Blackwell told him that Mr Warren was having problems at home because he was spending too much time at work.[157] Senior Sergeant Griggs' assessment was that he was not concerned by Mr Warren's behaviour but did think it was unnecessary that he remained back as often as he did, and that he really should have been home with his family.[158]

103 Senior Sergeant Griggs observed that it was common for Mr Warren to stay on an hour or more after his shift, and he estimated that this occurred on about 20 or 30 occasions.[159]

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149 Exhibit C29 at [68] and T104
150 T255
151 T272
152 T273
153 T86
154 T305
155 T342
156 Exhibit C29 at [25]–[28] and T110-T111
157 T269
158 T257 and T270
159 T256

Mr Warren also attended work on his days off, but this did not occur as frequently as the times he stayed back beyond his shift finishing.[160]

104 While Brevet Sergeant Blackwell's hope was for Senior Sergeant Griggs to send Mr Warren home on occasions when he was staying back, he told the Court that he cannot ever recall seeing this occur.[161] Senior Sergeant Griggs says he did speak to Mr Warren about staying late but he could not recall the number of times or the specific reason for having the conversations. He said the conversations were of a general nature and to the effect of 'What are you still doing here Ben?', in the context of knowing that Mr Warren did not have pressing paperwork or correspondence that needed to be actioned.[162] Senior Sergeant Griggs also said that Mr Warren was in a separate part of the station so sometimes he would not even know he was there.

105 Brevet Sergeant Blackwell was not sure if he told Senior Sergeant Griggs about any concerns he had in relation to Mr Warren's mental health,[163] but Senior Sergeant Griggs was sure that he had not raised any such concerns.[164] Senior Constable Hale also gave evidence that he did not form any concerns from a mental health perspective nor did Mr Warren ever discuss any concerns related to his mental health with him.[165] Senior Constable Hale told the Court that his daily interactions with Mr Warren had not changed since the time that they were in Whyalla.[166]

106 Given Brevet Sergeant Blackwell's lack of certainty around the topic of Mr Warren's mental health combined with Senior Sergeant Griggs' clear denial of having been informed of this by Brevet Sergeant Blackwell, I find, on balance, that Brevet Sergeant Blackwell did not convey to Senior Sergeant Griggs any concerns he held specific to Mr Warren's mental health.

107 Prior to the birth of Mr Warren's second child in 2018, there were complications with the pregnancy which required Mrs Warren to go to Adelaide sooner than expected. Mr Warren told Brevet Sergeant Blackwell that he could not change his leave because when he had asked to move it, Senior Sergeant Griggs said he would prefer that he did not.[167] Brevet Sergeant Blackwell recalled that this occurred at a time when several other members were on leave.[168]

108 Senior Sergeant Griggs told the Court that he did not recall a conversation of this nature. He did not have any recollection at all about a leave application or a conversation about leave proximate to the birth of Mr Warren's second child. He said that had a request been made under those circumstances he would have had no reason to decline it, even if other members were on leave.[169] He said he would have helped Mr Warren as much as he could. This evidence was predicated on his usual practice rather than actual memory.[170]

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160 T256
161 T89
162 T257
163 T88
164 T254
165 T305
166 T341
167 Exhibit C29 at [80]
168 T103
169 T259
170 T260

109 While I accept that Senior Sergeant Griggs was endeavouring to assist the Court in reliance on his general practice, I find that the circumstances of the application for leave made by Mr Warren were in accordance with the evidence of Brevet Sergeant Blackwell. He had a clear recollection that had cogency about it, surrounded by circumstances of other members being on leave at the time. Given Senior Sergeant Griggs could not recall this conversation, I was not able to explore further the reasons why such an approach was taken to leave at an important time in Mr Warren's life. Of course, Senior Sergeant Griggs was not to know the depths of Mr Warren's struggles, which was hidden from all.

110 Notwithstanding the leave issues, Mr Warren was present at the birth of his daughter. His mother, Michelle Warren, made a diary entry of him driving to Adelaide on 13 January 2018 in advance of the birth of his daughter on 15 January 2018.[171]

111 Senior Sergeant Griggs continued a friendly relationship with Mr Warren beyond his time at the Roxby Downs Police Station with the two regularly communicating with each other. Mr Warren never raised any concerns with Senior Sergeant Griggs in relation to his mental health and Senior Sergeant Griggs did not make any independent observations of anything concerning in that regard. Mr Warren did share issues related to other supervisors and managers that he had on occasions.[172]

112 Senior Sergeant Griggs told the Court that at the time that he was in Roxby Downs, he was not aware of the Knowles incident nor does he recall Mr Warren mentioning this incident to him.[173] Senior Sergeant Griggs agreed that as a supervisor, if a member had possibly been traumatised by a particular event, this would be helpful information for him to know.[174]

Coonalpyn – 2019–2020

113 Mr Warren was then stationed at the single-manned Coonalpyn Police Station. During this time, he and his wife separated for a period. She said she did not like the isolation and wanted to move back to the city.[175]

114 During his time at Coonalpyn Mr Warren was noted to have had a difference of opinion with another member of police who was stationed at Tailem Bend. This was Mr Warren's direct supervisor. Senior Sergeant Griggs recalled Mr Warren discussing this conflict with him. He did not attribute this to any mental health concerns. Rather he explained:

> Q. Did that information during those conversations cause you any concerns in relation to Benjamin Warren, given what you knew about him having disagreements with supervisors when you were his supervisor.
>
> A. It didn't give me any concern, that was Ben's nature.
>
> Q. When you say 'Ben's nature', what do you mean by that.

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171 Exhibit C42
172 T260-T261
173 T253
174 T263
175 Exhibit C3 at [2]

> A. He didn't take criticism all that well, from supervisors or peers or anyone; if he disagreed with their decision or assessment of things, he would voice his concerns and it often led to conflict with those supervisors.[176]

115 Senior Constable Hale kept in touch with Mr Warren beyond their posting at Roxby Downs. He gave evidence that they discussed taskings while Mr Warren was stationed at Coonalpyn, but that he never conveyed any concerns related to his mental health.[177] He described the issues that arose as being centred around wanting to keep the community safe and being the only officer at Coonalpyn.

116 Mr Warren remained at Coonalpyn for a little under 12 months before reconciling with his wife and transferring to the Northen District.

Northern District – 2020–2021

117 Senior Sergeant Griggs told the Court that Mr Warren did not take criticism from supervisors or peers well. If he disagreed with a decision or assessment, he would voice his concerns and it often led to conflict with those supervisors.[178] He said that he did not personally experience conflict with Mr Warren because they were 'on the same page for a lot of things'. He respected Mr Warren's strong worth ethic which he shared.[179] This was unlike the experience that Mr Warren had when he came to be stationed at Northern District, where he had to be transferred multiple times due to ongoing conflict with different superiors.

118 Chief Inspector Astrid Gustavson was the officer in charge of the Northern District in the time that Mr Warren was stationed there between 2020 and 2021. If there was a human resources or performance issue with a member in her district that needed to be escalated beyond the senior sergeant, she would become involved.[180] Chief Inspector Gustavson summarised the feedback she received from Mr Warren's superiors during his time at Northern District. She was informed that Mr Warren took on too much work, regularly worked beyond his shift time and struggled to find the balance required when being a supervisor.[181] Insofar as working long hours, Chief Inspector Gustavson said she was never concerned about this from a mental health perspective, but rather saw it as a fatigue and wellbeing issue.[182]

119 In about January 2020, Mr Warren was placed into a district team at Salisbury overseen by Sergeant Narelle Bache. His policing experience, including his ability to potentially mentor junior members in relation to police investigations played a role in that decision.[183] Chief Inspector Gustavson did not have any background information about Mr Warren except for where he had been previously posted. Inconceivably, she said she did not have his HIRS history.[184]

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176 T276
177 T306
178 T276 and Exhibit C20au at 1
179 T282
180 T754
181 Exhibit C39 at [11]
182 T774
183 T758
184 T760

120 By October 2020, Mr Warren and Sergeant Bache had experienced a breakdown in their professional relationship due to philosophical differences.[185] Efforts were made to move Mr Warren into another team, with Chief Inspector Gustavson identifying that Sergeant Matthew Keenan may be an appropriate fit. In the interim period until the roster aligned, Mr Warren was stationed at Golden Grove and overseen by Sergeant Scott Trenamen.[186]

