QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of FSGT**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Townsville
FILE NO:	2023/1254
DELIVERED ON:	11 February 2026
DELIVERED AT:	Brisbane
HEARING DATES:	Pre-Inquest Conference 28 February 2024 Inquest 24 June 2024 to 27 June 2024 Written submissions following inquest October 2024 – February 2025
FINDINGS OF:	Deputy State Coroner S Gallagher
CATCHWORDS:	Coroners: inquest, death in police operations, Australian Defence Force, veteran, Royal Australian Air Force, permanent member, mental health, royal commission into defence and veteran suicide, suicide, suicidality, weapons, weapons licencing, domestic and family violence, medical employment category, restrictions, senior non-commissioned officer

REPRESENTATION:

Counsel Assisting:	J Pietzner-Hagan
Commonwealth of Australia (Department of Defence):	M Rawlings instructed by B Keenan, Sparke Helmore Lawyers
Queensland Commissioner of Police:	M Nicolson, instructed by A Marszalek, QPS Legal
Queensland Police Service Officers Senior Sergeant M Lyons, Detective Sergeant A Flanders, Senior Sergeant D Tamblyn, Sergeant K Drury, Constable T Shaw and Constable C Harland:	J Greggery KC instructed by C Gnech, E Baulch, Gnech & Associates
Dr Anand Gundabawady:	R Nattrass instructed by R Crozier, Barry Nilsson Lawyers
Dr Philippa Waterworth:	P Noble, Serco
Dr Daniel Gwynne:	A Cappellano instructed by BUPA

ORDERS:

1. Non-Publication order 2023/1254 made 28 February 2024

2. Non-Publication order 2023/1254 made 24 June 2024

3. Non-Publication order 2023/1254 made 25 June 2024

Contents

Introduction

[1] FSGT was a full-time serving Australian Defence Force (ADF) member[1] at the time of his death. Aged 50 years, he enlisted in the Royal Australian Air Force (RAAF) on 27 August 1991, at age 19, and served 31 years and six months.[2] He is a Veteran as defined by the Australian Institute of Health and Welfare (AIHW).[3]

[2] As submitted by counsel assisting, I acknowledge the unique nature of military service for both the serving member and the family unit. FSGT's family provided valuable insight into the person he was. He is 'remembered as a husband, father, brother, son, uncle, and mate'.

[3] FSGT's Dad, shared details of his son's life, from his birth to his career in the RAAF, his interests in hunting and target shooting, and love of nature. His dad expressed the family's deep appreciation for the compassion and support offered to them:

> *'May I express the family's deep appreciation for the compassion and support of the Queensland and New South Wales Police, the counsel assisting this inquest, and the ongoing support for FSGT's family by the ADF. We are eternally grateful that despite FSGT's condition and the influence of medications and alcohol, that no Queensland Police Officers, nor members of the public were injured or killed in this very sad series of events. We can only hope, through the actions of this court, FSGT's death will bring a positive outcome. And thank the court and all the participants for their input.'*[4]

[4] FSGT's Dad, described FSGT as a great mate and son, always willing to help on the family sheep property. He recalled stories of bogged tractors and described the man FSGT grew to be:

> *'Later, in working life, FSGT was a perfectionist at everything he tackled, probably thanks to his earlier mistakes. We were very proud of FSGT, his great sense of humour, practical jokes, both giving and receiving, and his wicked chuckle. Out of the pain now, mate. Enjoy the afterlife, but we miss you greatly. Dad.'*[5]

[5] FSGT's Sister, described FSGT as her first companion and friend, her constant. She described fond memories of a shared childhood and FSGT's love for his children:

> *'He loved being a dad. He was very proud of his boys, as well as a great uncle to my son. I miss him, and it is very sad he will not*

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[1] SERCAT 7. ADF members are rendering full-time service in the Permanent Forces. SERCAT 7 represents the maximum service obligation.
[2] Exhibit I1 at [7] – [8].
[3] '*A person who is serving or has served at least one day in the ADF since 1 January 1985 and includes both permanent and reserve members.'* Exhibit G1 at [4.2.1]. *Defence Act* 1903 (Cth) s 23 Service in the ***Permanent Forces*** and s 24 Service in the ***Reserves***.
[4] 27 June 2024, T1-2, LL17-49, T1-3, LL 1-22.
[5] 27 June 2024, T1-5, LL 28-49, T1-6, LL 1-2.

be living on to watch his children grow and experience more … in this lifetime. I take comfort to know he is looking after us from afar. I wish to thank you all that has supported the entire family."[6]

[6] FSGT's Sister, described her fond memories of, and adoration for her big brother. She described the effect of FSGT's absence:

'It is really hard to live life in a world without my big bro. As you would expect, the loss of FSGT has had a profound effect on not only us, his family, but also those who worked with him as colleagues and mates, those who worked with him as part of his health and treatment team, the cops and counterparts whose job was to deal with the tragic situation on the night, and those that had to deal with the aftermath and pick up the pieces. I know FSGT touched you, and it has been hard for you, also. I thank you for the care, compassion, dignity and thoroughness you have shown, and continue to show, for FSGT in the process to help others."[7]

[7] FSGT's Sister, described the wonderful impact FSGT had on all those who knew him:

'I am thankful for the life of FSGT lived and the wonderful impact he had on those he came into contact with. I'm also thankful for FSGT's care team. We have been able to hear this week how a team of people helped FSGT through some very dark times. We now know that FSGT also had an impact on your lives. You laughed with him, understood him, and could see the man he was. We are glad you got to know our brother, and we are sorry for your loss. We encourage you to continue to support and help other serving members like FSGT. We hope the findings of this inquest assist you in preventing such a devastating loss for other families."[8]

[8] FSGT's Wife, and their two sons described FSGT as a man of great integrity whose love and commitment to them was second to none, a selfless man who put family first in everything he did: [9]

'Our hearts are so very heavy and broken, knowing that you are no longer here to continue on this journey called life with us. The memories made, the laughs had, are what keep us moving forward to eventually making new ones in your honour. I guess when I think about it, you are here every day, as I see you in our boys, their mannerisms, their strength, their courage, kindness, and amazingly cheeky sense of humour, which was one of the many traits that I loved about you… we love you and miss you more than words can ever say."[10]

[6] 27 June 2024, T1-4, LL 46-49, T1-5, LL 1-24.
[7] 27 June 2024, T1-3, LL 40-48, T1-4, LL 1-22.
[8] 27 June 2024, T1-4, LL 27-44.
[9] 27 June 2024, T1-6, LL 14 -31.
[10] 27 June 2024, T1-6, LL 14-31.

[9] Finally, FSGT's Mum, described her son's love of Australian wildlife and the bush noting that she would miss sharing photos of the bugs and butterflies they would see.[11] She described her son as strong, handsome, reliable, honest, trustworthy to a fault, and a gentle man who was proud of his achievements in the RAAF:

> *'As his mum I could not have asked for a better son. I am proud to have had him in my life for the 50 years, 11 months, and 12 days. I understand my son's deep sadness, his despair, and the feeling of being humiliated. I understand the decision to take his own life in those moments of worthlessness, and I will never condemn him for the way he chose to end his life. FSGT was broken. I love you, my dear son, FSGT, with all my being. Rest easy now, my boy.'*[12]

[10] I offer my condolences to FSGT's family and friends, his RAAF colleagues, and his medical practitioners, some of whom were Veterans themselves.

Coronial investigation

[11] FSGT's death was a reportable death, pursuant to s 8(3)(h) of the *Coroners Act 2003* (Qld) (the Coroners Act) as it happened in the course of police operations.[13] For such deaths, the Coroners Act presumes an inquest will be held unless the coroner is satisfied the circumstances of the death do not warrant an inquest. FSGT's death is also a violent or otherwise unnatural death in accordance with s 8(3)(b) of the Coroners Act.

[12] An investigation into the circumstances of the death was conducted by Detective Senior Sergeant (DSS) Alastair Hope of the Queensland Police Service (QPS) Internal Investigations Group (IIG), Ethical Standards Command (ESC). DSS Hope provided a comprehensive report[14] and gave evidence at the Inquest. His investigation included evidence from FSGT's family, his military colleagues, and QPS officers.

[13] I was also assisted by the Inquiry Report of the Inspector-General of the Australian Defence Force (IGADF), Directorate of Select Incident Review (SIR)[15] that considered the circumstances of the death, ADF management of suicide risk factors, ADF policies and practices, and family support and contact.

[14] FSGT 's military records (Medical and Personnel file), and the relevant sections of the Defence Health Manual (DHM), Military Personnel Policy Manual (MILPERSMAN) and Commanders and Managers Guide to Responding to Domestic and Family Violence (DFV) were obtained. The Queensland Centre for Mental Health Research

[11] 27 June 2024, T1-6, LL 35-49, T1-7, LL 1-20.
[12] 27 June 2024, T1-6, LL 35-49, T1-7, LL 1-20.
[13] Exhibit B1, 1.
[14] Exhibit B1.
[15] Exhibit I1.

(QCMHR) Report entitled: *Understanding and enhancing responses to suicide crises involving current serving and ex-serving members of the ADF: A data linkage study* was also obtained.

[15] Dr Andrew Khoo, Consultant Psychiatrist, Toowong Specialist Clinic, provided an expert psychiatric report.[16] Dr Khoo attained his fellowship from the Royal Australian and New Zealand College of Psychiatrists (RANZCP) in 2002 and received a college medal for his final year thesis on Post Traumatic Stress Disorder (PTSD). Dr Khoo is the Deputy Chair of the RANZCP Committee for the Military, Veteran's and Emergency Services Personnel Mental Health Network, Chair of the Open Arms National Advisory Committee, a member of the Department of Veterans Affairs (DVA) Mental Health Expert Advisory Group, the Principle Psychiatric Advisor to the Gallipoli Medical Research Foundation (GMRF) and a member of the GMRF Research Advisory Committee. He has worked for the last 24 years in the Group Therapy Day Programs at the Toowong Private Hospital where he has provided mental health treatment and care to numerous First Responders and Military Personnel.

Autopsy results

[16] On 16 March 2023, Forensic Pathologist, Dr Rebecca Williams, conducted an external and internal examination of the body. Postmortem computed tomography (PMCT) scans were obtained. Notably, examination of the head confirmed the presence of a gunshot entry wound, located within thick facial hair, in the undersurface of the chin. The wound coursed in an upward direction. Centrally, the edges were blackened and there was no abrasion rim, powder tattooing or muzzle impression.[17]

[17] Consultant Radiologist, Dr Trevor Watkins, interpreted the PMCT scans He opined the entry wound was beneath the chin, near the midline and the passage of projectiles and resultant injuries was recorded as:

> *'Trajectory: Inferior to superior; coronal plane to angled slightly posterior; slight right to left.*
>
> *Structures traversed: Skin and subcutaneous soft tissues of the chin; floor of mouth and oral cavity structure; hard palate and paranasal sinuses including the sphenoid sinus and medial left orbit; anterior cranial fossa, left frontal lobe; left frontal bone (with a reflected bony fragment where there is a semicircular bony defect and external bevelling); frontal scalp. Fragmentation of the projectile likely with additional bony and soft tissue injury. Multiple projectile fragments along the wound track and in the anterior cranial compartment.*
>
> *Exit wound: Superior left frontal scalp.*

[16] Commissioned by the Coroners Court of Queensland.
[17] Exhibit A5.

> *…*
> *Extensive facial bone fracturing related to GSW.[18] Comminuted mandibular fractures near the gunshot entry wound. Craniofacial fractures radiate from the GSW track into the right anterior cranial fossa and through the skull base.*
> *…*
> *Pneumocephalus and small volume subarachnoid haemorrhage.*
> *…*
> *Disruption of the soft tissues of the neck related to the GSW.*
> *…*
> *Fracture through the anterior aspect of the right greater horn of the hyoid bone.'[19]*

[18] Toxicological analysis of a post-mortem sample of femoral blood confirmed the presence of Alcohol (124mg/100mL) equivalent to a blood alcohol reading of 0.124%. Alcohol was also detected in a post-mortem sample of urine at a concentration of 191mg/100mL (0.191%).[20]

[19] Prescription drugs (anti-depressant medication) were also identified, namely Amitriptyline (0.04 mg/L – at a concentration within the usual therapeutic range); Nortriptyline (0.02mg/L – present at a low level); and Duloxetine (0.03mg/L – present at a concentration within the usual therapeutic range).[21]

[20] Dr Williams opined that there was a contact gunshot entry wound, in the under-surface of the chin, with an exit wound in the top of the head and associated catastrophic injury to the facial structures and brain.[22] Dr Williams determined the cause of death to be 1(a) gunshot wound to the head.[23]

[21] I accept the opinion of Dr Williams and Dr Watkins.

Inquest

[22] On 28 February 2024, a Pre-Inquest Conference (PIC) was convened. Written submissions were received in respect of the proposed issues for inquest and witness list.

[23] The Inquest was held in Townsville from 24 - 27 June 2024. The brief of evidence was tendered without objection at the commencement of proceedings. FSGT's family attended the Inquest and participated with

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[18] Gunshot wound.
[19] Exhibit A5, 7-8.
[20] Exhibit A5, 11. Exhibit A6, 1.
[21] Exhibit A5, 9 and 11. Exhibit A6, 1.
[22] Exhibit A5, 9.
[23] Exhibit A5, 9. *Coroners Act 2003* (Qld) s 45(2)(e) what caused the person to die. *'This subsection focuses on the medical cause(s) of death, not the legal responsibility for it, or the circumstances in which it occurred. To that extent it is quite different from the issue of causation that frequently tests judges and magistrates presiding over criminal or civil matters. The so-called chain of causation involves matters that should be dealt with in findings made under s 45(2)(b) How the person died. It is in that section of the findings that the external factors that led to the medical cause of death are also to be described'.* See State Coroner's Guidelines Chapter 8, section 8.6.

dignity. Following the Inquest, written submissions were received between October 2024 and February 2025.

[24] In accordance with section 45(5) of the Coroners Act, a coroner must not include in findings, statements that a person is or may be guilty of an offence or may be civilly liable for something. The focus of the coronial jurisdiction is on determining what happened, not on ascribing guilt, attributing blame to any person or party, or apportioning liability. The relevant standard of proof is that of the balance of probabilities, with reference to the *Briginshaw*[24] standard. The more significant the issue for determination, the clearer and more persuasive the evidence must be for a coroner to be sufficiently satisfied on the balance of probabilities that an issue has been proven.

[25] In adjudicating the significance of the evidence before the court, the impact of hindsight bias and affected bias must also be considered:

> *Hindsight bias is 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…It is an obvious point, but one that nonetheless bears repeating, particularly when coroners are considering assigning blame or making adverse comments that may damage a person's reputation…*
> *…*
> *Coroners should attempt first to understand the circumstances as they appeared at the relevant time to the people who were there.*
> *…*
> *Hindsight, of course, is a very useful tool for learning lessons from an unfortunate event. It is not useful for understanding how the involved people comprehended the situation as it developed. This distinction needs to be understood and rigorously applied.*[25]

[26] I am satisfied that there is sufficient evidence before me to make the findings required by section 45 of the Coroners Act.

Issues for inquest

[27] Following consultation the issues for inquest were settled as:

1. The findings required by section 45(2) of the Coroners Act; namely the identity of the deceased, when, where, and how he died and what caused his death; and

2. Consideration of the circumstances leading up to the death including:

<u>Mental health, treatment and care, suicidality</u>

[24] *Briginshaw v Briginshaw* (1938) 60 CLR 336.
[25] The Australasian Coroners Manual. Hugh Dillon and Marie Hadley, Federation Press, 2015, 10.

a. FSGT ’s mental health condition/s, and the appropriate treatment for him, including whether in all the circumstances there was an appropriate assessment of FSGT ’s suicide risk.

b. Whether FSGT had access to such treatment and absent his consent, could he be compelled to undergo such treatment?

c. In all the circumstances, was the treatment afforded to FSGT, for his condition/s appropriate?

d. Whether there was any failure to provide appropriate care that caused or hastened the death?

e. Whether any aspect of the care actually provided, caused or hastened the death?