121 On 29 January 2021, Sergeant Trenaman wrote a 'Thank You' email to Mr Warren. It said the following:[187]

> From: Trenaman, Scott (SAPOL)
> Sent: Friday, 29 January 2021 3:16:35 PM
> To: Warren, Benjamin (SAPOL)
> Cc: Schaedel, Robert (SAPOL)
> Subject: Thank You
>
> Morning Ben,
>
> Thanks for your comprehensive hand over email.
>
> Secondly I don't this that often but will where I value and or rate someone's performance.
>
> I deliberately gave you space to settle upon your arrival with the team at the end of the year as it was clear you needed time to clear your head and become comfortable in my team's environment. You have from that point forward fitted in very well with my team, even if you have the uncanny knack of finding work at the end of shifts that meant you didn't always knock off with a majority of us. Having said that you are not that much different than I when I was younger in age or years of service but please understand the organisation will not reward you for the extra hours you often work without payment and burning both ends of the candle will affect your mental health and your very important the relationship with your family.
>
> Your work ethic is something I do recognise daily and to be honest, is something to be proud of. The quality of your investigations and the associated investigational plans will stand you in good stead for the remainder of your time with response/DPTs moving forward. Thus my recent conversations with you about exploring a move into an investigations career stream. You consistently display to back your up all of the district's crews (regardless of the sector and or the team on duty), this is important and it does not go unnoticed.
>
> We've spoken about it briefly in the past, don't worry about what others are saying about you behind your back, let your work ethic and passion to be an effective Police officer speak volumes instead. I can testify that not everyone will be a fan of your hard work ethic and can effectively act as an anchor if you let them but your supervisor, Ops Snr Sgt and your workmates will appreciate that you always have their backs and this is the crucial difference between an ineffective 2IC or Sgt and the qualities you display in ample quantities.
>
> Stay keen but understand your overall workload, carrying too many tasks and not meeting due dates can be detrimental to your relationship with CJS and any supervisor you support as a 2IC. Your new supervisor (Sgt KEENAN) is a supervisor I do rate at Golden Grove, but he has similar expectations as I concerning staying on top of workloads, being responsive to issues associated with sector 3 and reflecting his values to the troops to ensure you are both seen to be a united front.
>
> Thank you for the short amount of time you spent with my team, the support you provide me and the team during that period.
>
> Kind Regards,
>
> Sergeant Scott Trenaman
> General Duties Supervisor
> Northern District Patrol Team 6 - Golden Grove Team 3 Banksia Park, Gulfview Heights, Modbury Heights Modbury North, Redwood Park, Ridgehaven, Surrey Downs, Tea Tree Gully & Wynn Vale Northern District Operations (48)
> South Australia Police

122 In my view, this was a particularly graceful way of dealing with what was a growing wellbeing issue.

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185 T763
186 T765; Exhibit C39 at [16]
187 Exhibit C23 at 21

123 Chief Inspector Gustavson said that the difficulties experienced between Sergeant Bache and Mr Warren were replicated with other superiors, but to a lesser extent with Sergeant Trenaman and then to a greater extent with Sergeant Keenan.[188]

124 At the time of giving evidence, Mr Keenan was no longer a serving member of police. He supervised Mr Warren from about 14 January 2021 for a period of about six weeks.[189]

125 Chief Inspector Gustavson described that there was immediate conflict with Mr Warren on Sergeant Keenan's team, similar to the conflict he had experienced with Sergeant Bache. She said that Mr Warren was argumentative with his superiors and had a firm view on how he wanted to tackle taskings.[190]

126 Upon Chief Inspector Gustavson enquiring as to Mr Warren's progress on the team, Sergeant Keenan was asked to provide a synopsis of his observations of Mr Warren in the short time he had been on the team, only a matter of a couple of weeks.[191] Sergeant Keenan did this by way of email on 27 February 2021.[192]

127 One observation related to Mr Warren's need to attend every job and Sergeant Keenan expressed concern at Mr Warren engaging in what he described as 'what if' thinking. Mr Warren had said that if something happened and he left the job while it was still pending, he would be held personally accountable. This included Mr Warren having mentioned being in the Coroners Court. It was again highlighted that Mr Warren had been staying at work past completion unpaid with a view that 'it just needs to get done'.[193]

128 After his 27 February 2021 email, Sergeant Keenan was asked to provide more comprehensive notes of his observations, which he did.[194] Sergeant Keenan reiterated his concerns about the 'what if' thinking he was seeing and outlined concerns he had about Mr Warren's excessive work hours, that he was not meeting deadlines, his lack of ability to delegate and also the volatility of their professional relationship, with Mr Warren expressing a lack of trust in Sergeant Keenan.[195]

129 Sergeant Keenan told the Court that Mr Warren would go from job to job, that he was a very hard worker and he would not spend time doing the required paperwork. When Sergeant Keenan attempted to intervene by suggesting that Mr Warren return to the station between jobs to complete paperwork, Mr Warren responded that he needed to get to the next job because if he did not, something bad could happen and it would be his fault.[196] Sergeant Keenan said that Mr Warren appeared to hold an obligation for himself to attend every job.[197]

130 Sergeant Keenan considered that some of the behaviours that Mr Warren was demonstrating were unusual. Sergeant Keenan said that when he endeavoured to provide

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188 T767
189 T222 and Exhibit C39 at [15]
190 T766
191 T230
192 Exhibit C23 at 11
193 Exhibit C23 at 11
194 Exhibit C23 at 13-16
195 Exhibit C23 at 13-16
196 T228
197 T228

feedback to Mr Warren, he took it as a personal attack and would attempt to justify his actions.[198]

131 Chief Inspector Gustavson compiled information from each of Mr Warren's superiors in the Northern District to make an assessment of what was to occur next in relation to Mr Warren.[199] This information included Mr Warren's lateral transfer application, which revealed potential conflict or differences in opinion he had with a supervisor while stationed at Coonalpyn.[200] This was not information that Chief Inspector Gustavson had at the time that Mr Warren was initially transferred to Northern District.[201] She took the view that Mr Warren remaining on Sergeant Keenan's team was not tenable.[202]

132 The purpose of gathering the information was for Chief Inspector Gustavson to speak to Mr Warren, in the presence of Senior Sergeant Robert Schaedel, with a view to working through why Mr Warren was not fitting in well in any teams.[203] According to Chief Inspector Gustavson, it was an opportunity for Mr Warren to speak through the troubles he was having and for her and Senior Sergeant Schaedel to discuss his understanding of the role of Brevet Sergeant in the metropolitan setting.[204]

133 She met with Mr Warren in the presence of Senior Sergeant Schaedel on two occasions. In advance of the first meeting, she spoke to the Chief Inspector of EAS to ascertain whether it may be appropriate for Mr Warren to be referred there due to what she observed to be personality difficulties which were creating workplace conflict. She thought he might be assisted by the development of insight about his personality traits.[205] She considered this to be a holistic approach to Mr Warren's management, and that a referral may ultimately provide strategies for him to use to alleviate the ongoing conflict with superiors.[206] She said that at no time was she concerned that Mr Warren had any mental health issues.[207]

134 During one of the meetings, Mr Warren spoke about his time in the far North, either Whyalla or Roxby, and his exposure to road fatalities. Notwithstanding its prominence in the events that had occurred up until that point, Chief Inspector Gustavson said that this was not information she had prior to Mr Warren talking about it. In particular, Chief Inspector Gustavson had no knowledge of Mr Warren's involvement in the Knowles incident that deeply affected Mr Warren's approach to work and appeared to be the root of so much of the workplace conflict that had come to surround him.[208]

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198 T234
199 The information received from Sergeant Bache is at AG-3 of Exhibit C39
200 See Exhibit C39 at AG-2
201 T808
202 T767 and Exhibit C39 at [19]
203 T767
204 T770 and T811
205 T772
206 Exhibit C39 at [29] and T776
207 T773 and Exhibit C39 at [31]
208 T775

135 Chief Inspector Gustavson observed Mr Warren's demeanour to be defensive at times during the meetings.[209] She said that, overall, Mr Warren appeared to understand that the purpose of the meeting was to support him.[210]

136 Chief Inspector Gustavson raised with Mr Warren the prospect of meeting with the EAS. Mr Warren was sceptical about this. She reiterated that this was not a mental health assessment but was instead for the purpose of developing strategies related to workplace conflict. Mr Warren said that he was concerned about the negative connotations from a referral to EAS. Chief Inspector Gustavson described to him that she uses the EAS to help people 'grow', which he thought was unusual.[211] While he found the approach to be 'weird', Chief Inspector Gustavson described that Mr Warren was ultimately happy to speak to the EAS about developing strategies.[212]

137 Chief Inspector Gustavson told the Court that if Mr Warren had not agreed to attend he would not have been forced. She explained that use of EAS services was not mandatory, but she would have continued to engage with him with a view to him reaching self-realisation that he needed to address the ongoing conflicts that he was having.[213] If such issues were to continue with a member, Chief Inspector Gustavson told the Court that it would probably end up being a disciplinary matter but that would be a last resort.[214] However, she said that she did not consider Mr Warren was merely complying due to her seniority in rank. She based this view on their good rapport and their interactions up to that date.[215]

138 Mr Warren attended at the EAS on the proviso that it was related to himself developing strategies for dealing with conflict with his superiors. I observe that the reluctance towards the EAS in 2021 mirrors what he had previously displayed in February 2015 in the context of the referral by Sergeant Humphris. While Chief Inspector Gustavson told the Court he did not tell her he was concerned about the career implications of using the service,[216] I am satisfied that it is likely that Mr Warren's scepticism did relate to these concerns which he had previously clearly expressed. In any event, given the assurance by Chief Inspector Gustavson on this occasion, Mr Warren was prepared to participate in the referral. Chief Inspector Gustavson did not identify any mental health issues with Mr Warren and the referral held no such purpose in her mind.

139 I note that Chief Inspector Gustavson is not a medically trained person. While an Officer of Police needs to be alive to identifying mental health issues, this is not actually her core role and she is not trained to pick up on subtle signs of such issues. It appears that Mr Warren was able to successfully mask his challenges during his time at Northern District, consistent with the 'tough exterior' he previously displayed back in Whyalla, including in front of his superiors and ultimately, as I will now discuss, the EAS in April 2021.

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[209] Exhibit C39 at [27]
[210] T770
[211] Exhibit C39 at [32] and T812
[212] T772
[213] T781
[214] T782
[215] T782
[216] T812

Assessment by Dr Jane Cooper – March and April 2021

140 Mr Warren was referred to the EAS through Senior Sergeant Schaedel and Chief Inspector Gustavson.[217] As I have observed, at the time, Dr Jane Cooper was the police psychologist working within EAS.

141 In the referral process, Dr Cooper was told that Mr Warren's superiors were concerned about his performance and wanted strategies for both them and Mr Warren as a means of moving forward.[218] This is perfectly consistent with the purpose for the referral that had been discussed and agreed. Dr Cooper's notation on the CareRight system was 'poor behaviours, conflict with managers, poor attitude'. It was noted to be 'mainly a management issue' and that there was 'nil evidence of risk of [Self Harm] or [Suicidal Intent]'.[219]

142 Dr Cooper made notes of her face-to-face conversation with Senior Sergeant Schaedel on 17 March 2021.[220] Dr Cooper noted a concern about a 'high level of paranoia'. She told the Court that her current interpretation of paranoia in the note referred to Senior Sergeant Schaedel conveying concerns that Mr Warren was worried about what people think, not actual mental illness or having a delusion.[221] Her understanding of Senior Sergeant Schaedel's use of the term in this context was that it was personality-based and linked to being very considerate and conscientious about performance or the way a person is viewed by other people.[222] Chief Inspector Gustavson also elaborated on what she understood 'paranoid' to be in the context of an email she received from Sergeant Bache, telling me that it meant that Mr Warren was worried about what others thought, rather than being a mental health concern.[223]

143 I am satisfied that all of the people involved were reporting an observation of paranoid as a less technical matter, rather than turning their minds to the behaviour being a clinical symptom of some mental health issue.

144 Senior Sergeant Schaedel was not sure whether a psychological review was needed but Dr Cooper said one could be performed.[224] The phone conversation largely related to concerns held by Senior Sergeant Schaedel about communication issues with Mr Warren and his combative style and the challenges experienced by superiors in their management of him.

145 Dr Cooper received emails from Chief Inspector Gustavson, which included the notes prepared by Sergeant Keenan.[225] Dr Cooper told the Court that she read the emails and notes before her meeting with Mr Warren.[226] She said she did not consider that the 'what if' thinking described by Sergeant Keenan was of significance from a mental health perspective as it was common in her experience to encounter members of police who

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[217] Exhibit C22 at 59
[218] T480
[219] T483
[220] Exhibit C21 at 139
[221] T486
[222] T533
[223] T773 and Exhibit C39 at AG-3
[224] Exhibit C21 at 141
[225] Exhibit C23 at 11-27
[226] T510-T511 and T576-T583

think in that way. She felt it might have simply been an indication of a desire to perform the job properly without being criticised.[227]

146 Dr Cooper had access to Mr Warren's EAS file, which is available through the CareRight system. The file included all contacts Mr Warren had had with EAS over the entirety of his career and any previous HIRS that had been made including how it was resolved. She could not specifically recall looking through it for Mr Warren but said that she would have done based on her standard practice.[228]

147 The notes within the CareRight system also have documents uploaded for some entries.[229] Dr Cooper said she would not usually open every single document that was attached to the file as there was not a capacity to do so due to time restraints.[230] Her standard practice was to look at the summary that the EAS practitioner had written in CareRight in terms of whether any concerns were held rather than going to each individual document.[231]

148 Dr Cooper considered that a lot of police are exposed to many traumatic events with multiple HIRS on the system so there was nothing unusual in seeing that in Mr Warren's case.[232]

149 On 7 April 2021, Dr Cooper met with Mr Warren and undertook a psychological assessment.[233] The assessment was subject to the General Order for psychological health management in force at the time.[234] Mr Warren signed a consent form[235] and completed a Depression, Anxiety Stress Scale questionnaire (DASS-21), which is a standard psychological metric.[236]

150 Within The DASS-21, Mr Warren answered zero to all questions, meaning that the particular criteria in question did not apply to him at all. In my view, some of the answers of zero, including those related to whether he tended to overreact in situations and whether he found himself getting agitated, appear to be inconsistent with the information which had been provided by his superiors, in particular Sergeant Keenan. Dr Cooper accepted that management had expressed problems with Mr Warren's behaviour at work. However, she said the measure is only for a short period of time (the past week) and that she took a whole range of information into account to put together a picture of Mr Warren's mental wellbeing.[237] Dr Cooper told the Court that it was not uncommon for members of police to answer zero to all questions within the DASS-21 and when asked whether she agreed that concerns surrounding confidentiality may also play into that typical response, she agreed.[238]

151 Notwithstanding that Dr Cooper somewhat agreed that she had received collateral information from his superiors that was inconsistent with his self-report during clinical

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227 T577-T578
228 T489
229 For example, see Exhibit C2259
230 T512
231 T527
232 T513
233 Exhibit C23 at 2-8
234 Exhibit C35 and T543
235 Exhibit C23 at 9
236 Exhibit C23 at 10
237 T491
238 T549

assessment, she did not challenge him on the differences because she prioritised building rapport[239] and also that she did not feel the need to.

152 As I have explained, Mr Simon Brown-Greaves, an expert organisational psychologist with extensive background in high-risk environments, including policing,[240] gave evidence on this topic. He said an expected part of assessment is to challenge the member if there is background or collateral information that might contradict the member's self-reported presentation.[241] Dr Cooper had an opportunity, with the information she had, to challenge Mr Warren's answers. However, given his persistent reluctance to make meaningful disclosures to EAS up to that point, had she done this, I am not certain that it would have altered the assessment and it may have led to immediate disengagement (perhaps passively).

153 Dr Cooper discussed with Mr Warren different management styles, which was what she had been asked to do.[242] She said that while she considered mental health as part of her assessment of Mr Warren, the main focus of the assessment was the management issues that Mr Warren was having with his superiors.[243] Dr Cooper's opinion was that Mr Warren presented as relaxed throughout and there was no indication that he was guarded in his engagement with her.[244] I accept that that is so, particularly in light of the fact that he was not challenged in respect of any of the conflicting information he was providing. He would simply have had no reason to be guarded about the topics under discussion. In relation to his deeper mental health issues, that were likely building at this time, I am satisfied that Mr Warren had developed a base level of guarding to the extent that it may have been very difficult to detect and certainly would not incidentally be uncovered without specific prompting.

154 As part of the mental health assessment, Dr Cooper considered the DASS-21 but also undertook a clinical assessment. She explored his marital status and his children. She made a note that Mr Warren was able to 'switch off'.[245] This was not entirely consistent with his noted pattern of remaining at work for hours beyond the end of his shifts, in that it tended to cast doubt on whether he genuinely could 'switch off'.

155 After the assessment, Dr Cooper noted on CareRight that Mr Warren had 'nil evidence of mental health issues', strong supports and good sleep, but that he possessed a rigid cognitive style with limited emotional intelligence and self-awareness. Mr Warren was provided with strategies to help him to establish positive relationships in the workplace.[246] Dr Cooper told the Court that there was nothing to indicate that she needed to do a specific risk assessment because Mr Warren was positive and optimistic and was keen to sort through the managerial problems. She said if there had been concerns, she would have delved deeper into issues such as his childhood, developmental history and his mental

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[239] T517
[240] T623
[241] T690
[242] T519
[243] Tp548, 554
[244] T540
[245] Exhibit C23 at 6
[246] Exhibit C22 at 59

health, including any substance abuse and then conduct a risk assessment. With Mr Warren's presentation, she considered that this was not required.[247]

156 Dr Cooper says she canvassed the issue of 'presenteeism' with Mr Warren.[248] Dr Cooper referred to the concept of presenteeism as a person who spends too much time at work[249] and says she explored Mr Warren's working habits with him to address this issue.[250]

157 Mr Brown-Greaves disagreed with Dr Cooper that presenteeism was a concern, because he considered that presenteeism is a member who attends work but is not productive, does not contribute and does not engage with it.[251] This is different to a member, like Mr Warren, who spent excessive time at work and was engaged with the content (perhaps even hyper-engaged). Mr Brown-Greaves opined that Mr Warren was not an example of presenteeism. Nevertheless, discussing Mr Warren's concerning work habits was a reasonable thing for Dr Cooper to have done, regardless of what label was put on it.