Weapons licencing and information sharing

f. What notification, if any, did the ADF provide to the QPS in relation to FSGT’s medical restrictions concerning weapons, and what effect, if any, would this have had on his ability to retain the firearms for which he was licensed?

g. If notification was given to QPS, what action, if any, did QPS take?

Domestic and Family Violence

h. Were any disclosures relating to potential Domestic and Family Violence (DFV) in the home made to the ADF by FSGT or his wife?

i. If so, what supports or referrals, if any, were offered by the ADF?

j. If FSGT were to have become subject to a DFV order naming him as the Respondent, what, if any effect would this have had on his employment in the ADF and his ability to hold (civil) weapons licences?

3. Whether the QPS officers involved acted in accordance with the QPS policies and procedures then in force, and whether said actions were appropriate.

4. Whether any changes to procedures or policies could reduce the likelihood of death occurring in similar circumstances or

otherwise contribute to public health and safety or the administration of justice.

Witnesses called

[28] During the Inquest, oral evidence was taken from the following witnesses:

a. Detective Sergeant Alistair Hope, QPS IIG, ESC;

b. Dr Daniel Gwynne, General Practitioner (GP) and Medical Officer (MO);

c. Dr Phillipa Waterworth, Psychologist - Mental Health Professional (MHP);[26]

d. Dr Anand Gundabawady, Psychiatrist - MHP;

e. Squadron Leader (SQNLDR);

f. Dr Andrew Khoo, Consultant Psychiatrist - MHP;

g. Dr Darrell Duncan, Director of Strategic Clinical Assurance and Ethics in Joint Health Command (JHC);

h. Inspector Cameron Barwick, Operations Support Command, QPS Weapons Licensing Group; and

i. Sergeant Kirsty Sutherland, QPS Scientific Officer.

[29] Three non-publication orders remain in force.

Evidence and findings on issues

[30] I accept the circumstances surrounding FSGT's death as established in the report of DSS Hope[27] and detailed in the submissions of counsel assisting. As FSGT was rendering full time service in the RAAF prior to his death, information about his employment was obtained, to understand what, if any stressors may be relevant to the circumstances surrounding the death. The Inquest heard evidence from SQNLDR regarding FSGT 's time in Townsville since posting into the unit at the beginning of 2022 and noted the following:

a. FSGT posted (on promotion) to Townsville at the beginning of 2022.

b. This posting had a lot of pride attached to it and a new level of responsibility.

[26] This is a term used in the ADF policies.
[27] Exhibit B1, 3 – 6.

c. FSGT was proud of his history in the RAAF and had achieved a good deal of work before he arrived.

d. Unfortunately he injured himself soon after posting in and required a significant time away from work to recover.

e. Due to the serious nature of his injuries, FSGT experienced some issued in his confidence and his ability to fulfil the expectations of his role.

f. There had also been stress on the family unit around the posting to Townsville, as while they owned a home in the location, it had been rented out and they were forced to find alternate accommodation until their own home was available.[28]

[31] On 12 March 2023, FSGT and his wife attended the Northshore Tavern in Townsville. They consumed alcohol and watched the Tim Tszyu boxing match. The couple argued about his behaviour at the Tavern, which his wife described as "too boisterous." In the afternoon they returned to the family home (the incident address) and FSGT prepared dinner for the family.

[32] At 6:57pm FSGT sent a text message[29] to his close friend Mr Simon Rockliffe ('Rocky')[30] describing his afternoon. Over several text messages, FSGT acknowledged what a great friend Rocky was to him, and the difficulties FSGT was having with his family and marital relationship. At 7:16pm they exchanged the following text messages:

a. Rocky: *'Families are important mate & I know how proud you are of your boys. I feel for you being in this situation mate.'*

b. FSGT: *'Thanks* [emoji smiley face].'

c. Rocky: *'See ya tomorrow & if you want a private chat I'm always willing to listen, can't say my advice is always good but I listen* [emoji thumbs up].'

d. FSGT: *'Thanks again* [emoji sad face].'

[33] At 7:21pm, FSGT sent his last text message to his friend Rocky.[31] When dinner was ready, the couples two sons (aged 14 and 15 years), were called to the dinner table however, one continued playing video games. FSGT argued with his family, and it is alleged that he pushed their eldest son during a verbal argument, an act that was considered by his wife to be out of character for FSGT.

[28] Exhibit H16.
[29] Screen shots of the text messages were provided by Mr Simon Rockliffe to Police.
[30] Mr Simon Rockliffe has provided a statement.
[31] Exhibit B1.51. At 8:58pm, Rocky tried to text FSGT asking if he was ok, as he had seen information on Facebook about a siege in the area. FSGT did not respond.

[34] At 7:53pm FSGT's wife dialled Triple 000 and requested police assistance. She told the call taker that FSGT was a little bit drunk, he had pushed their 15-year-old son, she was very scared and needed someone to come and help. The call taker asked if FSGT had any weapons with him or if there were any domestic violence orders in place. FSGT's wife answered *'no'* to both questions.[32] The police communications log noted: *'a loud disturbance between 2 males heard in the background of the call. No weapons. No orders.'* The job was listed as a DFV incident and assigned a priority two code.

[35] FSGT told his wife that if police came, he would lose his job and he would be taken away from the family. FSGT called his friend Rocky and told him that his wife had called the cops on him because he stood up to their eldest son and that they had been arguing. Rocky asked FSGT if he hurt his son and FSGT denied such behaviour. As Rocky had been consuming alcohol, he offered to collect FSGT in an hour or so when he was able to drive. FSGT declined the offer saying he would wait for the police and that Rocky could collect him from the house, or from the "cop shop, wherever he ended up." Before the call ended, Rocky recalled that FSGT's son said something to his father and FSGT responded: *'what? I've lost you too?.'*[33]

[36] At 8:11pm FSGT's wife dialled Triple 000 for the second time. She requested police assistance as soon as possible and told the call taker that FSGT had locked himself in a room that had guns in it and that she needed someone there now. The call taker asked why FSGT might have locked himself in that room? FSGT's wife told the call taker it was because they had just had a fight, he was drinking, she had called the police on him, and he was very upset. She told the call taker that she had left the house and walked around the block with their two sons. FSGT's wife cried and pleaded for help to keep her husband safe. The call taker asked about the type of guns FSGT had. FSGT's wife was unsure, but thought they were rifles that he used for target practice. Due to the new information provided, the call taker upgraded the call for assistance to a lights and sirens job and told FSGT's wife not to approach the house until police arrived.[34]

[37] The call dropped out and FSGT's wife immediately called Triple 000 for the third time. She told the call taker that FSGT was *'mortified'* that she had called Triple 000, and that he *'sort of lost it because this has never happened before.'* She told the call taker that she was just really scared as a mother and that because FSGT had gone through depression she was extra scared. FSGT had never done anything like this before and that was why she was so stressed. She was fearful that she would return home and find that her husband had killed himself. She told the call taker that her husband had not threatened to kill himself however,

[32] Exhibit H1. Exhibit H1.1.
[33] Exhibit B1.50.
[34] Exhibit H2. Exhibit H2.1.

he had said: *'fuck you all, I have had enough'* before locking himself in the spare room that contained a safe and guns. She told the call taker that all the guns were registered, provided FSGT's mobile phone number and stated that he was in the RAAF in communications. She told the call taker that FSGT had been suffering depression and having a hard time, he had taken a lot of time to recover from some broken bones and she had never seen him like this before, it was very out of character, and she was regretful as she believed that this potentially made him realise how badly he had been behaving. She was very scared that FSGT would shoot himself in the room. The call taker repeatedly reassured FSGT's wife that police were on their way and that as a mother she had done the right thing by removing herself and their children from the family home given the circumstances.[35]

[38] A QPRIME[36] check confirmed that FSGT had one Category A[37] .22 bolt-action rimfire rifle and two Category B[38] centre-fire rifles registered in his name.

QPS Response

[39] QPS officers, Constable Cooper Harland and Constable Tenille Shaw from the Kirwan Police Station were the first to respond to the call for service, tasked with observing the incident address from the front. On approach to the incident location, QPS officers were aware that FSGT was a registered weapons (firearms) holder.

[40] Constable Harland and Constable Shaw parked their QPS vehicle a short distance from the incident address and proceeded on foot, on the opposite side of the street, under the cover of darkness and trees. This allowed them the opportunity to observe the incident address from a safe position and confirm whether FSGT could be sighted. The incident address was a four-bedroom dwelling with a driveway leading to a garage. The front yard was unfenced and there were 6-foot side return fences enclosing the rear yard. There were three vehicles in the driveway.[39] Constable Shaw and Constable Harland activated their body worn cameras and used their police radio to update police communications. Constable Shaw reported that FSGT was attempting to get into the driver's side of the white utility parked in the driveway.

[41] Due to concerns about FSGT's behaviour and his access to firearms, QPS officers from the Townsville Tactical Crime Squad (TTCS) provided support to the first response officers. As TTCS officers drove past, Constable Harland and Constable Shaw ran alongside the TTCS vehicle, using the vehicle as moving cover. Constable Shaw shone a torch towards FSGT and her body worn camera footage recorded her

[35] Exhibit H3. Exhibit H3.1.
[36] Queensland Police Records and Information Exchange Database.
[37] Rimfire rifles, double- or single-barrel shotguns, paintball guns, air rifles and powerheads.
[38] Centre-fire rifles (other than semi-automatic), shotgun/rifle combinations. Lever action shotguns with a magazine capacity of no more than five rounds.
[39] Exhibit B1.53.

identification of FSGT standing at the front of the incident address, in possession of a longarm weapon (firearm). Constable Shaw radioed police communications: *'He's got a gun! 349 he has a gun! ... 349 it looked like a large rifle style weapon.'*[40]

[42] At 8:49pm FSGT discharged the firearm while standing at the front of the incident address. Constable Shaw radioed: *'349 he's shooting, he's actively shooting… 349 I've pulled my glock.'* Constable Shaw and Constable Harland were forced to seek protective cover and knocked on the door of a nearby house where the residents of the home permitted entry.[41]

[43] QPS traffic officer, Senior Constable Nathaniel Heyboer drove by the incident address and FSGT shot at the QPS vehicle. Due to the damage caused, Senior Constable Heyboer abandoned the vehicle and tactically withdrew to another location. FSGT continued to discharge the firearm. The residents of the home directly opposite the incident address, turned on an exterior light at the front of the property to see what was occurring, as they had heard gunshots. FSGT discharged the firearm, causing damage to the front of the property. This caused the residents inside to evacuate to the rear of their home for safety. Moments later, QPS Dog Squad Officer, Senior Constable David Sloan attended the incident address. FSGT shot at the QPS vehicle driven by Senior Constable Sloan who was forced to abandon the vehicle and tactically withdraw to safety. FSGT continued to discharge the firearm, from the driveway of the incident address. He shot at and deflated the tyres of QPS vehicles, parked nearby.

[44] A Toyota Hilux with two members of the public in it drove past the incident address. FSGT shot at and deflated the front driver's side tyre. The driver immediately drove to the Avenues Tavern, where he identified several QPS officers who had established a Forward Command Post. The driver informed QPS officers that his vehicle had been shot at. QPS officers established and maintained a cordon to contain FSGT within a known perimeter. Senior Constable William Pittaway and Constable Luke Willetts approached the incident address via Aird Avenue to assist in the cordon and identified what they believed to be gunshots fired in their direction by FSGT, which forced them to seek protective cover.

[45] At 9:01pm, the QPS made an Emergency Declaration under the *Public Safety Preservation Act 1986* (Qld) (the PSPA).[42] An extended cordon was enacted by QPS officers and a QPS drone was deployed to

[40] Exhibit B1.32. Approximately 20:49:00.
[41] Exhibit B1.32.
[42] See section 5 of the *Public Safety Preservation Act 1986* (Qld). *Emergency situation means (e) any incident involving a bomb or other explosive or a firearm or other weapon, that causes or may cause a danger of death, injury or distress to any person, a loss of or damage to any property* or pollution of the environment, and includes a situation arising from any report in respect of any of the matters referred to in paragraphs (a) to (g) that if proved to be correct would cause or may cause a danger of death, injury or distress to any person, a loss of or damage to any property or pollution of the environment.

maintain situational awareness. Residents inside the exclusion zone were urged to stay inside their homes and lock their doors.

[46] At an unknown time, FSGT moved back inside the incident address. The last gunshots were heard at approximately 9:15pm. QPS officers maintained a cordon of the area pending the arrival of the QPS Special Emergency Response Team (SERT). QPS negotiators were deployed in an effort to resolve the situation peacefully. Senior Sergeant Matt Lyons was the primary negotiator and made several attempts to establish contact with FSGT however, these were unsuccessful. The observations of Senior Sergeant Lyons, a highly experienced QPS negotiator, regarding his assessment of FSGT as a Veteran and the possibilities of what had occurred for FSGT that evening, giving rise to FSGT's behaviours were noteworthy. Every effort was made to establish contact with FSGT to encourage him to surrender. This included recorded messages from his wife and children.[43]

[47] On 13 March 2023 at 1:30am, SERT operatives arrived at the incident address. At 6:13am, Dr Daniel Gwynne, FSGT's GP and MO received a text message from SQNLDR seeking details of FSGT's medications and any recent changes. Dr Gwynne eventually spoke directly with the QPS negotiator and members of the Queensland Ambulance Service (QAS). Dr Gwynne disclosed FSGT's mental health diagnosis, current medications and that FSGT had access to personal firearms as he had formed the view that it was appropriate in the circumstances to make such a disclosure.[44]

[48] At 6:30am, SERT operatives breached the incident address and found FSGT deceased in the kitchen. The SERT operatives observed that the deceased was face down on the floor and a firearm was cradled in the left hand, under the body. The body was clothed in a singlet, shorts, and thongs. SERT operatives observed a gunshot entry wound under the chin and an exit wound in the top of the skull. Biological matter was spread on the adjacent walls and ceiling and a large pool of blood had formed around the head and upper body of the deceased. SERT operatives formed the view that what they observed was consistent with a self-inflicted gunshot wound. At 6:57am, a life extinct form was issued by QAS paramedic, Roger Thomson.[45]

[49] The PSPA Emergency Declaration was subsequently revoked, and a crime scene declared at the incident address, and surrounding streets, due to known damage caused by projectiles fired. Several other crime scenes were declared in respect of vehicles that had sustained damage when passing the incident address. QPS Scientific Officers and Investigators were deployed, and an investigative search of the local area was conducted. In addition to the QPS vehicles damaged, QPS officers observed projectile damage to civilian homes and vehicles.

[43] Exhibit B1.19.
[44] Exhibit D4 at [131] – [132]. The legislation relevant to such a disclosure is discussed in detail below.
[45] Exhibit A2.

Forensic examination of the scene

[50] QPS Scientific Officer, Sergeant (SGT) Kirsty Sutherland[46] forensically examined the incident address and surrounding areas (the scene). This included an examination of the body of the deceased, in location. SGT Sutherland collected samples, each labelled with a unique forensic exhibit number, and took photographs.[47] SGT Sutherland experienced some difficulty in the examination as some of the vehicles fired upon by FSGT, were moving at the time, or were parked in different locations to that in which they had sustained projectile damage. In total, FSGT shot at three houses, four QPS vehicles and two civilian vehicles. SGT Sutherland located a total of 34 spent cartridge cases and eight (8) shot gun shells in the driveway and front yard of the incident address. One unspent shotgun shell was found in the grass on the southern side of the driveway. Subsequent examination confirmed that there were four different types of spent cartridge cases:

a. Thirteen (13) x .22 cartridge cases;

b. Five (5) x .22-250 cartridge cases;

c. Eight (8) x .300 cartridge cases; and

d. Eight (8) x shotgun shells.[48]

[51] SGT Sutherland's evidence at the Inquest was that the majority of the damage caused by FSGT to vehicles, was primarily to the engine bays or tyres. Further damage caused to windows occurred when there were no persons in the vehicles. Given FSGT's considerable experience with firearms, the shooting was very accurate, and while FSGT had the capacity to injure people had he chosen to do so, no person was physically injured. [49]

[52] Counsel assisting submitted,[50] and I accept the evidence of SGT Sutherland as an accurate record of the damage caused by FSGT on the evening of 12 March 2023, when he stood in a primarily stationary position in the driveway of the incident address and repeatedly discharged his registered firearms. While no person other than FSGT was physically injured on 12 March 2023, it cannot be overlooked that FSGT, while intoxicated to some extent, fired multiple projectiles capable of travelling up to 45 metres, in a suburban area, and caused an emergency declaration under the PSPA to be enacted. Multiple items of property were damaged, and members of the public were ordered to remain in their homes to ensure their safety. Multiple members of the QPS responded to reports of an active shooter, under

[46] Exhibit B1.53. 26 June 2024, T3-53, LL 1 – T3-56, LL 24.
[47] Exhibit B1.54.
[48] Exhibit B1.53.
[49] 26 June 2024, T3-55 – T3-56.
[50] Submissions of counsel assisting at [50].

the cover of darkness, which one may reasonably speculate would have been a harrowing experience.