158 It was standard practice to provide the person with information about the EAP and Dr Cooper did this. She left the question of further follow-up with his management[252] and she received a thank you email later that day from Mr Warren.[253] This would have reinforced to Dr Cooper that Mr Warren had received assistance from her input.

159 While Dr Cooper might have conducted a more wide-ranging assessment and might have confronted more of the issues that Mr Warren was declaring that conflicted with information she had been given, it is important to bear in mind the nature of her task at that time; to give Mr Warren techniques for engaging with colleagues. Mr Warren was clearly unwilling to reveal any struggles. In those circumstances, I am satisfied, on balance, that there is no criticism to be made of her approach and her decision to prioritise rapport-building.

Driver Training Unit – February 2022

160 Mr Warren commenced at the Driver Training Unit on 3 February 2022.[254] A short time later, on 13 February 2022, Mr Warren formally separated from his wife and moved out of the family home and into a friend's house at Mawson Lakes.[255] Shortly after moving, Mr Warren went away with Senior Constable Hale to attend a four-wheel driving course in Port Augusta between 13 and 18 February 2022.

161 While driving to Port Augusta, Mr Warren and Senior Constable Hale were driving in separate unmarked four-wheel drive vehicles. They observed a person driving in a dangerous manner and overtaking at dangerous places on the road. Mr Warren immediately reacted by requesting uniformed police to attend and coordinated a police stop at Snowtown. Senior Constable Hale described Mr Warren as taking responsibility and acting as a member of police, even though other members may not have done

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[247] T492
[248] Exhibit C34 at [15]
[249] T495
[250] Exhibit C23 at 7 and T496
[251] T683
[252] T497
[253] Exhibit C21 at 144
[254] Exhibit C21 at 1
[255] Exhibit C3 at [6] and Exhibit C5 at [4]

anything.[256] Senior Constable Hale had heard similar stories involving Mr Warren intervening in police matters where others might not have, including responding to a robbery while at the Driver Training Unit, merely because he was the nearest member of police.[257] Mr Brown-Greaves told me that he considered that Mr Warren's behaviour en route to Port Augusta was on the border between him being a diligent member of police and someone who was overcompensating, over-alert or over-determined to carry out his duties.[258] He said this behaviour, coupled with others including nightmares or hypervigilance, may take on significance in the context of PTSD.[259] This need to attend at every job is reminiscent of what Sergeant Keenan was describing from his observations of Mr Warren in early 2021. It has a similar vein to the observations of Sergeant Humphris in early 2015 in that Mr Warren had been insistent that he must maintain observation and involvement with the vehicle on that occasion. In my view, this ongoing diligence is likely borne out of a need to overcompensate and was likely a presentation of Mr Warren's PTSD.

162 During one evening while on the course in Port Augusta, Mr Warren had an emotional conversation with Senior Constable Hale in relation to the Knowles incident, now some seven years earlier. This was only the second occasion that Senior Constable Hale had observed Mr Warren to be visibly emotional.[260] Mr Warren said to Senior Constable Hale that he had been having bad dreams about the Knowles incident and that when he was stressed, the dreams would be vivid and recurring. He would attempt to work through different outcomes in his dream and that this would sometimes occur several times a night.[261] He said the dreams had been occurring for a long time.[262] This evidence demonstrates that the PTSD that had developed was particularly entrenched and severe.

163 Mr Warren also told Senior Constable Hale of additional details from the Knowles incident. He said that police communications had been trying to locate Senior Sergeant Green on the night and Mr Warren became worried so he diverted his enquiries to check on the welfare of Senior Sergeant Green instead of looking for Mr Knowles. Mr Warren said he felt guilty for this decision. Mr Warren told Senior Constable Hale that one of his dreams was that if he did not check on Senior Sergeant Green at that time, that may have meant that Mr Warren would have located Mr Knowles before he crashed the car and killed others.[263] Mr Warren also said he knew there was a possibility that if he had in fact located Mr Knowles, he may have purposefully driven at Mr Warren's vehicle and he himself could have been killed instead.[264]

164 Other witnesses also knew that Mr Warren was experiencing nightmares related to the Knowles incident, including his former wife and former partner.[265] In relation to the

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[256] T301 and Exhibit C31 at [30]
[257] T299
[258] T650
[259] T651
[260] The first occurring years earlier while at Whyalla and following a disagreement between the two about a work issue, see T309
[261] Exhibit C31 at [36] and T310
[262] T310
[263] T312
[264] Exhibit C31 at [37]
[265] Exhibit C3 at [8] and Exhibit C8 at [5]

evidence about Mr Warren and nightmares, Mr Brown-Greaves considered that these were consistent with one of the diagnostic criteria of PTSD.[266]

165 Senior Constable Hale was concerned by Mr Warren's lack of sleep and that he was revisiting the Knowles incident.[267] He asked Mr Warren about engagement with the EAS. Mr Warren told Senior Constable Hale that he had spoken to them previously and they advised him to do more exercise to assist his sleep pattern. Senior Constable Hale then recommended seeing a sleep specialist. He saw this as a means of getting Mr Warren to engage with someone to speak about things and resolve the dreams.[268]

166 The following morning Mr Warren explicitly told Senior Constable Hale to keep the information confidential and that his wife was the only other person who was privy to that information.[269] When Senior Constable Hale raised a previous incident he had experienced with a colleague in Scotland having suicided, Mr Warren responded by smiling and saying that it was 'nothing like that'.[270] Senior Constable Hale told the Court that he believed Mr Warren when he said this as he trusted him and he was the type of person to always give an honest answer.[271] Mr Warren and Senior Constable Hale then went to dinner with a colleague the following evening. At the dinner, their colleague was discussing his engagement with post-traumatic stress disorder therapy. Mr Warren appeared disengaged and was texting on his phone.[272] Senior Constable Hale challenged Mr Warren later that evening about not participating in the conversation and Mr Warren said that he was using his phone as a distraction because he felt he was becoming emotional.[273]

167 The next morning, Senior Constable Hale observed Mr Warren to demonstrate a hypervigilant reaction upon hearing a loud bang outside of their room. Mr Warren had been seated at a table and when he heard the loud bang, he noticed that Mr Warren's right hand dropped to his hip. Mr Brown-Greaves opined that this behaviour is another example of one of the diagnostic criteria of PTSD; the heightened startled reaction that is typical of and present in most cases of police with PTSD.[274]

168 On 18 February 2022, after returning from the Port Augusta trip, Mr Warren travelled to Kadina to drop his dog with his friend Constable Rochea.[275]

Mr Warren's death

169 Mr Warren continued to see his children after moving out of the family home through mutual arrangements with his wife. On 24 February 2022, he dropped the children to school and kindergarten.[276]

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266 T648-T649
267 T312
268 T312-T313, T316 and Exhibit C31 at [38]
269 Exhibit C31 at [40]
270 Exhibit C31 at [42]
271 T315
272 T317 and Exhibit C31 at [44]
273 T317
274 T655
275 Exhibit C9 at [14]
276 Exhibit C3 at [7]

170 On 26 February 2022, Mr Warren contacted Mrs Warren to make plans to see the children the following day. He wanted to take the children to his parents' house for dinner. He said that his sister would also be attending.[277]

171 On the evening of 26 February 2022, Mr Warren attended a work function with a new partner, Vanessa Vukovic.[278]

172 On the morning of Sunday, 27 February 2022, Mrs Warren texted Mr Warren to inform him that the children were unwell. Ms Vukovic observed Mr Warren to be visibly upset when he read this.[279] Later that morning, Ms Vukovic suggested that the two spend time apart, but Mr Warren did not want this.[280] CCTV recorded Mr Warren arriving at his home address at 10:20 am.[281] At 12:42 pm Mr Warren messaged Mrs Warren enquiring about the children. She responded telling him that they were better.[282]

173 Mr Warren came out of his bedroom at about 3 pm. He told his housemate that he was going to see his mother.[283] CCTV footage recorded Mr Warren reversing out of his driveway at 3:25 pm.[284]

174 Mr Warren's movements over the course of the afternoon up to the time of his death can be deduced through messages sent on his phone, information within the Police Academy access system and CCTV as follows:

a. At 3:02 pm Mr Warren texted Mrs Warren to cancel the plans to take the children to his parents' house for dinner, saying that it was not a good idea if they were sick.[285]

b. At 3:06 pm, Mr Warren sent two messages to his mother cancelling the dinner plans stating that his daughter had a cold. His mother responded accepting that.[286]

c. At 3:07 pm, Mr Warren sent a message to Constable Rochea telling her that the relationship between himself and his new partner had ended. Constable Rochea was asleep at the time and did not see the message until some hours later.[287]

d. At 3:43 pm, Mr Warren accessed the Police Academy using his swipe card. He sat in his vehicle for approximately 33 minutes.[288]

e. At 3:58 pm, Mr Warren attempted to call Ms Vukovic. She says she was cooking dinner at the time and did not see the call.[289]

f. At 4:18 pm Mr Warren walked across the parade ground at the Police Academy. This is the last footage of Mr Warren.[290]

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277 Exhibit C4 at [6] and Exhibit C3 at [9]
278 Exhibit C8 at [9]
279 Exhibit C8 at [10]
280 Exhibit C8 at [11]
281 Exhibit C19a
282 Exhibit C3 at [10]
283 Exhibit C5 at [8]
284 Exhibit C19a
285 Exhibit C3 Annexure RW1 at 1
286 Exhibit C4 at [7]
287 Exhibit C9 at [21]
288 Exhibit C19 at 6 and Exhibit C19b
289 Exhibit C8 at [12]
290 Exhibit C19 at 16

g. At 4:36 pm Mr Warren sent Ms Vukovic a series of messages, including 'Things are going to get pretty rough for me for a bit. You just need to know it's not because of you'. He asked her to take care of herself. She did not reply until about 6 pm.[291]

h. At 4:42 pm, Mr Warren called Mrs Warren and spoke to their son. It was a short call. After the call, Mr Warren's son described that his dad sounded 'sick or sad'. Mrs Warren tried to call him back so he could speak with their daughter, but he did not answer.[292]

i. At 4:54 pm, Mr Warren accessed the main administration building at the Police Academy. This is the building in which Mr Warren was based and had a workstation. He logged onto his computer one minute after entering.[293]

j. At 5:07 pm he sent an email to the Commissioner of Police from his desktop computer regarding legislative amendments that he was working on in relation to domestic violence in South Australia.[294]

k. At 5:42 pm, Mr Warren messaged Ms Vukovic to tell her he loved her. Again, she did not respond.[295]

l. At 5:53 pm, Mr Warren gained access to the Driver Training Unit Administration Block. At the same time, he posted an article on his Facebook page about the sentencing of Mr Knowles that I have already described.[296]

m. At 5:54 pm, Mr Warren accessed the equipment room which he had access to using his swipe card. At the same time, Ms Vukovic had read his messages and replied saying 'Ben please don't torture yourself, stop looking at the Knowles [stuff]'. The evidence establishes that Mr Warren saw this message but did not reply.[297]

n. At 5:58 pm, Mr Warren changed his Facebook profile to a picture of a SAPOL wreath with a thin blue line; a symbol which signifies the death of a member of police.[298] Mrs Warren saw this and was immediately concerned for Mr Warren's wellbeing attempting to raise the alarm with his parents.[299]

o. At 6 pm, Mr Warren sent a message to Mrs Warren which read 'I'm sorry for everything. Take care of the kids for me'.[300] Mrs Warren then called police.

175 Mr Warren's phone also contained other messages dated 27 February 2022 in which he thanked various colleagues.[301]

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[291] Exhibit C8 at [13]
[292] Exhibit C3 at [11]
[293] Exhibit C19 at 6
[294] Exhibit C19 at 6
[295] Exhibit C8 at [14]
[296] Exhibit C19 at 7
[297] Exhibit C19 at 7 and Exhibit C8 at [16]
[298] Exhibit C19 at 7
[299] Exhibit C3 at [13]
[300] Exhibit C3 at [13]
[301] Exhibit C19c

176 Messages were sent by Ms Vukovic to Mr Warren at 6:02 pm that were never read by him. Observations of Mr Warren's phone at the scene indicated there were unread messages and missed calls from 6:01 pm onwards.

177 Police commenced a search at 6:11 pm and Mr Warren's building access was terminated at 6:30 pm. Police only later realised that he had already used his swipe card at the equipment room. Further investigations revealed that Mr Warren was likely inside the Police Academy. Upon patrols arriving at 6:42 pm, Mr Warren's car was observed in the car park. Police made repeated attempts to reach Mr Warren through his mobile phone.

178 At approximately 7:08 pm, Mr Warren was located in a small office within the driver training block. He had died.[302]

179 Reconstruction of the scene revealed that Mr Warren had fatally shot himself as he stood behind a desk.[303]

180 A specialist forensic pathologist from Forensic Science SA, Dr Cheryl Charlwood, conducted a post-mortem examination. She opined that the trajectory of the bullet was through the right temple, exiting the upper posterior parietal region of the scalp with a wound track of right to left, upwards and slightly backwards.[304]

181 Underneath Mr Warren's body, police observed a SAPOL-issued Smith and Wesson MP40 self-loading handgun. The firearm was in lock back mode indicating no further rounds of ammunition were in the magazine.[305]

182 There was a hole in the gyprock wall nearby, within which police later located the bullet that had killed Mr Warren.[306] The fired cartridge case was located on the floor underneath a chair proximate to Mr Warren.[307]

183 On the desk near Mr Warren, police located his Police Warrant Card flipped into an open position, his mobile phone and an A4 piece of paper with handwritten contact details of various people that would assist the police dealing with his death. The note further stated, 'No diagnosed depression/PTSD etc/no diagnosed mental health'.[308] This was clearly something of high importance to him.

184 I find that Mr Warren's death was caused by a single self-inflicted gunshot wound to the head which occurred proximate to 6 pm on 27 February 2022.

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302 Exhibit C10 at [11] and Exhibit C12 at [29]
303 Exhibit C18 at [25]
304 Exhibit C1a at 1
305 Exhibit C16 at [37]
306 Exhibit C18 at [21]
307 Exhibit C16 at [25]
308 Exhibit C20e

PTSD

185 Post-traumatic Stress Disorder is a mental health condition.[309] Its diagnosis requires:

a. exposure to one or more critical incidents, which comprises a serious event that involves threatened death, actual or threatened serious injury or sexual violence; and

b. persistent re-experience of the trauma; and

c. persistent avoidance of trauma-related stimuli, such as avoiding thoughts, feelings or sensations related to the event, or external reminders that are triggering; and

d. negative changes in thoughts, emotions and mood; and

e. heightened-arousal, including irritability, outbursts, hypervigilance, etc.[310]

186 The condition must have been observed for more than a month, cause functional difficulties and not be attributable to external factors such as medication.

187 In light of the history I have set out above, Mr Warren's EAS file comprises the following HIRS taskings involving fatalities:

a. 29 December 2014 – the Knowles incident[311]

b. 24 January 2015 – car and truck motor vehicle double fatality at Cowell[312]

c. 12 February 2014 – industrial accident involving deceased run over by an excavator[313]

d. 26 April 2019 – car and truck motor vehicle fatality at Culburra[314]

e. 25 November 2019 – three vehicle motor vehicle fatality at Tintinara[315]

f. 17 July 2020 – two car motor vehicle fatality at Edinburgh[316]

g. 24 October 2020 – death in police custody[317]

h. 15 March 2021 – suicide[318]

188 Brevet Sergeant Blackwell nominated additional fatalities which were either attended by Mr Warren and his team or in which Mr Warren's team assisted another. Those taskings comprised a death at the Whyalla speedway, a triple fatality north of Whyalla and double fatality towards Iron Knob.[319] While there were no HIRS reports lodged in relation to these additional incidents where Mr Warren was said to have assisted, I am satisfied that

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309 T631
310 Exhibit C36 at 3-4
311 Exhibit C21 at 30
312 Exhibit C21 at 40
313 Exhibit C21 at 52. I note that the HIRS does not appear to nominate Mr Warren as an involved member
314 Exhibit C21 at 71
315 Exhibit C21 at 94
316 Exhibit C21 at 111
317 Exhibit C21 at 121
318 Exhibit C21 at 134
319 This is not listed in the HIRS but Brevet Sergeant Blackwell nominates this as a fatality (Exhibit C29 at [34])

there were likely additional police taskings that Mr Warren was involved with that would have contributed to his traumatic symptoms.

189 I find that Mr Warren was exposed to a high number of traumatic events, but that this likely represents what a member of police would ordinarily be exposed to over a lengthy and distinguished career.

190 When Mr Brown-Greaves turned his mind to the confrontation event involving Sergeant Humphris, he told the Court that there may be a connection between the observations of Sergeant Humphris and PTSD. He said that PTSD can result in a heightened sense of vigilance and the desire to potentially compensate for earlier perceived failings.[320]

191 Having considered the evidence in relation to Mr Warren's transition to Roxby Downs and particularly the descriptions of Brevet Sergeant Blackwell, Mr Brown-Greaves opined that such observations were consistent with some of the criteria for a mental health condition, most likely PTSD.

192 Mr Brown-Greaves' consideration of the latter period in 2021 and the referral to Dr Cooper, was that it largely related to Mr Warren's relationship breakdown with superiors. Mr Brown-Greaves said that while there was an assessment undertaken, it was largely driven by the specific reason for the referral. Mr Brown-Greaves commended Mr Warren's supervisors for making the referral. Mr Brown-Greaves considered that the observations by superiors indicated a desire to be at work for inordinately long periods of time and that this could be related to a number of factors that may be indicative of a mental health condition.[321] However Mr Brown-Greaves conceded that he had the benefit of hindsight and that without such hindsight, he opined that Mr Warren had not elicited any responses that would have revealed a risk of mental health issues being present.[322]

193 Mr Brown-Greaves told the Court that, on balance, in his expert opinion Mr Warren suffered PTSD and that he had been managing it himself for several years prior to his death.[323] He expressed caution in that he had not personally examined Mr Warren which limited his ability to be confident in his diagnosis.