Forensic examination of the deceased at the scene

[53] SGT Sutherland identified eight holes, caused by projectiles, directly above the location in which the deceased was found. Pellets were located on the kitchen floor, bench, and dining room floor. SGT Sutherland concluded that FSGT was most likely standing centrally in the kitchen when the fatal injury was sustained. Trace DNA samples were collected from the trigger and butt of the firearm located under the deceased. Further firearms were located on the floor of the dining room.[51]

Suicide

[54] Counsel assisting submitted, and I accept that while the Coroners Act does not contain a prescribed definition of suicide, it would be appropriate for me to make such a finding in the circumstances. To do so, I must be satisfied that the deceased acted intentionally, knowing the probable consequence.[52] The capacity to form such intent is a threshold requirement for a finding of suicide.[53] Recognised circumstances which may deprive a person from having such capacity include mental disease, intellectual impairment, psychosis, extreme distress, intoxication under the influence of alcohol or drugs or infant immaturity.[54] In some circumstances, a death can have been an accident even though it appears to be intentional and in other rarer cases, there can be a suspicion of foul play. Accordingly, before a finding of suicide is made, the evidence supporting such a finding cannot be equivocal. A finding of suicide must be determined on the balance of probabilities, but its seriousness warrants the application of the upper spectrum of the *Briginshaw* scale, meaning that there must be clear evidence to support such a finding. Usually, the evidence supporting such a finding is circumstantial requiring inferences of fact to be drawn from those circumstances.

[55] I have considered the concerns expressed by FSGT's wife in the Triple 000 calls, and the observations of FSGT's mother regarding her son's likely state of mind, in the context of the circumstances of 12 March 2023, and what that may have meant for his career in the ADF:

> *'So to me, when this incident happened on the Sunday night, from what I believe it was a 20-minute span from the time he decided, well from the argument that he ended up shooting himself. And that to me was because he felt trapped, he didn't want, he didn't like the fact that the Police had been called because that would have meant something in loss in his career,*

[51] Exhibit B1.53 at [12] – [16].
[52] *Clark v NZI Life Ltd* [1991] 2 Qd R 11.
[53] *Inquest into the death of Tyler Jordan Cassidy* [2011] Coroners Court of Victoria.
[54] *Suicide Reporting in the Coronial Jurisdiction*, Coronial Council of Victoria Consultation Paper, 23 April 2014.

which would have degraded and embarrassed and deflated him and he would have felt insignificant.'[55]

[56] Dr Andrew Khoo provided an expert psychiatric report and gave oral evidence at the Inquest. Dr Khoo referred to the information provided to DSS Hope by FSGT's close friend Rocky and FSGT's wife. Dr Khoo opined:

> *'FSGT, a proud serviceman, a dedicated father, a team player and a perfectionistic rule follower was very emotional about the police being called. The passive presence of the police alone played a role in events, but in my opinion no reported actions taken by the QPS officers during the events of 12/13 March 2023 could reasonably be seen to have aggravated the situation. It is likely that once FSGT, whilst ashamed and under threat, fired the first shot on police, he had made the decision that he wouldn't be walking away. It was either so-called 'death by police' or something he would have to take care of.'*[56]

[57] I have also considered the concern expressed by FSGT's friend Rocky and his view of the last conversation he had with FSGT on 12 March 2023:

> *'Just before he [FSGT] hung up, I heard* [his son] *say something, and FSGT go, "What? I've lost you too?" And then he ended the call. I didn't think much of it at the time but to me now when I look back that would have been the trigger point for FSGT to do what he did. He thought he'd lost his son as well, one of the boys he idolised.'*[57]

[58] While FSGT, to some extent, was affected by alcohol on 12 March 2023, it is more likely than not, particularly given his extensive experience with firearms as an ADF member and in a recreational capacity, that FSGT was acting intentionally knowing the probable consequence of his actions. On all the evidence before me, I find that it is more likely than not, that FSGT's death was intentionally caused by him.

Issue one

The findings required by s.45(2) of the Coroners Act

[59] To prevent repetition I will deal with the medical cause of death and when FSGT died under this heading. I accept the opinion of Forensic Pathologist, Dr Rebecca Williams. I find that the cause of FSGT's death was traumatic injuries[58] as a result of a self-inflicted gunshot wound to the head.[59]

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[55] Exhibit H11.
[56] Exhibit F1, 15.
[57] Exhibit B1.50.
[58] Described under the heading *'Autopsy report.'*
[59] *Coroners Act 2003* (Qld) section 45(2)(e) what caused the person to die. Due to the extensive injuries and a lack of recorded fingerprints, circumstantial identification was accepted. Exhibit B1, 6. Exhibit B1.3.

[60] Counsel assisting submitted, and I accept that on the evidence, the last gunshots were heard at approximately 9:15pm on 12 March 2023, and noting the cause of death, it is more likely than not that FSGT died on 12 March 2023.[60]

Issue two

Consideration of the circumstances leading up to the death including mental health, treatment and care, suicidality, weapons licencing and information sharing, domestic and family violence.

[61] The QCMHR Report contains the following description of the term suicidality which highlights the importance for understanding such topics:

> *'Suicidality (suicide ideation, plans and attempts) is a source of morbidity and often precedes suicide death. It therefore presents an important opportunity for proactive suicide prevention interactions to alleviate suffering for veterans, their families, and communities.'*[61]

[62] The Royal Commission into Defence and Veteran Suicide (RCDVS) highlighted the importance of the coronial system identifying systemic issues to inform suicide prevention strategies. It is in this context, that the following issues are considered.[62]

Understanding the ADF health system

[63] Counsel assisting submitted, and I accept that an assessment of the issues for inquest requires consideration of the ADF health system, and how an ADF member's medical fitness for employment is assessed and classified in the context of certain health diagnoses.

[64] Dr Darrell Duncan, Director of Strategic Clinical Assurance and Ethics, JHC gave evidence that Regulation 49 of the *Defence Regulation 2016* (Cth) obligates the ADF to provide medical and dental treatment and the pharmaceuticals required for such treatment, to ADF members rendering continuous full-time service, to ensure they are fit to perform their duties. Where the ADF cannot meet a need for treatment internally, an appropriately qualified third party will be engaged at the ADF's expense to provide the clinically necessary treatment.[63]

> *'In FSGT 's case, as a full-time serving ADF member based in Townsville, he was provided with on-base access to a general practitioner, Dr Daniel Gwynne, and a clinical psychologist, Dr Phillipa Waterworth. The ADF also arranged for FSGT to receive*

[60] *Coroners Act 2003* (Qld) section 45(2)(c) when the person died. Submissions of counsel assisting at [62].
[61] Exhibit G1, 10.
[62] Final Report – Volume 6: *Families, data and research, and establishing a new entity.* Page 85.
[63] Exhibit D3 at [16] – [18]. Defence Health Manual, Vol 1, Part 3, Chapter 1 at [1.1].

treatment from an external psychiatrist, Dr Anand Gundabawady."[64]

[65] As an ADF member rendering full-time service, FSGT accessed treatment through the Lavarack Health Centre (LHC) at Lavarack Barracks, and the Townsville Health Centre (THC) at the RAAF Base, Townsville. The LHC is a larger health centre staffed seven days a week, with a 24/7 inpatient ward and on-call doctor. The THC operates Monday to Friday and is staffed by uniformed and contracted medical staff (doctors, nurses, psychologists, physiotherapists, and dentists). Specialists such as Psychiatrists are typically external providers.[65]

[66] Dr Gwynne, FSGT 's MO worked from the THC and provided primary healthcare and occupational health care services. He explained how ADF members[66] access the THC and LHC. ADF members can access the THC services by:

> *a. Calling the practice and making an appointment. The waitlist for non-urgent appointments is usually six to eight weeks;*
>
> *b. Attending a medical sick parade, which at the THC runs from Monday to Friday for approximately a 2-hour period (currently 0900 to 1130). Members can walk in and be triaged by a nurse and a medic. Attendance at the medical sick parade is usually for issues that require attention that day. For non-time sensitive issues, members are encouraged to make appointments; and*
>
> *c. Contacting me directly through Skype, when I'm on base, or for urgent after-hours issues, on my mobile by telephone or text message.*
>
> *…*
>
> *The LHC has a Mental Health Intake Program (MHIP) available during business hours, triaged by mental health examiners. The MHIP can be accessed as part of the LHC's medical sick parade or by showing up and requesting it."*[67]

[67] ADF members can also call the 24-hour Medical Advice Triage and Referral Service (MATRS) (formerly known as the 1800-IMSICK line), provided to Defence through a contract with BUPA.[68] Through this, the ADF can make a referral to a relevant hospital and track an ADF member's movements and recovery.

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[64] Exhibit D3 at [20].
[65] Exhibit D4 at [11] – [16].
[66] ADF full-time active members and ADF active reserves (but only for occupational review to assess restrictions and deployment. Exhibit D4 at [9].
[67] Exhibit D4 at [14] and [17]. DHM, Vol 2 Part 10, Chapter 1 at [1.13] – [1.16].
[68] 26 June 2024, T3-6, LL 37 – 46. T-37, LL 1 – 39.

2a) FSGT's mental health condition/s, and the appropriate treatment for him, including whether in all the circumstances there was an appropriate assessment of FSGT's suicide risk.

[68] I have been assisted by the Psychiatric Clinical Summary[69] prepared by Dr Khoo, noting his extensive clinical experience and speciality in the field of Military and Veteran's mental health.[70] I accept the clinical summary as an accurate and appropriately independent review of FSGT 's psychiatric history and the treatment and care that he received as an ADF member.

[69] Dr Khoo's understanding of the MEC Review (MECR) Records was that FSGT was MEC downgraded in March 2022 to allow for rehabilitation following a fall that resulted in fractured left ribs (8-12) with haemothorax, left lower lobe contusion and atelectasis. FSGT's MECJ31 status was extended based on his mental health symptoms. The Medical Employment Category (MEC) and Restrictions relevant to FSGT are discussed below.

[70] Dr Khoo noted that FSGT had served full-time in the RAAF for 32 years and was serving full-time at the time of death. He last worked as a Communications Electronic Technician in 452 Squadron and was working half days (due to his MEC J31 status). FSGT deployed to the Middle East for 8 months between 19 January 2016 to 3 August 2016.[71]

Dr Gwynne, MO

[71] FSGT first saw Dr Gwynne on 17 January 2022 and his last appointment occurred on 8 March 2023. During this period, Dr Gwynne reviewed FSGT approximately 22 times for conditions including MDD and anxious distress, musculoskeletal issues, insomnia, gastroesophageal reflux, and hypercholesterolaemia.[72]

[72] Dr Gwynne provided regular review, investigations, referrals, and medication. As the MO, Dr Gwynne was integral to the MEC process. He last reviewed FSGT on 2 March 2023 and noted that his MECJ31 status was for assessment and management of depressed mood and fatigue. Treatment was listed as medication, psychiatric review and psychological session. Dr Gwynne's assessment was that FSGT's mood was improving and issues with sleep and fatigue were slowly improving. FSGT had increased his work hours, working half days most days and full days when required by workplace demands. FSGT's MECJ31 status was recommended for a further six months and confirmed on 10 March 2023.[73]

[69] Exhibit F1, 8-10.
[70] Exhibit F1, 1. 25 June 2024, T2-50 – T2-75.
[71] Exhibit F1, 7.
[72] Exhibit D4 at [34] – [35].
[73] Exhibit F1, 9-10.

FSGT sought help for mental health concerns

[73] On 19 May 2022, FSGT presented to the LHC and self-reported prolonged sleeping difficulties that he attributed to mental health issues and difficulties managing physical pain resulting from a serious physical injury in the context of alcohol use (slip and fall on 5 February 2022 at a friend's birthday party).[74] FSGT was referred to the MHIP.[75] During the MHIP intake assessment FSGT was described as distressed, teary, fatigued and in pain. He reported feeling exhausted, having only three hours of sleep for months, experiencing flare ups of pain from his ribs and long-term back injury, being under pressure to perform at work to a high standard with a new chain of command and felt like he was failing because he was so tired, could not focus and was making mistakes.[76]

Dr Waterworth, Psychologist

[74] On 20 May 2022, FSGT saw Psychologist, Dr Waterworth[77] for the first time.[78] He presented through sick parade at the THC. In addition to the concerns noted the day prior, FSGT reported having to pull out of a professional course that he had been trying to get on for a few years and was disappointed.[79] On 27 May 2022, Dr Waterworth reviewed FSGT again and a Comprehensive Assessment and Management Plan[80] and Treatment Plan[81] was completed in compliance with the DHM.[82] Dr Waterworth reviewed FSGT approximately 18 times between 20 May 2022[83] and 22 February 2023.[84]

[75] FSGT was seen by Dr Gwynne that same day and prescribed pain medication and granted sick leave. He was restricted to working no more than 25 hours a week and half days until 21 June 2022.[85]

Dr Gundabawady, Psychiatrist

[76] FSGT was referred to Psychiatrist, Dr Gundabawady[86] on 6 June 2022. On 15 June 2022,[87] FSGT was seen for the first time by Dr Gundabawady who diagnosed him with Major Depressive Disorder (MDD) with anxious distress, based on a combination of recent physical

[74] Exhibit C4. He had also fractured his leg in 1997 after jumping from a balcony while intoxicated. Exhibit C6, 165.
[75] Exhibit D3 at [23] – [24]. For details of the medical care provided to FSGT by his GP/MO following his physical injury see Exhibit D4 at [41] – [51].
[76] Exhibit C6, 213. Exhibit D4 at [52].
[77] Dr Waterworth worked in private practice, in conjunction with doing contract work in the ADF.
[78] Exhibit D2 at [13].
[79] Exhibit C6 at [213]. Exhibit D4 at [53]. Exhibit F1, 9.
[80] Form AE412. Exhibit D4, Annexure DRG-4, 1 – 8.
[81] Form AE411. Exhibit D4, Annexure DRG-4, 9 – 13.
[82] DHM, Vol2, Part 10, Chapter 1 at [1.23]. Exhibit C6, 97 – 102. Exhibit D2 at [12].
[83] Please note there appears to be an error in the statement of Dr Duncan (Exhibit D3 at [24]) and the IGADF report (Exhibit I1 at [75]). Dr Waterworth first saw FSGT on 20 May 2022, as supported by the statement of Dr Gwynne (Exhibit D4 at [29b] and [53]), statement of Dr Waterworth (Exhibit D2 at [13]), and medical records (Exhibit C6, 213).
[84] Exhibit D4 at [29b].
[85] Exhibit D4 at [53].
[86] Dr Gundabawady is an external provider.
[87] Referral dated 6 June 2022.

injuries, pain symptoms and stressors in relocating to Townsville. FSGT was prescribed a sedative (Melatonin and Amitriptyline) and an antidepressant (Duloxetine). He was seen by Dr Gundabawady a further five times. Their last appointment was on 24 January 2023.[88]

[77] FSGT also had sessions with an ADF occupational rehabilitation professional. The medical records show regular (approximately weekly entries) from 4 October 2022.[89]

Mental health diagnosis

[78] I accept the opinion[90] of FSGT 's treating Psychiatrist, Dr Gundabawady and Dr Khoo, that the most appropriate DSM-5 diagnosis for FSGT was MDD with anxious distress.[91]

Review of the treatment provided

[79] Dr Gwynne's evidence was that he adopted a multi-disciplinary approach to primary and occupational health care:

> *'I engage third party specialists (such as psychiatrists…) and allied health workers (such as psychologists, physiotherapists and rehabilitation consultants) to support patient care. I also engage, with permission from the patient, with their supervisors to understand workplace demands and advise on appropriate return to work strategies.'*[92]

[80] This was evidenced by the fact that FSGT was supported by a psychiatrist, a psychologist, and an occupational rehabilitation consultant.[93]

[81] Counsel assisting submitted, and I accept that the approach taken by Dr Gwynne may be considered a "gold standard" approach, noting the evidence of Dr Khoo and the RCDVS as to the likelihood of ADF members and Veterans presenting with a multitude of concerns such as mental health, gastrointestinal and musculoskeletal issues, coupled with the known pressures of service in the ADF. I accept the expert opinion of Dr Khoo, that the treatment afforded to FSGT for MDD with anxious distress, was *'impressively responsive and accessible, multidisciplinary and comprehensive, evidence-based and patient centred.'*

[82] The Inquest took the following evidence from Dr Khoo which highlighted the responsiveness and appropriateness of the treatment FSGT received:

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[88] Exhibit F1, 9.
[89] Exhibit F1, 10.
[90] This is the term used in the ADF policies.
[91] 25 June 2024, T2-52, LL 7-8.
[92] Exhibit D4 at [28].
[93] Exhibit D4 at [29].