194 I find that Mr Warren was suffering from post-traumatic stress disorder at the time of his death and for some years before that. I find that the disorder was the result of exposure to various critical incidents during the performance of his duties as a member of police.

195 It is hard to determine whether there was an individual event which was the critical incident for Mr Warren, particularly when there is a history of multiple events. Mr Brown-Greaves considered that the Knowles incident may be an event that is high on Mr Warren's list of critical events and that other events may have also aggravated or contributed over time.[324] I find that the Knowles incident had a significant and enduring impact on Mr Warren. That it was a critical stressor operative at the time of his death is emphasised by the Facebook message he posted about it shortly prior to his death. I find

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320 T637
321 T645
322 T646
323 T658 and Exhibit C36 at 2
324 T657

that it was likely a combination of multiple other traumatic events together with the Knowles incident that brought about his symptoms.

196 Similarly, I accept that there would have been other stressors in Mr Warren's life, such as the breakdown of his marriage and the practical impact that this had on his time with his children. Although I note that he and his wife approached the role of co-parenting amicably. I am however satisfied that work-related PTSD played a significant role. While it is true that I did not receive any information about Mr Warren's upbringing, I am satisfied that it was the exposure to numerous deeply traumatic events that brought about his condition, rather than issues which either did not exist or that he did not discuss with anyone, even in an abstract way. I would find it astonishing if Mr Warren's PTSD was caused by some other incidents and that his traumatic work, which he was focused on in the height of his mental health crisis, was unrelated.

197 None of the members of police who dealt with Mr Warren in the course of his duties detected that he was suffering from a mental health condition. In my view, they are not to be criticised for that. None of them are trained professionals and it is only with hindsight that it can be observed by lay persons that there were signs.

Lack of engagement with the EAS generally

198 Brevet Sergeant Blackwell told the Court that he was contacted by the EAS on two occasions when he was in Whyalla. One of those contacts followed a fatal car accident. During each of the phone contacts, Brevet Sergeant Blackwell was on the way to another job and was in the vehicle with another member[325] so the timing was inappropriate.[326] He said that he did not find the service to be personally useful to him.[327] Brevet Sergeant Blackwell also said that the EAS was not widely used by team members in Whyalla during 2013 to 2015.[328] He described Whyalla as 'wild-west policing' and a 'very old-school led station'.[329] He said that Roxby Downs was not like this at all.[330] He said he had not used the EAS service for some time[331] but had heard anecdotally that it is more widely utilised now.[332]

199 Sergeant Humphris also considered that there was a reluctance by some members at the Whyalla Police Station in 2015 to engage with EAS. He thought this was possibly an indifference to the service as opposed to seeing them as a direct threat to career aspirations.[333] While he suspects that there was an attitude held by some members that EAS were detrimental to a members career, largely he considered that members were more ambivalent towards EAS and probably saw the service as not effective or worthwhile.[334] He said that he was not aware of any widespread fear within the team about the prospect of becoming non-operational following disclosures made to the

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[325] T64-T65
[326] T106
[327] T64-T65
[328] T68
[329] T108
[330] T123
[331] T108
[332] T109
[333] T161
[334] T162 and T207

EAS.[335] Sergeant Humphris' personal observations in recent years are that members are more open to engaging with EAS following a significant incident.[336]

200 Senior Sergeant Griggs told the Court that he had made multiple referrals to the EAS over the course of his career in relation to a member's mental health. He said that historically this was rarely done but had become standard practice towards the end of his career.[337]

201 Chief Inspector Gustavson has referred other members to the EAS in relation to matters including mental health concerns. In her experience, it is dependent on the individual as to whether there is a negative reaction to these referrals. She said that she understood that some members share concerns about the confidentiality of the service and the impact on their career aspirations.[338]

Mr Warren's engagement with the EAS

202 Mr Warren was contacted on the following occasions after a HIRS had been raised related to a fatal incident:

a. 30 December 2014 – a notation was made that Mr Warren was 'all good'.[339]

b. 8 January 2015 – EAS performed a face-to-face psychological *group* debrief with all members involved in Knowles incident. It was noted that Mr Warren was appropriately engaged and did not report any dominant or enduring symptoms of PTSD.[340] Since approximately 2019, psychological debriefs are no longer undertaken given it is considered an outdated practice, as established by scientific literature.[341]

c. 27 January 2015 – responded with 'no dramas'.[342]

d. 20 February 2015 – conversation with Helen Reed, assessment resulted in nil concerns.[343]

e. 28 November 2019 – advised nil issues and scene was not too bad, just busy.[344]

f. 29 April 2019 – 'all good here' in response to a check-in by a social worker.[345]

g. 20 July 2020 – phone call made to Mr Warren's supervisor Narelle Bache. She had checked in with the team and nil issues.[346]

h. 15 March 2021 – emailed regarding wellbeing following hanging/suicide (no information as to his response was recorded).[347]

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335 T208
336 T161
337 T281
338 T815
339 Exhibit C21 at 28-29
340 Exhibit C21 at 159
341 T360-T361, Exhibit C32a at [13] and Exhibit C28 at 22
342 Exhibit C21 at 51
343 Exhibit C21 at 46-47 and 67
344 Exhibit C1 at 155
345 Exhibit C21 at 75-76
346 Exhibit C21 at 154
347 Exhibit C21 at 154

i. 7 April 2021 – assessment with Dr Jane Cooper. No mental health concerns identified or disclosed by Mr Warren.

203 While Mr Warren politely engaged with EAS on those occasions in which he was either referred or contacted, he did not make any disclosures of any mental health concerns at any time.

204 Brevet Sergeant Blackwell told the Court that Mr Warren was not open to talking about his feelings or showing weakness but was happy to have conversations about the challenges of the job.[348] Brevet Sergeant Blackwell said that Mr Warren prided himself on 'thick walls and a strong shield of armour'.[349] He said that Mr Warren would never have sought counselling or any type of support in relation to his mental wellbeing.[350]

205 The evidence establishes that Mr Warren had a pattern of not openly engaging with EAS in that he was not forthcoming in his dealings with mental health professionals. This included his last engagement with EAS in April 2021.[351] To use the terminology of Mr Brown-Greaves, Mr Warren might be characterised as having 'gone through the motions' in his engagement with EAS, which is understood to be a common attitude among serving police.[352]

206 Notwithstanding that Mr Warren's close friends and some colleagues identified concerns with his behaviour over the course of time, Mr Warren never made any disclosures to the EAS despite repeated opportunities to do so when the service engaged with him.

207 While Mr Warren was aware of his symptoms, he was also aware of the prospect of a PTSD diagnosis and refused to accept this. This can be inferred through his reaction at the dinner table in Port Augusta when colleagues were discussing the topic of PTSD. It is possible that he was actively avoiding the concept of a PTSD diagnosis for fear of becoming non-operational or limiting his career, issues which Mr Brown-Greaves told the Court that he had observed in other members.[353]

208 The conversation between Sergeant Humphris and Mr Warren in mid-February 2015 makes it clear that there was an apparent understanding by Mr Warren that a suggestion of mental illness referred to the EAS might prevent future career aspirations.[354]

209 Senior Constable Hale said that he knew it would be difficult to get Mr Warren to engage with the EAS as the two did not consider there was any value in the EAS or EAP and that there was stigma towards reaching out to the EAS as you can be made non-operational as a result. Senior Constable Hale considered this was the reason behind Mr Warren's request to keep the information that he had shared confidential following their discussion of the Knowles incident in February 2022.[355] Senior Constable Hale said that members of police have a perception that what is disclosed to the EAS is not in confidence because it is 'in house'. Information might be provided to your superior which would impact

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348 Exhibit C29 at [32]
349 T68
350 Exhibit C29 at [42]
351 T662-T663
352 T665
353 T665
354 T206
355 T314-T315

promotional opportunities.[356] Senior Constable Hale maintained his concerns about the 'in house' nature of EAS and said that if he required assistance, he would be inclined to seek external support. Even with the EAP being an external support which is available, Senior Constable Hale understood that the referral needed to be initiated from within SAPOL, so his preference would still be to engage someone privately.[357]

210 The EAS are charged with undertaking assessments but not treatment. A member requiring treatment is referred to external support. The likelihood of a person reporting concerns in a mental health assessment is based on the relationship with the potential therapist. In my view, it is not surprising that some members, including Mr Warren, who are already reluctant, are less likely to disclose information in a one-off capacity with the EAS.

211 Mr Warren was a proud member of SAPOL with aspirations within the organisation. It is clear that Mr Warren perceived those aspirations to be threatened through the demonstration of vulnerability involved in seeking support. If Mr Warren had been minded to make disclosures to EAS, given it is not a treatment service, this would have necessitated involvement of the EAP (or another external provider). The EAS can compel a member to engage with the police medical officer and a psychologist in circumstances where significant risk is identified. In my view, such circumstances are likely to be at the extreme end of the spectrum and would inevitably result in a member becoming non-operational or on restricted duties.