'Upon becoming aware of FSGT 's depressive symptoms, he was able to receive a face-to-face psychology review the next day with subsequent weekly appointments. He was referred for a psychiatry review and had his first face to face appointment 9 days later. In post-Covid Australia this is incredible access made even more impressive by the semi regional nature of Townsville. For comparison most people in Brisbane would wait at least 4 weeks for a psychology appointment and 6 months for a psychiatry appointment.

FSGT had excellent access to a mental health treatment team involving his MO, a psychologist, a psychiatrist, an occupational rehabilitation professional, a couple's counsellor and a physiotherapist. All of his team had an understanding of military cultural issues and military mental health, maintained good lines of interdisciplinary communication and corresponded regularly with his workplace.

FSGT has received an evidence-based approach to the management of his MDD with anxious distress. He was involved in treatment decisions regarding the initiation of antidepressant therapy with Dr Gwynne first discussing this with him and allowing him to consider this. Dr Gundabawady commenced biological treatment after providing him with information on Escitalopram (SSRI) and Duloxetine (SNRI) discussing relative pros and cons of therapy with each. First line therapy for a depressive illness is an SSRI on all contemporary pharmacological treatment guidelines and Escitalopram is specifically identified as a first line agent on the RANZCP Mood Disorder Guidelines 2020. The RANZCP Guidelines also state that as antidepressants are difficult to separate on the basis of efficacy, selection should be guided by the agent's tolerability or idiosyncratic additional effects. Hence, Duloxetine, a SNRI with some documented evidence of additional effects in reducing chronic and neuropathic pain was also a very reasonable option. He was commenced on the usual starting dose, allowed for the usual treatment lag and dose escalation occurred in a timely manner to a therapeutic dose of 60mg (please also note that the postmortem serum level was in the range where most individuals respond). After failing to respond to Melatonin (a well tolerated, non-addictive sleeping agent not associated with a daytime hangover), FSGT was put on a low dose (10-20mg) of Amitriptyline to assist with sleep and provide additional neuropathic pain cover. This is not seen to be an adult antidepressant dose (MIMS adult dose of 75-150mg/d). Of note however is the postmortem serum reading in the therapeutic range which raises the question of possible overuse or possible postmortem haemoconcentration of the drug – with the latter circumstance perhaps suggesting higher/overestimation of alcohol and duloxetine readings as well. Finally, FSGT received psychological session utilising 'psychoeducation, CBT and emotional regulation'. These modalities are all supported in the evidence base for use in depressive disorders.'[94]

[94] Exhibit F1.

Medical Employment Category (MEC)

[83] Counsel assisting submitted, and I accept that medical fitness and MEC have significant implications for an ADF member and can affect decisions around their employment, training, rehabilitation, payment of specialist allowances and ability to remain in the ADF.[95] It is accepted that an ADF members MEC can weigh heavily on their self-esteem, confidence, and psychological wellbeing, particularly when matters of military culture are also considered.[96]

[84] Prior to his death, FSGT was MECJ31 and had employment restrictions in respect of service weapons, ammunition, and defence vehicles however, he was also a registered firearms holder and had personal weapons at his home. This is a curious situation and one that was considered during the coronial investigation, particularly in light of the two ***critical contributors*** [emphasis added] identified by Dr Khoo in the circumstances surrounding FSGT's death, namely, alcohol intoxication and access to lethal means (firearms). This is discussed further below.

[85] The ADF assigns a MEC to every ADF member, indicating their medical fitness for employment within the ADF or to be deployed on active duty. The MEC system is described in the MILPERSMAN and the DHM. It is not a healthcare tool, but rather, a personnel or resource management tool. The MEC system is applied through regular physical examinations of an ADF member, targeted at assessing their individual medical fitness for service and is communicated through the assignment of a combination of letter and numbers:

> *'A MEC is an alphanumeric code determined according to each Defence member's primary military occupation. This assessment is made with consideration of the employment environment in which that occupation is performed. The allocation and management of MEC will therefore differ depending on the employment environment.*
>
> *Employment restrictions highlight key limitations, requirements and restrictions for a Defence member and support and amplify the allocated MEC.'*[97]

[86] The environment in which an ADF member is required to operate is considered. Joint (J) is the default for ADF members. An ADF members chain of command is responsible for the administrative management of the member based on advice provided by health practitioners, career management and the MEC review board (MECRB) which is a personnel management function that enables review of employment

[95] Submissions of counsel assisting at [72]-[73].
[96] The MEC system and matters of military culture were extensively considered by the Royal Commission into Defence and Veteran Suicide (the RCDVS).
[97] DHM, Vol 2, Part 6 at [2.9].

where an ADF member's long term medical fitness for employment or deployment is in doubt.

[87] As previously noted, FSGT was MEC J31 (temporarily not deployable with restrictions). The MILPERSMAN[98] notes:

> *'7. A member with a J31 or J31 Extension classification is employable:*
>
> *a. within a formal rehabilitation program, with employment restrictions and/or health materiel support.*
>
> *b. for defined field or seagoing activities in accordance with designated single- Service Medical Officer endorsed employment restrictions.*
>
> *8. A member with a J31 or J31 Extension classification is not deployable. Active medical management and rehabilitation programs are to have priority over all other employment. During the period of rehabilitation a progressive return to full duties should be anticipated.*
>
> *9. A member may have a J31 classification for a defined period up to 12 months. A J31 Extension may be granted for an additional rehabilitation period of 12 months.'*

Employment Restrictions

[88] The DHM[99] provides guidance on employment restrictions:

> *'2.21 A MEC and, where applicable, SPEC alone do not provide sufficient administrative guidance on the safe employment of Defence members. Employment restrictions highlight key employment requirements that must be recorded in full at each review of a Defence member's MEC and on the Form PM53211—'Military employment classification (MEC) advice.'*
>
> *2.22 Restrictions are grouped in the following series:*
>
> *a. 1–series. Physical fitness activities*
> *b. 2–series. Specific employment activities*
> *c. 3–series. General duties*
> *d. 4–series. Medical support requirements*
> *e. 5–series. Geographic and environmental limitations*
> *f. 6–series. SPEC duties*
> *g. 7–series. Multiple restrictions during treatment or rehabilitation.'*

[98] Part 3, Chapter 2, Annex 2E.
[99] Volume 2, Part 6, Chapter 2, [2.21]-[2.23] and Annex 2G.

[89] FSGT was subject to general duties employment restrictions. Dr Duncan gave evidence that the rationale behind the imposition of these employment restrictions was to limit FSGT 's access to equipment that he could use to seriously injure or kill himself or any third party.

[90] As an ADF member, following confirmation of his mental health diagnosis (MDD with anxious distress), FSGT was placed on the following employment restrictions:

a. 3-5 Unfit for weapons handling – fit for Weapons Training Simulation System[100] (WTSS);

b. 3-8 Unfit to drive ADF vehicles; and

c. 3-17 No access to live ammunition. [101]

[91] Such restrictions provide guidance and recommendations as to an ADF member's limitations in employment and the health support requirements, to assist Commanding Officer's (COs) and managers in personnel management decisions.[102]

[92] I have been assisted by the evidence of Dr Duncan, and Dr Gwynne, and the guidance provided in the DHM[103] entitled *Military Employment Classification System* and the MILPERSMAN[104] entitled *Australian Defence Force Military Employment Classification System*. The imposition of employment restrictions on an ADF member is the responsibility of the MO, in this case, Dr Gwynne[105] as opposed to the MHP involved in an ADF member's treatment and care. Psychologist, Dr Waterworth, gave evidence that:

> *'Weapons restrictions are part of the medical assessment process called MEC. The MEC restrictions are not within the decision-making jurisdiction of a mental health professional.'*[106]

[93] FSGT 's treating psychiatrist, Dr Gundabawady, was not asked to advise on FGT 's capacity to utilise service weapons.[107] Dr Gundabawady understood that due to the treatment FSGT was receiving, automatic restrictions would be imposed by the ADF on his use of service weapons.[108]

[94] At the Inquest, the imposition of employment restrictions, and general themes of "risk" were considered. Dr Duncan gave evidence of how the

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[100] The WTSS is a simulator that allows for realistic, repeatable, and cost-effective FSGTsmanship training. The system is controlled and there is no live ammunition or weapons.
[101] Exhibit D3 at [56] – [57]. 26 June 2024, T3-10, LL 21 – T3-12.
[102] MILPERSMAN Part 3, Chapter 2 at [2.17].
[103] Volume 2, Part 6, Chapter 2.
[104] Part 3, Chapter 2.
[105] Submissions of counsel assisting at [79].
[106] Exhibit D2 at [26]. Mental Health Professional (MHP) is used by defence to refer to Psychologists and Psychiatrists.
[107] A service weapon is a firearm issued to military personnel for official duties.
[108] Exhibit D5.

imposition of restrictions and the way in which ADF members with diagnosed mental health conditions are managed by the ADF has evolved over time. He acknowledged that there was still work to do, particularly in consideration of how restrictions were applied to ADF members following a mental health diagnosis:

> *'Look, the genesis of even the patented way we put restrictions on grew over many years where we found we were applying the same restrictions. So we started to codify them. It was then considered, you know, what should we do with someone who's acutely depressed and who is acutely unwell? My own practice would be – and I haven't spoken to Dr Gwynne, but my own practice would be I would've asked him why he's putting those on because what I'm finding is it is that automatic – as you read out the policy, it said consider them.*
>
> *A lot of people and a lot of our doctors take "consider" to be, "I have to do it and, if I don't do it, I'll get in trouble."*
>
> *And I point out to young doctors, when I'm – I'm teaching them how to do this, to say, you know, what is the reason? The restrictions are out risk mitigators. So that's how we mitigate the risk. So what risk are you actually mitigating? In particular, for instance, you know, I would – discussing this case, in particular, if you're not going to stop him driving his own car.*
>
> *The only thing you're protecting is Defence's reputation. It doesn't help the person or anyone else and it's no better if they go and do something in their own car. You know, the – and the weapons restrictions in particular prove problematic over time, especially if they're not needed when the member does have to access weapons for their work. So it's slowly – there's a slow process of people suddenly realising that, hang on, there's an issue here. My own view would be, depending on what I'm allowed to realise publicly when the report's here, I'm going to use this as a case example to say think about what you're doing here. There's some really good points, but you know, we looked really silly because we put this restriction on as a default mechanism when it was – when you consider it, it wasn't really, really needed.'*

[95] At the Inquest I noted the discord between parts of Dr Duncan's statement[109] and that they could not be read together noting the rationale was to limit FSGT 's access to weapons, yet he had weapons at home. Counsel assisting submitted, and I accept Dr Duncan's opinion that despite his reflections on the MEC restrictions imposed, there were continual and appropriate risk assessments of FSGT ,[110] and information gathered regarding his access to personal weapons. It is on that information that decisions with a view to ensuring and promoting FSGT 's welfare were made by Dr Gwynne.

[109] Exhibit D3 at [57] - [61].
[110] Exhibit D2 at [17] - [20].

[96] Counsel assisting submitted, and I accept that in circumstances where input is not sought from MHPs regarding employment restrictions that are enlivened, upon an ADF member being diagnosed with a mental health condition, that the MO may have somewhat of an unfair burden placed upon them to ensure the restrictions are not "overly cautionary" or "risk averse." In short, the delineation between – "we've always done it that way" and a proper assessment of risk, based on the individual, is questionable.

[97] I accept that there was no clinical indication in respect of FSGT, prior to the incident on 12 March 2023, that would have satisfied the "threshold" requirement under the *Weapons Act 1990* (Qld) whereby a *professional carer*[111] would be satisfied that he was an unsuitable person to possess a weapon, because of a mental or physical condition or because he was a risk to himself or another person.

FSGT's suicide risk

[98] Counsel assisting submitted, and I accept the expert opinion of Dr Khoo in respect of FSGT's suicide risk.[112] I have also been assisted by the Final Report of the RCDVS:[113]

> *'This Royal Commission has revealed that serving in the ADF may be associated with an increased risk of death by suicide for some cohorts. The data demonstrates that both serving and ex-serving populations face higher risks of suicide than comparative cohorts in the general Australian population. Further, the persistently high rates of suicide and suicidality among serving and ex-serving ADF members over time speaks to the entrenched nature of the problem and the need for systemic change in the approach taken to address it.*[114]
> *…*
> *While no theory has been found to accurately predict an individual's risk of suicide, we have uncovered powerful insights through data and research findings, and in hearing the stories of thousands of people. We have found that:*
>
> *Suicide is not a reflection of the character of an individual or indicative of an inherent deficit in their psyche or moral framework.*
>
> *Risk factors for suicide and suicidality are diverse. They can be physical (for example, the onset of pain or injury), psychological (including mental ill health, substance abuse or poor emotional regulation) and psychosocial (including problems within relationships, troubled family history and a lack of connection with community).*

[111] Defined at s 151(4)(a) a doctor (b) psychologist.
[112] Exhibit F1, 12-15.
[113] Published in September 2024.
[114] Final Report – Volume 1: Executive summary, recommendations, and the fundamentals. Page 21 at [46].

Risk factors can exist at both the group level and the personal level. For instance, organisational culture, operational stressors and the structural dynamics of how agencies deal with people can strongly affect mental health and wellbeing and act as risk factors for suicide and suicidality.

Risk factors cannot be considered in isolation and are highly contextual. It is the interaction between – and often compounding of – many intersecting factors that contribute to a person dying by suicide.

Risk factors for suicide and suicidality affect people differently.

The level of risk of suicide and suicidality is dynamic. Risk factors may take on greater or lesser significance at different times and can be counterbalanced or influenced by protective factors that alleviate risk.'[115]

[99] As noted by Dr Khoo: *'when faced with reviewing completed suicide, it is always speculative to assess relative contributions of various factors in retrospect.'*[116]

[100] Counsel assisting submitted, and I accept the opinion of Dr Khoo in respect of FSGT 's risk factors that put him in an "at risk" cohort. This included:

a. His status as a permanent fulltime member of the ADF;

b. His history of deployment to the Middle East and attachment to an Army unit which may have further loaded risk;

c. Physical injuries to his chest wall and C spine with bilateral brachialgia which led to chronic pain and limited his ability to engage in outdoor activities that he enjoyed (this was improving towards the end of 2022 and early 2023);

d. Ongoing life stressors related to work and relationship/domestic stressors; and

e. His perfectionism and unrelenting high self-standards, high work ethic, a personal feeling that he was not performing at a level that he should be and a subsequent sense of guilt about working half days and letting his team down.

[101] Dr Khoo's evidence was that full-time permanent service in the ADF was for some time seen as protective against suicide due to the support offered by structure, brotherhood, routine, and purposeful activity. However, a recent re-examination of the data by the RCDVS compared the currently serving cohort with employed Australian males and found

[115] Final Report – Volume 1: Executive summary, recommendations, and the fundamentals. Page 24 at [64].
[116] Exhibit F1, 12.

permanent members were 30% more likely to die by suicide and 100% more likely than their counterparts in the Australian population if they were serving in combat or security roles. The QCMHR Report[117] found that a serving or ex-serving ADF member had contact with emergency services every four hours, and that current serving permanent ADF members had 5.84 times the odds of contact with police and paramedics in suicide crisis versus ex-serving or reserve members of the ADF.[118]

[102] Further, Dr Khoo opined that FSGT's death occurred in the context of a relatively recent diagnosis of MDD (within the prior nine months). Dr Khoo considered that this was a static risk factor for suicide; however it was his opinion that the contribution of FSGT 's mental illness in the events leading up to his death was minor. This was based on the fact that FSGT self-presented for treatment, received timely, evidence based, patient-centred, multidisciplinary management to which he was adherent at all times and to which he identified symptomatic (mood, anxiety, sleep, energy) and functional (domestic, social, occupational) gains. FSGT identified positive future plans. He never endorsed suicidal ideation or behaviours to family, close friends or his treatment team (being the most significant or predictive static risk factor). He had previously been more symptomatic and more impaired and not engaged in self-harm or suicidal behaviour.[119] Dr Khoo opined:

> *'The reference material/documentation would suggest across the MD team over time a reasonable assessment of risk in terms of examination of static and dynamic risk and protective factors and identification of proximal life stressors (so called 'suicide drivers') occurred. Further there appeared to be a reasonable level of vigilance applied given the absence of a history of suicidality or overt/identified suicidal distress."*[120]

[103] It is apparent on the evidence that Dr Gwynne, Dr Waterworth and Dr Gundabawady were aware of FSGT's risk factors and considered them in the provision of treatment and care.

Critical contributors

[104] Dr Khoo opined that there were two ***critical contributors*** [emphasis added] in the circumstances surrounding FSGT's death, the absence of which may have altered the tragic circumstances on 12 March 2023:

> *'In my opinion one could make a solid argument that without either of these critical contributors, FSGT would not now be deceased. The postmortem toxicology certificate listed FSGT's*

[117] *Understanding and enhancing responses to suicide crises involving current serving and ex-serving members of the ADF: A data linkage study.* Exhibit G1.
[118] Exhibit F1, 13.
[119] Exhibit F1, 13.
[120] Exhibit F1, 13.

blood alcohol reading as 124mg/100ml which is equivalent to a BAC of 0.124.'[121]

FSGT's BAC would have resulted in him exhibiting poor judgement and decision making and becoming behaviourally disinhibited. *These circumstances I believe were pivotal in him firstly confronting and (allegedly) pushing his 15-year-old son (a circumstance which his wife in her 000 call described as never happening before and that FSGT 'was mortified', and that Simon Rockliffe believes was the 'trigger'). In my view his intoxication was similarly a critical element in him discharging his weapon at police and then in turning his weapon on himself.*

His ***ready access to high lethality means i.e. the rifles in his home gun safe, meant that there were less barriers for him to overcome*** *(meaning less time for him to consider the nature of his actions and for his system to metabolise the alcohol) before making the decision to fire on police.*

The police interviews with both [Simon Rockliffe] and his wife outline how FSGT, a proud serviceman, a dedicated father, a team player and a perfectionistic rule follower was very emotional about the police being called. The passive presence of the police alone played a role in events, but in my opinion no reported actions taken by the QPS officers during the events of 12/13 March 2023 could reasonably be seen to have aggravated the situation. It is likely that once FSGT, whilst ashamed and under threat, fired the first shot on police, he had made the decision that he wouldn't be walking away. It was either so-called 'death by police' or something he would have to take care of.'[122]

[105] While Dr Khoo noted the presence of two "drivers of suicide" (relationship and vocational concerns) as per the Collaborative Assessment and Management of Suicidality (CAMS) model, Dr Khoo expressed the opinion that in the absence of the two critical contributors, these drivers ***would not*** [emphasis added] have resulted in FSGT engaging in suicidal behaviour.

[106] At the Inquest, Dr Duncan alluded to the ADF moving from a ***'risk-based system to a recovery-oriented program utilising a contemporary evidence-based approach'.*** A supplementary statement[123] was provided by Dr Duncan which confirmed at the time of FSGT's death, the ADF was using a three-tiered risk assessment system for members diagnosed with mental health issues. Under the 2023 procedure, a treating MO and/or MHP was required to assess an ADF member against a risk matrix of seven identified factors in order to determine their level of risk (low, medium or high). The procedure then prescribed whether the member required hospitalisation for treatment, whether their CO should be notified of the assessed risk

[121] Exhibit F1, 14.
[122] Exhibit F1, 14 – 15.
[123] Dated 26 February 2025.

level and how often the treating MO and/or MHP would meet with the member. The 2023 procedure provided no substantive guidance regarding what treatment or support an ADF member should receive depending on the level of risk assigned.

[107] Dr Duncan noted that the 2023 procedure focussed more on providing guidance to MOs and MHPs on how to complete the risk assessment process than on consideration of the member's individual circumstances, needs and access to resources. He considered that the 2023 procedure, in that regard, could be characterised as a "one size fits all" approach to assessing and managing ADF members who were at risk of suicide, self-harm and/or harm to others. In Dr Duncan's experience, the suicide/self-harm/harm to others risk assessment process ran parallel to and informed the assessment of an ADF member's MEC status. In Dr Duncan's experience, if an ADF member was assigned a risk level of low or above, the treating MO would typically then apply MEC restrictions, on a member's access to military firearms and ammunition, in order to minimise their access to lethal means of harming themselves or others.[124]

Defence shift from a risk-based system to a recovery-oriented program utilising a contemporary evidence-based approach

[108] On 1 October 2024, Defence published the current version of DHM[125] *Procedures for assessing and supporting members at risk of suicide, self-harm or harm to others.* The 2024 procedure sets out the ADF's new approach to assessing an ADF member's risk profile for suicide, self-harm and/or harm to others and developing a plan to assist the member to address and resolve their risk factors. Under the 2024 procedure, an ADF member's risk profile is assessed against the individual member's personal risk baseline and that of comparable members in a similar setting to the member in question, rather than being measured against a set risk criteria and assigned a generic level of risk, as was the case under the 2023 procedure. The 2024 procedure is less focussed on how the treating MO and/or MHP completes the risk assessment process and more directed towards the welfare and treatment of the at-risk ADF member. Both the risk assessment and treatment plan processes are more member-focussed. The 2024 procedure, requires the treating MO and/or MHP to take the following into account when developing a safety plan for an ADF member:

a. The member's "risk status", which refers to the member's risk in comparison to others in a similar setting to the member (eg. other individuals in the member's unit);
b. The member's "risk state", which refers to the member's current risk in comparison to their own personal risk history;
c. The availability of safety and treatment resources for the member; and

[124] [30]-[34].
[125] Volume 3, Part 10, Chapter 2.

d. The existence of any foreseeable changes that could quickly impact on the member's risk profile.

[109] The 2024 procedure sets out a broader list of factors the treating MO and/or MHP need to consider when assessing the ADF member's risk of suicide, self-harm and/or harm to others, so that they have a more complete and nuanced understanding of the member's personal circumstances and risk profile. This process then leads not to a generic assignment of risk level (eg. high, medium or low risk), but to a status that describes the member's current risk profile relative to their personal risk history (eg. "same/similar as", "lower than", or "higher than"). The 2024 procedure goes into greater detail regarding the development, and minimum expectations, of a "**Member safety plan**". The MO and/or MHP is encouraged to develop the plan in collaboration with the member and any support person/s they have authorised to be involved in the process. The plan is highly tailored to the member's personal circumstances and is subject to ongoing review by the treating MO and/or MHP in conjunction with the member. Even where the member's risk profile is assessed to be limited, the 2024 Procedure still requires MOs and MHPs to identify any risk factors that exist for the ADF member and propose measures to reduce or eliminate those factors. In short, the 2024 procedure is patient-focussed and puts the at-risk ADF member at the centre of the risk assessment and treatment process, with the aim of providing more personalised care and support for members.[126]

2b) Whether FSGT had access to such treatment and absent FSGT's consent, could he be compelled to undergo such treatment?

[110] Counsel assisting submitted, and I accept that this issue for inquest requires an understanding of how ADF member's access mental health treatment as a condition of service in the ADF. As noted above, FSGT accessed treatment through the LHC at Lavarack Barracks, and the THC at the RAAF Base, Townsville. Specialists such as Psychiatrists are typically external providers.[127] The LHC has a MHIP available during business hours, triaged by mental health examiners. The MHIP can be accessed as part of the LHC's medical sick parade or by showing up and requesting it (as FSGT did). ADF members can also call the 24-hour MATRS. Through this, the ADF can make a referral to a relevant hospital and track an ADF member's movements and recovery.

[111] The Inquest took evidence from Dr Duncan[128] as to how an ADF member may be compelled to undergo treatment for mental health:

> *'The first is in accordance with a direction from their CO. This will most typically occur where the CO receives information from a member's direct supervisors to indicate they are exhibiting*

[126] Supplementary statement of Dr Duncan dated 26 February 2025, at [35]-[40].
[127] Exhibit D4 at [11] – [16].
[128] 26 June 2024, T3-7 to T3-10, LL 19.

behavioural issues that call into question their fitness or suitability for ongoing engagement with the ADF. A CO may also issue a direction in circumstances where they are considering taking disciplinary action against an ADF member and want specific advice on the member's fitness, from a health perspective, to participate in the disciplinary process. In these circumstances, the CO will typically issue a direction requiring the member to attend before a psychologist to undergo a mental health assessment.'[129]

[112] Dr Duncan confirmed the first process involved the completion of a Form PM008 and direction from their Commanding Officer (CO). At no time was FSGT subject to a PM008.[130] In the event that an ADF member did not comply with such a direction, they may face administrative or potentially disciplinary action from their chain of command however Dr Duncan's experience was that it was extremely rare for a member not to comply with a direction to attend such an assessment.[131]

[113] The second process involved a referral by the ADF members treating MO to a MHP such as a psychologist or psychiatrist. While an ADF member may refuse to comply with the referral, such refusal (where a member has capacity to make the decision) would have repercussions for their MEC that could detriment their employability:

'The second way this can occur is if an ADF member's treating medical practitioner/s within the ADF refer the member to a psychologist or psychiatrist for mental health treatment. In these circumstances, the member is not compelled to attend for the treatment, or if they do attend, they are at liberty to elect not to actively participate in the treatment. This is because ADF members, as is the case with any individual, have the right to refuse to consent to the provision of medical treatment or care, provided they are assessed by their treating medical practitioner/s as retaining sufficient capacity to make such a decision.'[132]

[114] If an ADF member was deemed to lack capacity to consent to treatment, for those residing in Qld, they may be subject to the provisions of the *Mental Health Act* 2016 (Qld) and Public Health Act 2005 (Qld):

'The only circumstance in which an ADF member could be compelled to attend for mental health treatment against their will on the referral of a treating medical practitioner is if the practitioner formed the view that the member was sufficiently mentally ill to justify an involuntary assessment, or admission to a mental health facility. In that instance, ADF medical practitioners have the same referral rights as civilian practitioners

[129] Exhibit D3 at [29].
[130] 26 June 2024, T3-9, LL 28 – 47.
[131] Exhibit D3 at [30].
[132] Exhibit D3 at [31].

> *to issue an involuntary admission referral. In Townsville, this situation would be managed in accordance with the Mental Health Act 2016 (Qld).'*[133]

[115] The third process is that of self-referral:

> *'The third and final way an ADF member can enter the mental health care pathway within the ADF is through self-referring and accessing the services of an on-base psychologist directly. Specifically, no referral from a third party (chain of command or a medical practitioner) is required for this pathway to access care. This pathway still relies on the member consenting to undertake any treatment recommendations from the psychologist.'*[134]

[116] If an ADF member required an admission to a mental health ward, for those posted to Townsville, they may be admitted to the ward at the LHC or referred to a civilian mental health unit. Dr Duncan noted in his statement:

> *'The ADF generally refers such cases to the Townsville Private Clinic for voluntary admission. If a patient meets the criteria for involuntary admission under the Mental Health Act 2016 (Qld), the member would be taken to the Townsville University Hospital, where there are appropriate resources for this.'*[135]

[117] On the evidence, FSGT had access to treatment and care for his mental health, as detailed above. In respect of whether FSGT could, absent his consent, be compelled to undergo treatment and care (receive involuntary treatment), pursuant to the Mental Health Act, a person can receive treatment and care for their mental illness[136] under a Treatment Authority (TA) when they do not have capacity to consent.[137] An authorised doctor[138] may make a TA where they are satisfied the treatment criteria[139] apply and there is no less restrictive way[140] for the person to receive treatment and care for their mental illness.[141]

[118] Counsel assisting submitted, and I accept the opinion of Dr Khoo that in the 12 months preceding FSGT's death, there was no clinical situation where FSGT would have met the criteria for psychiatric admission and/or involuntary treatment under the Mental Health Act.[142] As such, there was no circumstance in which he could have been compelled to undergo (involuntary) treatment.

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[133] Exhibit D3 at [32].
[134] Exhibit D3 at [29] – [33].
[135] Exhibit D3 at [36].
[136] Mental Illness is defined in Section 10 of the *Mental Health Act 2016* (Qld).
[137] Section 14(1) *Mental Health Act 2016* (Qld)
[138] Schedule 3 *Mental Health Act 2016* (Qld)
[139] Section 12(1) *Mental Health Act 2016* Qld)
[140] Section 13 *Mental Health Act 2016* (Qld)
[141] Involuntary Patient is defined in Section 11 (a)(iii) of the *Mental Health Act 2016* (Qld)
[142] Exhibit F1, 15.

2c) In all the circumstances, was the treatment afforded FSGT, for his condition/s appropriate?

[119] Counsel assisting submitted, and I accept, in all the circumstances, the treatment afforded to FSGT for his diagnosed conditions was appropriate. Given the multidisciplinary and comprehensive nature of the treatment provided to FSGT, the care afforded is properly described as "wrap around care" that was flexible and dynamic and considered both FSGT's mental and physical injuries and sought to address them in a holistic way. By virtue of the ADF system of MEC and involvement of commanders in management and welfare decisions, FSGT's care included support from not only health professionals, but welfare support from SQNLDR.

[120] It was evident at the Inquest how seriously SQNLDR, Dr Gwynne and Dr Waterworth carried their duty to ensure FSGT's welfare and the value of their own lived experience as Veterans.[143] Information in the brief confirmed that SQNLDR and Dr Gwynne also provided support to FSGT's ADF colleagues following FSGT's death.[144]

2d) Whether there was any failure to provide appropriate care that caused or hastened the death?

[121] Counsel assisting submitted, and I accept that on the available evidence, there is no factual basis to find that there was any failure to provide appropriate care, that caused or hastened FSGT's death.[145]

2e) Whether any aspect of the care actually provided, caused or hastened the death?

[122] Counsel assisting submitted, and I accept that on the available evidence, there is no basis to find that any aspect of the care actually provided, caused or hastened FSGT's death.[146]

2f) What notification, if any, did the ADF provide to the Queensland Police Service ('QPS') in relation to FSGT's medical restrictions concerning weapons, and what effect, if any, would this have had on his ability to retain the firearms for which he was licensed?

[123] Pursuant to section 24(2)(a)(ii), the Weapons Act obligates a licensee to advise police of a *change* (within 14 days) when there is an *event*, such as a change in a licensee's[147] mental or physical fitness. FSGT did not inform the QPS Weapons Licensing Group of any change in his mental fitness, nor his mental health diagnosis. Had the QPS Weapons Licensing Group been notified of the change in FSGT's mental fitness, it would have triggered a review of his weapons licence and may have

[143] Submissions of counsel assisting at [120]-[121].
[144] Exhibit D4 at [133].
[145] Submissions of counsel assisting at [122].
[146] Submissions of counsel assisting at [123].
[147] Or the licensee's representative.

led to restrictions being placed on his licence, or for his weapon's licence to have been suspended or revoked.

[124] Despite the employment restrictions, restricting FSGT's access to service weapons and ammunition, the ADF did not give any information to the QPS Weapons Licensing Group, despite knowing he had access to personal firearms. This issue for inquest required consideration of the duties of disclosure under the Weapons Act.