Preventability

212 Mr Brown-Greaves opined that, on balance, Mr Warren's death was not preventable. While some who were close to him observed apparent changes in his demeanour over time or became privy to small pieces of information that might have suggested he was struggling internally, I find that Mr Warren was determined to conceal his mental health struggles.[358] Mr Warren did not seek support internally or even privately. He did not express an intention to self-harm and in fact denied these feelings when asked by a close friend and colleague.[359] I therefore find that on balance, Mr Warren's death was not preventable.

213 However, it does not follow that nothing should be done differently in future. Mr Warren's death has highlighted an appreciable gap in the psychological support for police members suffering from PTSD. Mr Warren's strong desire to keep his struggles to himself and his death should be a lesson for SAPOL in how to approach members involved in traumatic incidents in future who may mask or conceal difficulties they face. In my view, any improvements that encourage the proactive engagement of a reluctant member with mental health support have the capacity to prevent future suicide. This brings into focus the role of the EAS and the EAP, to which I now return in the context of current and future improvements.

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[356] T331
[357] T334
[358] T676 and Exhibit C36 at 9
[359] Exhibit C31, paragraphs 41, 42; T314

Improvement

214 The Select Committee on Support and Mental Health Services for Police (the Parliamentary Select Committee) tabled its report before the Legislative Council on 1 April 2025. Recommendation 2 of the report is that consideration be given to a review of the operation of EAS and associated cultural and operational issues in accordance with the findings of the Parliamentary Select Committee. Like this Inquest, such findings included that SAPOL members can be reluctant to disclose mental health issues to the EAS.[360]

215 The impetus for change might best be described through the evidence of Senior Constable Hale. He said that to open your heart and your mind and put yourself out there in a vulnerable position, you need to have trust with that mental health practitioner. You need to feel that the disclosures made are completely in confidence.[361] This is simply not the case at present.

216 During her time at SAPOL, Dr Cooper observed some members to be distrusting of the EAS and agreed that the two main concerns surrounded confidentiality and being deemed non-operational.[362]

217 In my view, the need for members to have faith in the confidentiality of the process is at the core of the issues in this Inquest and, if addressed, this in turn will encourage engagement.

218 Ms Reed told the Court that initially the procedure for referral to the externally-based EAP needed to involve the EAS but this changed during the time that she was there. This meant that members were permitted to self-refer directly to the EAP. There was apparently a recognition that not everyone wanted to call the EAS to speak about concerns, especially those which were wholly arising out of their private lives and unrelated to the work environment.[363] This is a positive initiative. It will allow members who are willing to contemplate that they are dealing with a mental health issue to seek assistance without worrying about confidentiality and career issues.

219 Senior Constable Hale said that even if Mr Warren had told him that he was struggling and on edge following their emotional conversation, he would not have sought out assistance from EAS but would have looked at other ways to help Mr Warren so that he had privacy and would not face stigma. He said he knew if he had encouraged Mr Warren to go to the EAS, it would not have happened.[364]

Restriction of duties

220 The EAS are further bound by General Order 8540 Psychological Health Management.[365] Pursuant to General Order 8540, which was operational in April 2021 and at the time of Mr Warren's assessment by Dr Cooper,[366] if EAS staff consider that the employee is suffering a medical condition that 'affects their ability to perform full duties of their

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360 Exhibit C25 at 127
361 T334
362 T478 and Exhibit C34 at [8]
363 T599
364 T316
365 Exhibit C26
366 Exhibit C35

position', the Manager of EAS may impose a condition, which can result in the employee being deemed not capable of performing the full range of duties relevant to their position.[367] Notwithstanding this, Dr Cooper told the Court that only in extreme cases of high risk would a member of police be made non-operational.[368] However, medical condition is not defined nor is there any guidance within the General Order as to the threshold for the members condition 'affecting their ability to perform full duties'.

221 Chief Inspector Stubing told the Court that a component of the level of risk that would mandate a person to have an assessment with EAS is the risk associated with carrying a firearm as part of their duty. There is also the risk associated with a person's capacity to undertake other aspects of work. If there is a concern about the risk, not only related to the carriage and access to firearms but the person's ability to contribute to a safe environment (which might be separate), then the person would be required to attend the police medical officer for a work capacity assessment. This is a doctor within EAS.[369]

222 Of note, the new SOP for EAS will also outline triage and reporting obligations.[370] This may provide a more comprehensive framework around decision-making related to members being deemed non-operational and this clarification could instil confidence in members.

223 Dr Jane Cooper told the Court that she was aware of members being made non-operational having occurred in numerous situations.[371] EAS try to reassure members of the confidentiality of the service and issues related to becoming non-operational through presentations.[372]

Recommendations

224 Chief Inspector Stubing's evidence was that SAPOL encourages employees to seek support when they feel ready rather than sole reliance on scheduled reviews.[373] Consistent with this position, Mr Brown-Greaves considered that communication in the non-mandatory context with the right structure results in a better uptake. Shared responsibility means that the employer as well as the member needs to be part of the conversation.

225 Promotion of the principles of shared responsibility is considered by a Beyond Blue study, *National Mental Health and Wellbeing Study of Police and Emergency Services*, to be fundamental to the health of any organisation.[374] The study recommended that agencies prioritise people-leadership skill development which includes the creation of psychologically safe workplaces.[375] The skillset of a good supervisor is to meet with their team members regularly, conduct wellbeing check-ins in a trusted and safe environment and to be able to provide capability development of the member. If those things are done,

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[367] Exhibit C35 at 8
[368] T479
[369] T357
[370] Exhibit C32a at [19]
[371] T479
[372] T480
[373] Exhibit C32a at [21]
[374] Exhibit C28 at 27-28
[375] Exhibit C28 at 29

it enhances the supervisor's ability to make a difference in the mental health context and the ability to connect members to mental health services.[376]

226 The ability to connect members to mental health services, including those that are external to SAPOL, is vital to organisational wellbeing. Awareness and promotion of the available mental health services outside of EAS, most significantly the EAP, will facilitate greater voluntary engagement of members with the mental health treatment that they need.

227 Mr Warren was linked with EAS on several occasions and consistently masked any issues that he was clearly experiencing. His mental wellbeing would have been better supported through an external service that could provide greater confidentiality, offer ongoing treatment, and without involvement of the EAS. Greater awareness and promotion of self-referral to the EAP as an available alternative for those in Mr Warren's position should be made. I therefore make the following recommendation to the Minister for Police:

One That SAPOL increase promotion and education to members on the EAP (and other external providers) as a confidential treatment service that members can self-refer to.

Identification and monitoring of sustained exposure to traumatic incidents

228 Upon Sergeant Humphris commencing his role as Sergeant at Whyalla, he received an incoming briefing from Senior Sergeant Murray in relation to his new team. Sergeant Humphris agreed that it was important for him to know the wellbeing of his team prior to his commencement as Sergeant in Whyalla in 2015 and he appreciated the insight provided by Senior Sergeant Murray in the handover process.[377]

229 The current framework is that if the EAS considers that there has been a significant exposure to trauma over a sustained period that warrants intervention despite a member not wanting it, the EAS navigates this to ensure a continued relationship with the member. A strategy is to engage the supervisor to ensure that the member is monitored, or to ensure that the supervisor is across this information about the exposure (particularly for a supervisor of a new team).[378]

230 Sergeant Keenan did not have any knowledge of Mr Warren's prior work history, including his involvement in the Knowles incident and several other motor vehicle fatalities. He said he would welcome information about members whom he was supervising if they had sustained post-traumatic stress disorder or mental health challenges so that he would be aware of the triggers for a particular person, as a means of protecting the person from further stressors.[379]

231 Chief Inspector Gustavson also had very little information about Mr Warren's policing history, including no knowledge of his involvement in the Knowles incident and no overview of his HIRS history. She had no knowledge of the reasoning behind Mr Warren's lateral transfer to the Northern District or the documentation that supported

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[376] T696
[377] T196
[378] T381
[379] T238

it.[380] Chief Inspector Gustavson was also not aware of the forwarding minute in relation to that transfer in which there is mention to recent workplace Diversity and Inclusion Branch intervention and referral to the EAS. This is information that Chief Inspector Gustavson said she would have wanted to know as it may have informed her decision-making in his later management.[381]

232 When Chief Inspector Gustavson was asked about the idea of a platform which identifies exposure to serious fatalities over the course of a person's policing career as something that could assist, she considered that the more information you have the better when it comes to making decisions.[382]

233 Chief Inspector Stubing told the Court that a program known as IAPro is being considered, which has the capacity to set a threshold around early warning or risk rating to a particular member based on exposure. Human effort is presently used to do that, namely the allied health professional going through recent exposure for every member in accordance with HIRS.[383]

234 In my view, an elevated system of recognising sustained exposure would have served Mr Warren better in that he was a member who did not raise concern in any individual tasking, but a global consideration of his profile may have informed a different approach and may have put his particular behaviours in a different light when assessed by a clinician or even potentially his supervisors.

235 The Parliamentary Select Committee heard evidence that the EAS was developing a psychosocial risk assessment tool to identify psychosocial risk factors of all roles across the organisation and to better identify and support high-risk work groups.[384] Inspector Mark McEachern recommended an upgraded HIRS system to link reported instances and flag multiple exposures to traumatic incidents.[385]

236 I therefore make the following <u>recommendation</u> to the Minister for Police:

Two That SAPOL develop and implement an electronic platform which captures and flags repeated exposure to potentially traumatic taskings.

The operation and utility of mandatory reviews

237 SAPOL's Local Policy 14 prescribes those members who are mandated to undertake annual psychological reviews performed by EAS.[386] Outside of those positions, employees can undertake individual reviews upon the request of their manager if they may have been or are likely to be exposed to high levels of psychological distress.[387]

238 The Parliamentary Select Committee specifically considered whether an annual psychological review is sufficient for employees in roles where there is higher

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[380] T821 and see Exhibit C21 at 232-233
[381] T822
[382] T818
[383] T387
[384] Exhibit C25 at 50-51
[385] Exhibit C20 at 39 (recommendation 7)
[386] Exhibit C27
[387] Exhibit C27 at 2

psychological demand.[388] It recommended consideration be given to the operation of Local Policy 14, which requires members in specified roles to participate in such reviews, as the evidence received by the Committee was to the effect that members can be reluctant to make disclosures of mental health issues to health practitioners within EAS. As I have observed, impact to operational capacity or future career aspirations were identified to be a barrier to engagement in such reviews.[389] The Parliamentary Select Committee also noted the absence of general duties members as part of the prescribed work groups.[390]

239 Reducing stigma as a barrier to member engagement is one focus of the EAS.[391] The Beyond Blue study found that stigma was a prevalent barrier to individuals seeking support.[392] In my view, mandatory annual reviews of a wider cohort of members may contribute to reducing the stigma. That is, if members are required to attend, they will not expect to experience the stigma they might think they will receive if they were to voluntarily attend. Once there, they are more likely to obtain assistance if they need it.

240 Brevet Sergeant Blackwell considered that SAPOL is behind in breaking the stigma and that mandatory annual assessments might be a way forward.[393] Sergeant Keenan also expressed there was merit in mandated assessment but if this was to be within SAPOL, most members would still not make disclosures for fears of becoming non-operational.[394] Sergeant Humphris told the Court that, in his experience, members are more open to accessing mental health support in recent years. He queried the benefit of forcing a one-off interaction and the prospect that it would actually identify risk factors if the member was not already open or in touch with their symptoms.[395] In my view, that is the point of an assessment by an expert who will draw out symptoms that a member might not appreciate the significance of.

241 Inspector Mark McEachern, in the Commissioner's Inquiry report into Mr Warren's death, recommended that EAS consider mandatory psychiatric reviews being provided to all operational members given their regular exposure to traumatic events. Inspector McEachern acknowledged that if implemented this would likely require engagement of external resources to support the EAS. He considered that such mandatory reviews may encourage members to disclose issues that may not occur when a review is optional and that it may remove perceived stigma.

242 It is said that these reviews, conducted in isolation, often yield limited clinical value given their structured nature. Voluntary reviews which are initiated by the employee are more likely to lead to more accurate assessment and timely intervention.[396] I agree with that. However, as I have observed, there are likely to be members who will benefit from a mandatory review and who would not otherwise have attended voluntarily. One of those members might be drawn away from a path that leads where Mr Warren's did.

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388 Exhibit C25, Terms of Reference (b) at 48-57
389 Exhibit C25 at 130
390 Exhibit C25 at 131
391 Exhibit C32a at [22]
392 Exhibit C28 at 20
393 T67-T68 and Exhibit C29 at [109]
394 T240 and T244
395 T208
396 Exhibit C32a at [20] and T393

243 Chief Inspector Stubing raised challenges in a suggested framework for mandatory review which involved any external psychological provider. SAPOL employees now have a greater range of options of supports available through the EAP. He considered that the external provider still has obligations surrounding risk in the context of access and use of a firearms and the need to report to the Firearms Registrar (which in turn will notify EAS) if a risk is identified. In such case, the outcome would be the same in that the member's duties would be restricted by EAS.

244 In his evidence, Chief Inspector Stubing considered a mandatory review framework for members to have some merit in that it would alleviate confidentiality issues and potentially also reduce stigma. He further supported members who are reluctant to engage to be able to undertake their mandatory reviews with the EAP or a community provider. His concern was the volume of transactional interactions between finite health resources in the community and SAPOL, and that strong monitoring and evaluation processes would need to be in place to ensure that mandatory obligations are met.[397]

245 Mr Brown-Greaves took the view that forming a relationship with a therapist is important and increases the likelihood of a person making disclosures. He said that he struggles with the concept of mandatory reviews for this reason. He identified that specific groups prescribed by SAPOL as at higher risk often leaves out general duties members, who arguably have the greatest amount of exposure.[398]

246 Mr Brown-Greaves preferred a needs-based system which shifts the review process from perceived high-risk environments to a system that is about a person who is presenting with the need for support. He conceded that this places a burden on superiors who are charged with overseeing their team, but he thought not an unachievable one.[399] Chief Inspector Stubing told the Court of the value in shared responsibility, which includes making sure that supervisors are more capable and confident to have conversations with members around mental health and checking in more generally.[400]

247 Mr Brown-Greaves made a strong argument for the needs-based system. While still operating within the confines of a needs-based approach involving shared responsibility, in my view, a framework which can identify those members at risk (in accordance with recommendation two) and mandate their participation in a review by an external provider will encourage earlier identification and better uptake.

248 Making the process mandatory may also encourage those who might be willing to engage but are hesitant to take the first step.

249 Further, I consider that a cultural change to the attitudes of those within the organisation is required. SAPOL's leadership may wish to engage with EAS services themselves and publicise their engagement as a step towards reducing stigma. To embed cultural change, an introduction of mandatory reviews will, over the course of some years, make the use of EAS and EAP completely unremarkable. In my view, this will naturally lead to an

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397 T466-T467
398 T671
399 T673
400 T408

uptake in the use of the services when needed by future members. I therefore make the following recommendation to the Minister for Police:

Three That SAPOL implement mandatory psychological or psychiatric reviews (through EAP or another external provider) for those members that the platform identifies to reach a threshold level of traumatic exposure (as per recommendation two).

250 I am satisfied that an external agency should conduct this work. That is not to suggest that the EAS does not have its usual functions within SAPOL nor that the external agency is not bound by its usual code of mandatory reporting. This recommendation focuses on capturing those individuals that the system has identified as being at higher risk of PTSD, who may not appreciate their own symptoms and/or be unlikely to open up in an internal setting.

Collateral Information from family

251 Insofar as psychological testing for any mandated review, notwithstanding DASS-21 is a widely used screening tool, it has high face validity and is easy to respond in a way that suits the person's intention. This is precisely what Mr Warren did. Mr Brown-Greaves considered it an important tool where the stakes are not related to job or career.[401] There are no other tools that deal with the face validity issue. He considered it was appropriate to use if the practitioner is aware of the limitations. Other tools, including the Personality Assessment Inventory (PAI) and NEO might also be appropriate, although are more resource intense.[402] The clinical interview remains the crucial means by which the member can be assessed. This involves challenging the member on any collateral information which is inconsistent with how the member is presenting. EAS clinicians will, no doubt, read these findings and be alive to that issue.

252 I received submissions that encouraged me to recommend that family members be included in the mandatory review process or otherwise undergo mandatory reviews themselves. Submissions made on behalf of Mrs Warren outlined that one of the most concerning aspects of the engagement with EAS was the absence of any challenge to Mr Warren's self-reports to EAS when there was collateral information which contradicted his account. The submissions cited the evidence of Dr Brown-Greaves who explained that challenging a person's self-report with contradictory collateral information was an expected part of an assessment, and this was able to be done whilst maintaining trust and rapport with the patient.[403]

253 The importance of collateral information in a mental health setting cannot be overstated. This Court has made many recommendations in the context of mental health related deaths to that end. In my view, any mandatory review should include input from a partner or the next of kin of the member but only with the consent of the member. The focus of the mandatory review is for a therapeutic outcome with ongoing psychological or psychiatric support if needed. If family members are mandated to participate, this setting could be at risk. I therefore make the following recommendation to the Minister for Police:

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401 T664
402 T690
403 Transcript, page 690

Four That as part of the mandatory review, the member's consent be sought for the clinician to speak to a close family member to obtain their perspective, which will assist in identifying signs or symptoms of mental health issues.

Condolences

254 Mr Warren served the community with distinction. He was repeatedly exposed to traumatic events because he was a talented member of police. He left behind a young family. He will clearly be missed. I express my condolences to his family and to all those who cared for him.

Keywords: *SAPOL; PTSD; Mental Health*