[125] At the Inquest, DSS Hope confirmed that no information was provided by the ADF to the QPS regarding FSGT's employment restrictions.[148] The Inquest also took evidence from Inspector Cameron Barwick, of the QPS Weapons Licensing Group, an *authorised officer* pursuant to section 153 of the Weapons Act. FSGT was first issued a Qld firearms licence (26613086) for category A and B weapons for the genuine reason of sport or target shooting on 31 July 2019 and he was a prior licence holder in the Northern Territory. No concerns were identified during the application process and FSGT did not disclose any physical or mental health issues.[149] Inspector Barwick's evidence at the Inquest was that:

> *'The ADF did not provide the QPS with any information regarding FSGT 's medical restrictions. No information was received in relation to FSGT. Had the QPS been informed of any medical restrictions or mental/physical fitness concerns, an Authorised Officer would have reviewed and assessed the suitability of FSGT to continue to be a weapons licence holder.'*[150]

[126] Counsel for the Commissioner of Police submitted[151] that as of 12 March 2023[152] there was only an obligation upon medical practitioners[153] to advise the QPS about a licensee being unsuitable to possess a firearm, pursuant to section 151 of the Weapons Act:

> ***151 Disclosure by professional carer of certain information***
>
> *(1) If a professional carer is of the opinion that a person is an unsuitable person to possess a firearm for either of the following reasons, the professional carer **may** inform the commissioner of the opinion and give the commissioner any relevant information about the person including the person's identity—*
>
> *(a) because of the person's mental or physical condition;*
>
> *(b) because the person may be a danger to himself, herself or someone else.*

[148] 24 June 2024, T1-21, L 17-45.
[149] Exhibit D1, 2.
[150] Exhibit D1, 2-3. 26 June 2024, T3-39, LL 20-26.
[151] Submissions of the commissioner of police at [5]-[9].
[152] The date of the incident involving FSGT.
[153] Referred to as a *'professional carer.'*

(2) The giving of an opinion or information by a professional carer under subsection (1) does not give rise to any criminal or civil action or remedy against the professional carer.

(3) This section applies despite any duty of confidentiality owed by the professional carer to the person.

(4) In this section— health services means services prescribed under a regulation for maintaining, improving and restoring people's health and wellbeing. professional carer means—

(a) a doctor; or

(b) a person registered under the Health Practitioner Regulation National Law to practise in the psychology profession, other than as a student; or

(c) a person registered under the Health Practitioner Regulation National Law to practise in the nursing profession, other than as a student; or

(d) a person prescribed under a regulation who is engaged in providing health services.

[127] The evidence heard at the Inquest from FSGT's medical practitioners confirmed that they were of the consistent view that during their treatment of FSGT, he did not meet the "threshold" requirement under the *Weapons Act,* whereby a *professional carer*[154] would be satisfied that he was an unsuitable person to possess a weapon, because of a mental or physical condition or because he was a risk to himself or another person.

[128] DSS Hope's evidence at the Inquest was of assistance in understanding how difficulties in obtaining information about FSGT, from the ADF, might cause difficulties for police responding to incidents such as what occurred on 12 March 2023:

[Nicolson]	'*And in fairness, that the Act only talks about the discretionary word, "may"?*
[DSS Hope]	*Yes.*
[Nicolson]	*Do you have any opinions in relation to what you consider, moving forward, whether or not that should be tightened up or – or strengthened?*
[DSS Hope]	*My opinion in respect to that is that "may" means nothing. I believe that by then – unless there's some direct – very, very direct or major risk, then they're not going to – they're not going to provide anything.*

[154] Defined at s 151(4)(a) a doctor (b) psychologist.

If it was – if it was "must", they would have to and it's their duty to report any issues that they are able to. And even then, it would allow the police – or the weapons – the Weapons Act would allow the police officer to at least assess them and – and have some sort of duty of care to report in relation to their possession of the firearms. So - - -Yeah. And I'm not suggesting that anything may have changed in terms of the circumstances of possession of weapons, but it appears that at least if Weapons Licencing were aware of the situation, there could have been steps put in place and information sharing? That way they could have assessed it. And assessed it in a – and assessed the risk. And I guess, if my – my understanding – and this is – was a red flag in – in my investigation was, if they – if the – if the ADF or the defence Force has taken his weapons off and they believe that the risk is there, to take that excess away from him, they also knew that he'll have firearms at home and there was an easy access for him to have those. So it would be beneficial if there was some type of memorandum of understanding or communication just to at least assess the risk so that they can see that.

[Nicolson] *And on that issue you raise about memorandum of understanding, you identified in your report – in your supplementary report – that on the night when police officers attended the scene, the normal process is that information from QPRIME – that's the police internal database – is able to identify and assist police at the scene as to what they're dealing with in terms of the person of interest?*

[DSS Hope] *Yep.*

[Nicolson] *And there was no mental health concerns that were – was noted on QPRIME. And from your investigation, was it the transition or the information provided at the time through defence, was that difficult to obtain in terms of who the person was?*

[DSS Hope] *In terms of their mental health status? Yeah, definitely. There was no – I – I don't – that would be very difficult to obtain that*

information. Especially at that time of night. There's – I don't believe there was a specific contact or that would have even provided that. That was only gleaned afterwards, once medical records are obtained, that type of thing.

[Nicolson] *And when police, at the scene, are trying to get as much information as – as they can about the person?*

[DSS Hope] *Yes.*

[Nicolson] *Is it your – your view that the person's mental health considerations would be a relevant consideration for a risk assessment for the attending police at the scene?*

[DSS Hope] *The more information we have, the – as police officers, the better it is. It – if they had that information, they might – might have been able to at least assess it in a – a better way, I guess.*

[Nicolson] *And were there some attempts, at least, at the scene, to try and get – to communicate with FSGT through – at the scene, by police?*

[DSS Hope] *Yes, definitely. There was a number of negotiators that were called, as part of that major incident response. Negotiators had tried to work with the family and also with – my belief it was – it was after the fact, anyway. But they did make a lot of attempts to try and communicate with FSGT.'*[155]

[129] The evidence of QPS Negotiator, Detective Sergeant Flanders[156] also highlighted some of the difficulties encountered by the QPS in seeking information from the ADF about FSGT, on 12 March 2023. On the evidence, an opportunity exists to consider information sharing provisions between the QPS and ADF in future, particularly when an ADF member is in a state of crisis that gives rise to an interaction with police.

2g) If notification was given to QPS, what action, if any, did QPS take?

[130] As noted above, no notification was given.

[155] 24 June 2024, T1-21 L 47 – T1-23, L 11.
[156] Exhibit B1.20.

2h) Were any disclosures relating to potential Domestic and Family Violence (DFV) in the home, made to the ADF by FSGT or his wife?

[131] Counsel assisting submitted, and I accept that on the evidence, it does not appear that the disclosures made by FSGT to his treating practitioners in respect of his marital relationship and experiences at home, met the definition of family and domestic violence as adopted by the ADF. However, there was clear recognition by Dr Gwynne and Dr Waterworth as to how FSGT's home stressors, including relationship issues were weighing upon him, and support was offered to him.

[132] Dr Gwynne's evidence was that he was aware FSGT was experiencing marital issues and Dr Waterworth was managing (primarily) and coordinating care in relation to FSGT's personal stressors. Dr Gwynne outlined in his statement the steps taken to make inquiries as to FSGT's welfare.[157]

[133] Dr Waterworth's evidence was that there was no disclosure of FSGT engaging in domestic or family violence. In terms of the relationship he had with his wife, FSGT described his wife as *'changeable and at times unsupportive.'* He stated that when his wife consumed alcohol, she could become argumentative and insensitive.[158] On the evidence, FSGT appeared committed to his wife and efforts to improve their relationship.

2i) If so, what supports or referrals, if any, were offered by the ADF?

[134] No referrals were made. The *Commanders and Managers Guide to Responding to Family and Domestic Violence* outlines the supports available to ADF members in reporting incidents of DFV and referral options.[159]

2j) If FSGT were to have become subject to a DFV order naming him as the Respondent, what, if any effect would this have had on his employment in the ADF and his ability to hold (civil) weapons licences?

[135] As part of the coronial investigation, DSS Hope identified that FSGT told his wife, if police came, he would lose his job and he would be taken away from the family. This concern was examined at the Inquest to consider what, if any weight might be placed upon such a statement by FSGT, to understand his stressors in his moment of crisis on 12 March 2023, considering the two *critical contributors* identified by Dr Khoo.

[136] Counsel assisting submitted, and I accept that the evidence of Dr Waterworth supports the view that the circumstances in which FSGT found himself on 12 March 2023, (despite his employment and

[157] Exhibit D4 at [134] – [139].
[158] Exhibit D2 at [25].
[159] Exhibit G2. Submissions of counsel assisting at [130].

improving family situation being otherwise considered a protective factor) would have weighed heavily upon him, particularly in the context of alcohol intoxication and resultant disinhibited behaviour, such that, a *perception* that he had lost or could lose his family and career meant those factors shifted from being protective to dynamic risk factors (risk of self-harm):[160]

> [DSC Gallagher] *And the police were called by his wife, and what we need to understand, given – I can see, for example, in this assessment, you did a mental health – risk of self-harm assessment and found that there was no such risk?*
>
> [Dr Waterworth] *Yeah.*
>
> [DSC Gallagher] *But given that consistently seems to be his history, as described, at least, in medical records and the statements I've seen, I suppose what you're being asked is whether or not the risk of disharmony in the family, the risk of a domestic violence order, would be sufficient to make him act precipitously?*
>
> [Dr Waterworth] *Thank you. Yes. I think that it's true to say that FSGT was very attached to his family, so the loss of his family would be very detrimental to him.*
>
> [DSC Gallagher] *And if you add to that, the loss of his thirty-odd years of service?*
>
> [Dr Waterworth] *Absolutely. And it's an interesting one, isn't it, because it's a protective factor in itself, but it's also when the threshold is met, it's – it's the other concern as well, and I – and I get that. I guess I would be very keen to re-iterate that those were also very strong protective factors, and when we assess risk of harm to self and others, we're looking for those sorts of things that will keep them protected from making some sort of act that can cause.*
>
> [DSC Gallagher] *They'd gone from being protective factors to dynamic factors in the assessment, haven't they?*
>
> [Dr Waterworth] *Absolutely.'*

[137] As previously noted, FSGT's mother expressed a view of her son's likely mental state in his final moments, noting that:

[160] Submissions of counsel assisting at [132].

> '*He felt trapped, he didn't want, he didn't like the fact that the Police had been called because that would have meant something in loss in his career, which would have degraded and embarrassed and deflated him and he would have felt insignificant.'*

[138] Counsel assisting[161] submitted, and I accept that if FSGT were concerned that his employment in the RAAF may be affected, such a concern is not without merit or a legitimate basis. While the ability of the ADF to maintain high standards of discipline is vitally important to the effectiveness of the organisation, the final report of the RCDVS acknowledged the distinct nature of scrutiny ADF members are subjected to personally and professionally by virtue of their employment:

> *'While the ADF military justice system is complex, it is broadly comprised of two streams, 'disciplinary' and 'administrative', under which different kinds of incidents and behaviour are managed. As distinct from some workplaces, serving members' conduct and behaviour when they are not on duty is subject to scrutiny as well as their actions in the workplace. The disciplinary system is used when member conduct constitutes an offence under the Defence Force Discipline Act 1982 (Cth) (the DFDA), such as theft, assault and sexual offences. Penalties can include imprisonment. The administrative system is for managing sub-standard performance or conduct that does not comply with Defence values, standards or policies. Breaches of ADF codes of conduct can have serious repercussions, including administrative termination. Unlike the disciplinary system, the application of the administrative system is not restricted to a list of specific offences. Commanding officers have significant discretion in taking administrative measures. In some cases, both disciplinary and administrative action may be taken against a member for the same behaviour or incident.'*[162]

[139] Further, the work of the RCDVS identified areas of concern in the administrative system and opportunities for the "weaponization" of administrative processes that may adversely affect an ADF members mental health. [163]

Possible effect on employment in the ADF

[140] DSS Hope's evidence at the Inquest confirmed the likelihood that FSGT would have become subject to a DFV order, following police attendance

[161] Submissions of counsel assisting at [134].
[162] Final Report – Volume 1: Executive summary, recommendations, and the fundamentals. Page 42 at [164] – [168].
[163] Final Report – Volume 1: Executive summary, recommendations, and the fundamentals. Page 43 at [174]. *'Our inquiry has identified many factors in the military justice system that can cause or aggravate poor mental health outcomes and contribute to risks of suicide and suicidality. These include a lack of fairness and transparency in the administration of military justice, inconsistencies in the use of the administrative system, opportunities for the 'weaponization' of administrative sanctions against serving members, and inconsistencies in the quality and availability of legal and welfare support. While risk factors in themselves, these issues take on greater significance in the context of suicide and suicidality, as they can influence the likelihood of administrative termination.'*

on 12 March 2023, noting a police officer's duty under the *Domestic and Family Violence Protection Act 2012* (Qld):

[Counsel assisting]	*'Now, hypothetically speaking, and obviously this inquest examines things with the benefit of hindsight, as a Queensland Police Officer, in considering the earlier conduct of FSGT, the allegation of having had a verbal altercation with his family, the allegation of having shoved one of the children, might that conduct be classified as domestic or family violence?*
[DSS Hope]	*Yeah. It – it – it could be taking into account the circumstances. If police attended, there'd be a possibility that a police protection notice would be issued, and if that was issued, the police would issue him with a notice. They would predominately, depending upon the risk and the assessment of the risk, take him away. But on face value a notice would be issued, and the police would have taken the weapons.*
[Counsel assisting]	*And in terms of that notice, who would be named as the aggrieved in that notice?*
[DSS Hope]	*That'd be* [his wife].
[Counsel assisting]	*And would the children be listed at all?*
[DSS Hope]	*Yes. Definitely.*
[Counsel assisting]	*And how would they be listed?*
[DSS Hope]	*Well, they'd just be – they'd be listed as the concerned parties in respect to the domestic violence. So they'd be – they'd be subject to the protection also of that order.*
[DSC Gallagher]	*Before you move on, that course of action, if taken, is not at the request of any party is it. It's an action by police?*
[DSS Hope]	*Yeah, your Honour. If police are involved, it's up to them to assess the situation, and if they believe there's any type of domestic violence risk or breach in that respect or – that would trigger that, then they would do that on their behalf not – not on behalf of anybody else.*

[DSC Gallagher] *So it doesn't matter if somebody asks them to. If* [his wife] *had said, "please don't?"*

[DSS Hope] *Yes. No.*

[DSC Gallagher] *It doesn't matter?*

[DSS Hope] *No. Doesn't matter.'*

[141] Turning to the ADF policies, the MILPERSMAN,[164] *Protection Orders and Weapons Prohibition Orders* states:

> *'4.1 Under Australian law, a State or Territory Court or Police can issue orders that protect a person/s from another person. For the purpose of this chapter, such orders are referred to as a Protection Order (PO) and includes any interim, provisional and/or final orders. A PO may include orders that control access to, or possession of, weapons.*
>
> *4.2 A State or Territory Court or Police Force can issue orders that pertain to the possession of weapons and is referred to in this chapter as a Weapons Prohibition Order (WPO). A WPO may include orders issued under Commonwealth legislation such as the Family Law Act 1975.*
>
> *4.3 In some circumstances, compliance with restrictions imposed by the PO or WPO may impede the member's ability to meet Individual Readiness requirements, adversely affect the reputation of the ADF and reduce Defence operational capability.'*

[142] Counsel assisting submitted, and I accept the evidence of SQNLDR given at the Inquest, that[165] where a SERCAT 7, ADF member such as FSGT is named as a respondent on a PO or WPO they must notify their commander in writing no later than 24 hours after becoming aware that they are a respondent to the PO or WPO.[166] In response to such a notification, the responsibilities of the Commander are listed at paragraphs [4.17] to [4.20]. Paragraphs [4.25] to [4.30] detail additional responsibilities of the Commander in respect of weapons when an ADF member is named as a respondent. Guidance in respect of possible administrative action that may be taken against an ADF member named as a respondent is contained at paragraphs [4.31] to [4.34]. Should an ADF member breach a PO or WPO, the policy states that such action *'is a serious offence and will not be tolerated by Defence. Commanders may issue a notice for proposing involuntary separation from the ADF.'* The MILPERSMAN,[167] *Reporting, recording, and managing civilian and service legal and disciplinary matters* details the obligations of an ADF member to inform their CO and the Australian

[164] Part 9, Chapter 4.
[165] 25 June 2024, T2-40, LL 6-46. T2-42, LL 26-45. T2-43, LL 1-32.
[166] MILPERSMAN Part 9, Chapter 4 at [4.9].
[167] Part 9, Chapter 7.

Government Security Vetting Agency (within 24 hours) when they have *'been arrested and/or charged with a civilian offence.'*[168] Upon receiving such notice, the CO is to consider (amongst other things) administrative action in accordance with the MILPERSMAN,[169] *Formal warnings and censures in the Australian Defence Force*, whether the ADF member should be suspended from duty, and whether they should be prevented from accessing weapons, ammunition, body armour and explosives.[170]

[143] Counsel assisting submitted, and I accept that noting the discretion given to COs in consideration of administrative sanctions, that while it cannot be said definitively what repercussion FSGT would have faced had he been named as a respondent in a Qld DFV Order following the events of 12 March 2023, it is certain that as an ADF member he would have been subject to the guidance provided in the MILPERSMAN policies outlined above, and failure to comply with those policies may also have attracted further repercussions for him that could have affected his employment in the RAAF.

Effect on civilian weapons licenses

[144] Counsel assisting submitted, and I accept the evidence of DSS Hope given at the Inquest that when a Qld Police Protection Notice (PPN) or Temporary Protection Notice (TPN) is made, a person's weapon's licence is automatically suspended, pursuant to section 27A of the Weapons Act, while the order, notice or conditions are in force.[171]

[145] The making of a Final Protection Order (FPO) will, pursuant to section 28A of the Weapons Act, cancel a person's weapons licence, and any weapons and licences must be surrendered to the QPS within one day after the court makes the order. A person cannot apply for a further weapons licence for five years from the date of the order.[172]

Issue three

Whether the QPS Officers involved acted in accordance with the QPS policies and procedures then in force, and whether said actions were appropriate

[146] Counsel assisting submitted and I accept the opinion of DSS Hope that there is no evidence to indicate any breach of discipline or misconduct by members of the QPS. I am satisfied that the QPS officers acted in accordance with the QPS policies and procedures then in force and that their actions were appropriate.[173]

[168] MILPERSMAN Part 9, Chapter 7 at [7.9] – [7.10].
[169] Part 9, Chapter 2.
[170] MILPERSMAN Part 9, Chapter 7 at [7.11].
[171] 24 June 2024, T1-21, LL 1 – 15. Submissions of counsel assisting at [141]-[142].
[172] 26 June 2024, T3-41, LL 22-47. Section 10B *Weapons Act* 1990 (Qld).
[173] Submissions of counsel assisting at [143].

[147] In respect of this issue for inquest, counsel for the QPS officers adopted the submissions of counsel assisting.[174]

Issue four

Whether any changes to procedures or policies could reduce the likelihood of death occurring in similar circumstances or otherwise contribute to public health and safety or the administration of justice

Defence policy amendment to enquire about registered weapons (civilian licences)

[148] Counsel assisting submitted[175] that I may comment on or recommend changes to Defence policy that would assist and empower MOs and MHPs to consider an ADF members access to registered weapons (via civilian licences) when developing a mental health treatment plan.

[149] Counsel assisting submitted, and I accept that the advice provided by Dr Khoo should be held in high regard given his specific knowledge of Veterans experiencing poor mental health and the need to ensure the therapeutic relationship between patients and health professionals is not undermined, and recovery is promoted. Noting the evidence of Dr Khoo, Dr Waterworth and Dr Gwynne at the Inquest, it is not uncommon that ADF members would have registered weapons, for social and recreational shooting (as FSGT did) and that there may also be an associated therapeutic benefit.[176] Dr Khoo's evidence was that:

> *'Caution however is required in applying ADF weapons restrictions to civilian licencing and access to firearms. For example thoughtful consideration should be given to:*
>
> > *Whether restriction is required for mental health MEC downgrades only.*
> >
> > *A streamlined process to reinstate civilian licences and access to firearms (is often a complicated and protracted process) once the ADF MEC/weapon restriction lifts.*
> >
> > *The fact that target/range shooting and hunting remains a common interest, recreation and social opportunity for many serving and ex-serving personnel which adds in a significant way to their quality of life during and after service.'*[177]

[150] The RCDVS made substantial observations about the traditional culture of "sacrifice and self-sufficiency" in the ADF. The RCDVS observed that the MEC structure provided an incentive for ADF personnel to avoid seeking assistance, given the on-going threat of being medically

[174] Submissions of counsel for the QPS officers at [2]-[3].
[175] Submissions of counsel assisting at [158]-[161].
[176] Exhibit D4 at [92] and [93].
[177] Exhibit F1, 15.

downgraded, which is perceived by members as a sign of weakness and as rendering them unfit to perform their principal duties. [178]

[151] Research demonstrates that the core motivation for ADF personnel is career progression in their chosen field and being utilised as a resource by the ADF. Being MEC downgraded impacts the esteem that members have for themselves, and their careers. The RCDVS observed that this perception or culture, was a product of the nature of military service, rather than the consequence of any conditions or program imposed by the ADF. This perceived need to be self-sufficient and internalise ailments, was found to be particularly acute in respect of mental health concerns.[179] The RCDVS referred to shame and 'self-stigma' associated with reporting mental health concerns, observing a common concern about being viewed as a malingerer[180] by an ADF member's superiors and weak by their peers.[181] Such stigma can be exacerbated when an ADF members physical injuries are compounded by psychological injuries, resulting in longer recovery time with ongoing restrictions to an ADF member's MEC status. The RCDVS observed that where medical information was disclosed in the clinical environment and was provided, for a variety of reasons, to officers in an ADF member's chain of command, that those experiences can have a deleterious effect on the willingness of ADF members to engage with Defence mental health services.

[152] Counsel for the department of defence submitted that having regard to these observations, defence prioritises the confidentiality of an ADF members use of the health system, promoting their mental health services as a resource to support the self-reporting and voluntary participation of ADF members. It is against this background that counsel for defence highlighted the importance of the therapeutic relationship between an ADF member and their treating practitioners.[182]

[153] I also note Recommendation 68 of the RCDVS (Strike the right balance between upholding confidentiality and disclosing information when a member is in distress):

> *Defence should ensure that members and commanding officers understand how the Privacy Act 1988 (Cth) operates and the importance of members' consenting to their health information being shared with those able to facilitate appropriate care and support, in the event members are distressed or experiencing mental health challenges.*

[178] RCDVS findings, 5.3.1, Volume 2.
[179] RCDVS finidngs, Vol 2, [235] – [247].
[180] Recommendation 63 of the RCDVS (reduce stigma and remove structural and cultural barriers to help seeking) recommended that reference to the word 'malingering' be removed from section 38 Of the *Defence Force Discipline Act 1982* (Cth).
[181] RCDVS findings, Vol 4, [125]-[140].
[182] Submissions of the Department of Defence at [14] – [20].

[154] To that end, I consider there is more that may be done.

[155] At the time of imposing restrictions on FSGT's access to service weapons on 8 September 2022, MO Dr Gwynne was not aware that FSGT had access to personal weapons – he subsequently became aware of that on 15 September 2022 when he attended an Individual Welfare Board (IWB) with Squadron Leader and Dr Waterworth.[183] Dr Gwynne's evidence at the Inquest was that:

> *'Every time I see someone from now on who has a weapon, I'm probably going to be – think of FSGT, I think. Should I continue with this? Is this safe? And probably, my threshold would be lower, but I don't – with the information I had available at the time, I think I made the best decision I could've at that time.'*[184]

[156] Counsel for the Department of Defence submitted that as of 1 October 2024, the DHM was amended to include a reference to weapons in clinical assessments. The two amendments were made to:

a. The general considerations for MOs when assessing risk of suicide/self-harm/harm to others; and

b. The mandatory considerations for a safety plan, when conducting that risk assessment.

[157] Considering the amendments to the DHM, I do not consider that any further recommendation is required.[185]

Command encouragement of ADF members to consider personal disclosure obligations for registered weapons

[158] Counsel assisting submitted[186] that I may comment on or recommend an amendment to defence policy whereby the CO of the ADF member (noting the CO's heavy involvement in welfare and personnel management, including their communication with MO's and attendance at IWB's) could encourage the ADF member to consider their disclosure obligations as a registered weapons licence holder, which might support the member to meet their personal obligations under s 24 of the Weapons Act.[187]

[159] Counsel for the Department of Defence supported this submission. The MILPERSMAN[188] provides specific guidance on the management of personnel who are at risk of suicide or self-harm. Defence submitted that they intend to include guidance in the MILPERSMAN prompting commanders in their discourse with a relevant ADF member to discuss their access to registered (civilian) weapons and to remind them of their

[183] Exhibit D4 at [141] – [144] and [92] – [93].
[184] 24 June 2024, T1-76, LL 18 – 22.
[185] Submissions of the Department of Defence at [21]-[24].
[186] Submissions of counsel assisting at [163].
[187] 26 June 2024, T3-22, LL 3-23, LL12.
[188] Part 3, Chapter 9, *Management of Members at Rick of Suicide, Self-Harm or Harm to Others.*

statutory reporting obligation in a manner that is appropriate to the circumstances (having regard to the nature of the risk, the rank and age of the member and their personal circumstances). [189]

Recommendation One:

[160] **I recommend that the MILPERSMAN be amended to include guidance for COs to support ADF members to consider their disclosure obligations as a registered weapons licence holder when they are identified as a person at risk of suicide or self-harm.**

ADF reporting when employment restrictions are imposed on an ADF member

[161] Counsel assisting submitted that I may comment on or recommend that when an ADF member is subjected to employment restrictions (such as FSGT was for weapons and ammunition) that there be a mandatory requirement that the ADF make appropriate inquiries with the ADF member to confirm what, if any, registered weapons they hold, so that notification may be provided by the ADF to the QPS Weapons Licensing branch.[190] This would enable the QPS Weapons Licencing branch to conduct an assessment of the ADF members suitability to hold that weapons licence.[191]

[162] This submission was supported by the Queensland Commissioner of Police who further submitted that I should consider a recommendation that places a disclosure obligation on entities that employ people that have, as part of their work duties, a requirement to possess weapons. As part of that obligation, if restrictions are placed on an individual licensee by the entity due to a change in licensee's mental fitness, the entity would be obliged to advise QPS of the change in circumstances. This could be achieved through the addition of a new section to the Weapons Act, following and complementing sections 151 and 151A, that the entity employing the licensee must advise the Commissioner of Police about a licensee being unsuitable to possess a firearm.

[163] The Department of Defence submitted[192] that if these submissions were accepted, such a policy would result in the QPS Weapons Licensing Group becoming inferentially aware of the mental health treatment of an ADF member. Such a mandatory disclosure by a treating practitioner has the potential to damage the therapeutic relationship and, may discourage ADF members from seeking treatment. It was further submitted that such a requirement dispenses with the exercise of a MO's clinical assessment of whether an ADF member with a civilian weapons license remains fit to hold that licence which would be a significant departure from the current reporting regime and the accepted practice in the civilian medical profession.

[189] Submissions of the department of defence at [25]-[28].
[190] For example, through a Memorandum of Understanding.
[191] Submissions of counsel assisting at [167].
[192] Submissions of the department of defence at [29] – [37].

[164] In considering such a recommendation, Defence submitted that I should weigh the nature of the mischief (how many ADF members use registered (civilian) firearms with lethality or harm in the community) against the impact that such a reporting scheme may have on the on-going treatment of ADF personnel and the sanctity of the therapeutic relationship. Given the observations of the RCDVS, and the general observations of Dr Khoo in this Inquest, the cultivation of a culture of self-reporting of mental health concerns is a matter of primacy in the ADF.

[165] The Department of Defence submitted, and I accept that, an appropriate response may be an amendment to the Weapons Act. As previously noted, pursuant to section 24(2) of the Weapons Act, a licence holder has a series of reporting obligations when an *event* occurs. To address the concerns, an additional sub-section to section 24(2) of the Weapons Act may be appropriate:

> *(…) if the licensee holds, operates, or stores a weapon as a part of the licensee's employment or calling, where the licensee's right to hold, operate or store the weapon has been suspended or removed by their principal, employer or other regulatory authority;*

[166] This requirement would make the reporting obligation broader than the ADF and would include other weapons-bearing professions. This coupled with the support of other recommendations that are proposed, would mean the ADF member would be reminded of their obligations to report by their CO, and registered weapons would be considered by a treating MO in considering the imposition of any MEC and employment restrictions.

[167] The department of defence submitted that this approach is a whole answer to the concerns of Counsel Assisting and the Commissioner of Police and has the benefit of preserving the therapeutic relationship between an MO and their patient.

[168] I have also been assisted by the submissions of counsel for the QPS officers in respect of this issue.[193] Potential inconsistencies in the interrelationship between various 'protective' provisions of the Weapons Act were identified by various witnesses during the Inquest. It was also identified that the potential inconsistencies may not best achieve the principles and object of the Weapons Act which are set out in section 3:

> *(1) The principles underlying this Act are as follows—*
>
> *(a) weapon possession and use are subordinate to the need to ensure public and individual safety;*

[193] Submissions of counsel for the QPS officer at [4] – [26].

(b) public and individual safety is improved by imposing strict controls on the possession of weapons and requiring the safe and secure storage and carriage of weapons.

(2) The object of this Act is to prevent the misuse of weapons.

[169] These potential inconsistencies may, in certain circumstances, have the result that front line QPS officers do not have access to all relevant information about a weapons licence holder when attending frontline duties such as that involving FSGT. The relevant provisions are contained in separate parts of the Weapons Act; Part 2 "Licenses" and Part 7 "Miscellaneous". The provisions are:

a. Section 24 imposes conditions on the holder of a weapons licence;

b. Section 28(1)(b) permits an authorised officer to suspend a licence on specified grounds; and

c. Section 151 permits a professional carer to disclose confidential information to the Commissioner of Police about the unsuitability of a licence holder to possess a firearm.

[170] The potential inconsistency is created because of the different thresholds for notification to the Commissioner of Police (or an authorised officer) and the different nature of the obligation to notify, for example, mandatory or discretionary (*may* as opposed to *must*).

[171] Before addressing the specifics of sections 24 and 151 of the Weapons Act, it is useful to note section 59(2) of the Weapons Act, prohibits the possession or use of a weapon if a person is under the influence of liquor or a drug and creates a summary offence for contravention of the prohibition which is punishable by 40 penalty units. A person convicted of an offence against this section is for that reason *"not a fit and proper person to hold a licence"* for a period of five years.

[172] The operative effect of section 28(1)(b) of the Weapons Act permits an authorised officer to suspend a licence if the officer *"considers, on reasonable grounds, that the licensee may no longer be a fit and proper person to hold a licence."* In the circumstance of a *change* to the licensee's mental and physical fitness, the two likely sources of information are the licensee and their *professional carer*. In the case of an ADF member such as FSGT, this would have included his MO and/or MHP.

[173] In less common circumstances, a licensee's employer may have the relevant information. Although there is no prohibition on other persons who are close to the licensee informing an authorised officer of a concern about a licensee's mental or physical fitness to hold a licence, the Weapons Act does not protect the identify of a person who provides

that information to police. This may create some reluctance on those close to a licensee to notify police of such matters and highlights the desirability of concurrent notification obligations on relevant persons.

Sections 24 and 151 of the Weapons Act

[174] Section 24 of the Weapons Act imposes, as a condition of a weapons licence, a mandatory obligation on a licensee to notify police of a relevant *event* which includes *"a change in the licensee or licensee's representative's … mental or physical fitness"*.

a. The term *"fitness"* in section 24 relates to the concept of "a fit and proper person to hold a licence" which includes *"the mental and physical fitness of the person".*[194]

b. Unlike other relevant *events* specified in section 24 (such as change of address, a conviction for an offence or the making of a domestic violence order against the licensee), a change to the person's mental or physical fitness is often difficult to objectively confirm by an authorised officer.

c. A *"change … in mental fitness"* is also difficult to quantify and section 24 reflects a low standard for such a notification. That is, it does not require the change to reach a threshold of *unsuitability* to hold a licence or a demonstrable risk to the person or others.

d. Rather, the section operates to impose a mechanism for the provision of information which engages the functions of an authorised officer. It is also reasonably foreseeable that a person who enjoys the sport of shooting would be less likely to notify police of an intangible event such as a change of mental fitness to hold a licence if the person was concerned that it might result in a review of their fitness by an authorised officer with the possible consequence of a suspension or revocation of their licence.

e. In this way, section 24 imposes a condition upon a licence holder which is, to a large extent, in the form of a self-regulation provision.

f. Further, to the extent that the events specified in section 24 relate also to a licensee's representative, the notification obligation is only imposed upon a licensee.

[175] It may be envisaged that an entity which employs a person who has possession or use of weapons as an incident of their employment

[194] Section 10B of the *Weapons Act 1990* (Qld)

duties, would be better placed to notify a police officer of a change in the licensee's mental or physical fitness. Although that information would be confidential employment information, it would not involve a breach of any duty of confidence which arises with a professional carer within section 151 of the Weapons Act and the interests of the employer, and the public interest are likely to co-exist to the same extent.

[176] Section 151 of the Weapons Act is permissive, not mandatory. It provides that a *"professional carer"*[195] *"may"* notify the Commissioner of Police of their opinion that a person is unsuitable to possess a firearm for the reason of the persons mental or physical condition or because the person may be a danger to themselves or others.

a. Section 151 confirms that such notification is lawful despite any duty of confidence owed by the *professional carer* and precludes any civil or criminal liability attaching to the *professional carer*.

b. The threshold for the exercise of the *professional carer's* discretion to notify the Commissioner of Police is a high threshold, namely when the carer forms the opinion of *"unsuitability."*

c. There is some awkwardness in imposing this threshold on a professional carer where the question of a person's suitability or unsuitability to hold a weapons licence according to section 10B of the Weapons Act vests solely in an authorised officer.

d. This raises the question of why a *professional carer* is not required to notify the Commissioner of Police if they form the opinion that the person is unsuitable to hold a licence? The obvious justification for the permissive approach is the importance of preserving the therapeutic relationship and the potentially discouraging effect upon seeking treatment if the licensee knows the *professional carer* "must" notify the Commissioner of Police. This is a significant consideration.

[177] A potential gap in the licensing scheme established by the Weapons Act may be created in circumstance where a licence holder does not comply with the low threshold imposed by section 24(1)&(2)(a)(ii) of the Weapons Act and the *professional carer* either is not satisfied of the high threshold of unsuitability or decides not to notify the Commissioner of Police out of concern for the treatment relationship or other reason.

[195] Defined in section 151(4) to mean a doctor, a person registered under a Health Practitioner Regulation National Law to practice in the psychology profession or nursing profession and a person prescribed under regulation engaged in providing health services.

[178] In either case, an authorised officer's functions under section 24(5)(b) to *"take the appropriate action in relation to the licence"* or issue a suspension notice under section 28 of the Weapons Act is not engaged.

[179] A further gap may be created where, in the same circumstances, police who attend an incident have no ability to access information on QPRIME which might have been uploaded in the event of a notification by a *professional carer*. That is, they would not have available to them the information known to the carer which founded the carer's opinion of the licensee's unsuitability irrespective of any action which had been taken or is yet to be taken by an authorised officer.

[180] Counsel for the QPS officers submitted:

a. There was merit in considering aligning the threshold for notification under section 151 of the Weapons Act with the threshold in section 24 (which is a condition of the licence).

b. There is merit in considering the concerns about a licensee seeking medical treatment and engaging with professional care providers in circumstances where there is a representative of a licensee.

c. There is also merit in considering aligning the nature of the obligation to notify under section 151 with the mandatory obligation in section 24.

[181] Counsel for the QPS officers proposed several amendments that may improve section 24 of the Weapons Act, considering the above points. Counsel for the QPS officers submitted, and I accept there are competing considerations which attach to the important question of sharing information about the licensee and mandatory reporting. Mandatory reporting is likely to discourage people from seeking mental health treatment but there is a public interest in effectively managing public health and safety consistently with objects of the Weapons Act. These questions involve some nuance and complexity which go beyond the scope of the evidence given at the Inquest.

Recommendation Two:

[182] **I recommend that relevant stakeholders (from the ADF, including the Provost Marshall, JHC, QPS and Qld Health) and other relevant specialists be assigned to a government working group under the Minster for Police and Emergency Services to consider the question or take further action according to the Minister's direction.**

Proposed changes to the Qld Health Information Booklet 'Health and Weapons'

[183] Counsel assisting submitted[196] that I may comment or recommend that a joint project be undertaken by representatives from the ADF JHC, QPS and Qld Health to develop a clearer understanding of disclosure requirements and to update the Queensland Health Information Booklet entitled *Health and Weapons*. This recommendation was supported by the Department of Defence[197] and the Commissioner of Police.[198]

Recommendation Three:

[184] **I recommend that a joint project be undertaken by representatives from the ADF, including the Provost Marshall, JHC, QPS and Qld Health to develop a clearer understanding of disclosure requirements and to update the Queensland Health Information Booklet entitled *Health and Weapons.***

Creation of Weapons Register within Defence

[185] Counsel assisting submitted[199] that I may comment on or recommend that the ADF collect information from ADF members regarding their status as registered firearms holders, in a central database managed by the Office of the Provost Marshall of the Defence Force. Such a database could be appropriately linked with or visible to a "point or crisis contact" (discussed below). It may also assist MOs to ensure they are appraised of any registered weapons an ADF member may have, in the event there are concerns regarding their mental health. Counsel assisting acknowledged that consideration must be had to who would be able to view the weapons register and in what circumstances, to ensure appropriate privacy considerations were met.

[186] This recommendation was supported by the Commissioner of Police.[200]

[187] Counsel for the Department of defence did not support the proposed recommendation in its current form. They submitted that it did not address the perceived existing deficiency. In the event of a crisis, the QPS will already have access to the registered weapons information of an ADF member, such that the Provost Marshall's database would be redundant.

[188] If the intent of the scheme was to ensure information was accessible in a crisis, Defence submitted that civilian law enforcement would be better placed to know the status of an ADF member's civilian weapons licence than Defence itself. While such a register *may* aid MO's and MHP's in the assessment of an ADF member's risk of suicide/self-harm/harm to others, the amendments to the DHM (discussed above)

[196] Submissions of counsel assisting at [170].
[197] Submissions of the department of defence at [38] – [39].
[198] Submission of the commissioner of police at [12].
[199] Submissions of counsel assisting at [171] – [172].
[200] Submission of the commissioner of police at [13].

already exist as a means of informing health personnel that an ADF member may have access to registered weapons and to raise this issue with the member in question during the assessment and subsequent treatment processes.

[189] Should the QPS Weapons Licensing Group want to know if an ADF member holds a civilian weapons licence, the license application forms and/or re-application forms may be amended to seek the employment information of the licence holder (or applicant for a licence). No amendment to the law or regulation is required to achieve this outcome and it is a less onerous recommendation, which would also provide the QPS Weapons Licensing Group oversight of other weapons-holding occupations, or occupations with a high risk of firearm-related incidents. While I accept this submission in part, I would urge that any future working group for further change, also consider this issue.

Recommendation Four:

[190] **I recommend that the QPS Weapons Licensing Group amend their application forms to seek employment information from the licence holder (or applicant for a licence).**

Establishment of a "point of crisis" contact

[191] Counsel assisting submitted[201] that I may comment of recommend that a "point of crisis contact" be established within JHC that is available on a 24/7 basis:

a. Such a position should be staffed by an appropriately qualified health professional with immediate access to ADF members medical records and PMKEYS details, including emergency contacts to ensure state authorities (such as the QPS and QAS) are capable of immediate unimpeded contact and provided information that will assist in situations (including negotiations during a siege) such as that in which FSGT found himself.[202]

b. A suggestion may be an area health duty officer capable of accessing records, understanding privacy considerations, and the sensitivities around providing treatment to ADF members in such a way that seeks to uphold the therapeutic relationship between the member and health staff.

c. Dr Gwynne gave evidence at the Inquest that he believed it might have been outcome changing had he been able to speak to FSGT on the evening of 12 March 2023.

[201] Submissions of counsel assisting at [173] – [175].
[202] 26 June 2023, T3-23, LL 29 – 39.

d. While it was not submitted that MO's should staff the point of crisis contact position, such a position could assist in contacting MO's quickly and efficiently when required.

[192] This recommendation was supported by the Commissioner of Police.[203]

[193] The Department of Defence submitted that the gravamen of this proposal was to ensure the QPS could swiftly obtain health information about an ADF member in a crisis situation, and they endorsed the concept and intended outcomes of this recommendation.[204]

[194] Within its current systems, Defence maintains a 24-hour helpline staffed by the Joint Military Police Unit (**JMPU**):

a. One of the purposes of this helpline is to assist in connecting civilian authorities to information available to the JMPU, such as defence service records, current posting date and next of kin details.

b. However, the JMPU does not have immediate access to the medical information of ADF members.

c. The ADF is exploring the implementation of a functionality whereby the JMPU could transfer a verified caller from a civilian police service to a 24-hour garrison health Duty officer, who has access to ADF members' health records.

d. This would enable, subject to compliance with the *Privacy Act 1988* (Cth) (specifically Australian Privacy Principle 6), civilian police to discuss their concerns with a member of the JHC, to access relevant health information about a member (to the extent necessary to lessen or prevent a serious threat to life, health, or safety of an individual, or as otherwise permitted under the *Health Practitioner Regulation National Law*).

e. While this model is not identical to that of the proposed recommendation, Defence submits it is more efficient to use existing infrastructure to achieve the same outcome advocated for by Counsel Assisting.

Recommendation Five:

[195] **I recommend that a point of crisis contact be established within the ADF. I would urge that any future working group for further change, also consider this issue.**

[203] Submission of the commissioner of police at [14].
[204] Submissions of the department of defence at [46] – [49].

Safety plans within the ADF members unit or as part of the treatment plan for an episode of care

[196] Counsel assisting submitted[205] that I may comment of recommend that ADF policy be amended to provide suggestive guidance to MO's and CO's, relating to the questions about the storage of personal weapons or parts of the weapon (such as removing the bolt or other working part so as to render the weapon the inert), and storage of that part in a defence armoury or with a designated person for the duration of an episode of mental health care, as a further means of providing support to ADF members experiencing episodes of mental health care.

[197] The Department of Defence supported this recommendation[206] insofar as it related to the CO of an ADF member. The role of the MO in the medical treatment of a member is distinct from the administrative and operational considerations involved in the approval to store private firearms on Defence premises. It is understood that the MO would have a role in the formulation of the mental health care plan but cannot be involved in the decision regarding whether or not to store the weapons in a Defence armoury. Under current policy, there is a discretion for commanders to approve the storage of private weapons "where private storage is not available". Defence agreed that an amendment to the MILPERSMAN should occur to permit a CO the discretion to accept civilian firearms, or their critical parts, into ADF armouries if such a step is consistent with a mental health care plan.

Recommendation Six:

[198] **I recommend that the MILPERSMAN be amended to permit a CO the discretion to accept civilian firearms, or their critical parts, into ADF armouries if such a step is consistent with a mental health care plan for an ADF member.**

Findings required by s. 45 of the *Coroners Act 2003*

[199] I make the following findings:

Identity of the deceased	FSGT.[207]
How they died	QPS officers responded to a call for assistance from FSGT 's wife, in circumstances where there had been an argument and his family had left the incident address. Prior to his death, FSGT had a confirmed diagnosis of MDD with anxious distress. He was MECJ31 and had employment

[205] Submissions of counsel assisting at [176].
[206] Submissions of the department of defence at [50] – [52].
[207] *Coroners Act 2003* (Qld) s 45(2)(a) who the deceased person is. Due to the extensive injuries and a lack of recorded fingerprints, circumstantial identification was accepted. Exhibit B1, 6. Exhibit B1.3.

	restrictions (prohibiting his use of weapons, ammunition, and defence vehicles). In the months leading up to his death, he was prescribed medication in connection with his diagnosis and was receiving appropriate treatment and care through the ADF. FSGT also suffered several serious physical injuries prior to this time from which he had an extended period of rehabilitation. Two critical contributors to FSGT 's actions immediately prior to his death were his level of alcohol intoxication and access to lethal means (registered firearms). FSGT fired numerous rounds into the street from the driveway of the family home, before going back inside the home, where he fatally shot himself.
Place of death	Kirwan, Qld.[208]
Date of death	12 March 2023.[209]
Cause of death	1(a) Gunshot wound to the head.[210]

[200] I close the inquest.

S Gallagher
Deputy State Coroner

[208] *Coroners Act 2003* (Qld) s 45(2)(d) where the person died. Exhibit A2. Life Extinct Form. Exhibit B1, 2 and 5.
[209] *Coroners Act 2003* (Qld) s 45(2)(c) when the person died. Exhibit B1, 2.
[210] *Coroners Act 2003* (Qld) s 45(2)(e) what caused the person to die.

Schedule of Abbreviations

452 SQN	RAAF Unit responsible for the air traffic control services in Northern Australia
ADF	Australian Defence Force
ADFCMH	Australian Defence Force Centre for Mental Health
ADFRP	Australian Defence Force Rehabilitation Program
ADFMATRS	Australian Defence Force Medical Advice, Triage, and Referral Service (formerly 1800 IM SICK)
AIHW	Australian Institute of Health and Welfare
CO	Commanding Officer
CRT	Critical Response Team
DeHS	Defence eHealth System
DFDA	Defence Force Disciplinary Act 1982 (Cth)
DFV	Domestic and Family Violence
DHM	Defence Health Manual
DSS	Rank: Detective Senior Sergeant
DVA	Department of Veterans Affairs
EOC	Episode of Care
ESC	Queensland Police Service – Ethical Standards Command
FPO	Final Protection Order
FSGT	Rank: Flight Sergeant
GMRF	Gallipoli Medical Research Foundation
GP	General Practitioner
HCCF	Health Care Coordination Forum
HQJOC	Headquarters – Joint Operations Command
IGADF	Inspector General – Australian Defence Force
IIG	Queensland Police Service – Internal Investigations Group
IWB	Individual Welfare Board
JHC	Joint Health Command
LHC	Lavarack Health Centre (at Townsville's army base – Lavarack Barracks)
MDD	Major Depressive Disorder
MDT	Multidisciplinary Group (Case Review Forum)
MEC	Medical Employment Classification
MECR	Medical Employment Classification Review
MECRB	Medical Employment Classification Review Board
MILPERSMAN	Military Personnel Policy Manual
MHIP	Mental Health Intake Program
MHP	Mental Health Professional
MHT	Mental Health Team
Minute	Written correspondence to an individual or class of persons used to convey orders, directives, requests or information
MO	Medical Officer

MWD(U)	Member with dependent(s) – unaccompanied: An ADF member who is living in a different location than their family
PIC	Pre-Inquest Conference
PMCT	Postmortem Computed Tomography
PMKEYS	Employee number of ADF Member
PO	Protection Order
POPS	Post-Operational Psychological Session
PPN	Police Protection Notice
PTSD	Post Traumatic Stress Disorder
QAS	Queensland Ambulance Service
QCMHR	Queensland Centre for Mental Health Research
QPS	Queensland Police Service
RAAF	Royal Australian Air Force
RANZCP	Royal Australian and New Zealand College of Psychiatrists
RCDVS	Royal Commission into Defence and Veteran Suicide
SEMPRO	Sexual Misconduct and Prevention Office
SERCAT	Service Category
SERT	Special Emergency Response Team
SIR	Select Incident Review
SGADF	Surgeon General of the Australian Defence Force
SGT	Rank: Sergeant
SQN	Squadron
SQNLDR	Rank: Squadron Leader
THC	Townsville Health Centre, RAAF Base Townsville
TPN	Temporary Protection Notice
TTCS	Townsville Tactical Crime Squad
White Fleet	Defence owned civilian grade vehicles – eg Toyota Camry
WPO	Weapons Prohibition Order
WTSS	Weapons Training Simulation System
WRR	Workplace Rehabilitation Representative