CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of CPL Ian Turner
Hearing dates:	19-23 October 2020; 2-6 August 2021; 10-13 August 2021; 29 August 2022; 1, 6 and 9 September 2022; 1, 3, 6, 7, 8 and 9 February 2023
Date of findings:	19 December 2024
Place of findings:	NSW Coroners Court, Lidcombe NSW
Findings of:	**Magistrate Harriet Grahame, Deputy State Coroner**
Catchwords:	CORONIAL LAW – intentional self-harm – multi-drug toxicity – Post Traumatic Stress Disorder (PTSD) – combat-related PTSD – mental health supports for ADF member whilst on deployment and while at home – risks of deployment to ADF member with PTSD – medical clearances and command waivers – history of domestic violence and alcohol abuse – effect of disciplinary proceedings, reduction in rank, transfer to another company, and rejection of study plans
File number:	2017/216798
Representation:	**Counsel Assisting**: Ms Kristina Stern SC, Ms Madeleine Ellicott, and Ms Naomi Wootton instructed by Mr Paul Armstrong of the Crown Solicitor's Office **Counsel for Ms Joanna Turner:** Mr Bruce Levet OA **Counsel for Mrs Patricia Turner and Mr Mike Turner**: Mr Jonathan Hyde, instructed by Mr Greg Isolani of KCI Lawyers **Counsel for the Commonwealth**: Ms Jennifer Single SC and Mr Joe Edwards, instructed by Ms Karina Harvey of the Australian Government Solicitor **Counsel for Dr Sujaya Sringeri**: Ms Kim Burke, instructed by Ms Lauren Rickersey of Barry Nilsson Lawyers **Counsel for Dr Muhammad Malik**: Mr Ryan Coffey, instructed by Ms Marie Panuccio of Makinson d'Apice Lawyers **Counsel for Dr Brendan Hale**: Mr Geoffrey Gemmell, instructed by Ms Kerrie Chambers of HWL Ebsworth

Counsel for CAPT MH: Mr Joshua Nottle

Counsel for Group Captain James Ross: Ms Laura Johnston

Counsel for CAPT BJ: Ms Catherine Gleeson

Counsel for CPL TJ: Mr Luke Chapman

Protective orders: Pseudonym orders protecting the identities of a number of serving members of the Australian Defence Force have been made in this Inquest.

Non-disclosure orders and non-publication orders have also been made. A copy of these orders can be found on the Registry file.

Publication order: In accordance with s 75(5) of the *Coroners Act 2009* (NSW), I make an order permitting the publication of a report of the proceedings as I consider that it is desirable in the public interest to permit a report of the proceedings of the inquest to be published.

s 61 certificates issued: None issued

Findings:

Identity

The person who died was Ian Turner.

Date of death

He died between 14 and 15 July 2017.

Place of death

He died at 206/18 Amelia Street, Waterloo, NSW.

Cause of death

He died of multi-drug toxicity. The antecedent cause was combat-related Post Traumatic Stress Disorder (PTSD).

Manner of death

His death was intentionally self-inflicted in the context of combat-related PTSD.

Recommendations: To the Chief of the Defence Force, I recommend that consideration be given to:

1. Introducing a systematic process for mapping the history of an ADF member's deployments, their RtAPS and POPS screens data, and other reported psychiatric diagnoses and treatment, that forms part of the member's health record and including systems to record and action such notifications and to ensure that they are taken into account in decisions relating to deployment.

2. Including a mandatory annual training for all Special Forces members in recognising and destigmatising the symptoms of and managing PTSD, which appropriately includes simulations of real-life scenarios and recommendations about methods of decision-making.

3. Establishing a system by which psychological distress in the home environment can be communicated to an ADF member's unit by family members including systems to record and action such notifications and to ensure that they are taken into account in decisions relating to deployment.

4. Providing opportunities for ADF families to be notified of and involved in treatment programs provided to ADF members for PTSD and other combat-related psychological conditions.

5. Making it a requirement that the impact upon mental health be taken into account in decisions relating to deployment, change of company, or support of members' study plans or transitional plans to non-combat roles within the ADF or employment roles outside the ADF.

6. Implementing a requirement for psychological screening and support to be automatically offered to ADF members who are undergoing disciplinary proceedings.

7. Providing psychological screening and support whilst on deployment to ADF members who have previously been diagnosed with PTSD.

8. Employing enlisted ADF psychiatrists with:
    a. specialist training in military and veterans' psychiatry; and
    b. security clearances at a level consistent with the clearances of the ADF members who are being treated by them.

9. Ensuring that enlisted psychologists and contracted psychologists have security clearances at a level consistent with the clearances of the ADF members who are being treated by them.

10. Establishing systems and a culture of transition from Special Forces, including providing adequate support for transitions:
    a. to non-combat roles within the ADF; and
    b. to employment roles outside the ADF.

11. Undertaking an evidence-based review as to whether and how the ADF should limit the number of combat deployments upon which an ADF member can deploy during their career before being required to transition to non-combat roles.

12. Reviewing the ADF policy framework with respect to the making of deployment decisions for ADF members who have or have had a diagnosis of PTSD or another similar mental health condition, with a view to developing clear guidelines and procedures about:
    a. How such decisions should be made (including whether and how they can be "appealed");
    b. The roles and responsibilities of operational personnel, medical personnel and any external health practitioners in the making of such decisions;
    c. The information to which operational personnel, medical personnel and any external health practitioners may and may not have access in making such decisions; and
    d. In the event that a decision to deploy is made, the development and implementation of risk mitigation strategies (a plan of action should also be formulated as part of the mitigation plan/strategy in the event the condition for which the ADF member received a clearance or waiver begins to deteriorate).

13. Where an RtAPS or POPS reveals severe PTSD symptoms and permission to advise the Chain of Command is not forthcoming, that the Chain of Command is promptly notified by issuing a simple alert.

14. Implementing training programs for ADF members in command roles in relation to PTSD, including the identification of PTSD symptoms and the appropriate management of soldiers experiencing PTSD.

15. Reviewing the management of soldiers suffering from mental health conditions in 2CDO in consideration of:
    a. best clinical practice;
    b. longitudinal management of conditions and treatments; and

c. the appointment of a single point of coordination and responsibility for the overall treatment of the individual.

16. Reviewing the role of the padre in relation to the identification, treatment, and management of soldiers with mental health conditions in 2CDO.

17. Implementing a system whereby the ADF formally track the time members deploy by establishing a system for mapping the history of an ADF members leave entitlements, the leave taken, and lapsing/lapsed leave and to ensure that they are considered in decisions relating to deployments.

18. Undertaking a study of the effects of repeated deployments on a member's home and family life.

19. Conducting greater research and analysis on the correlation between incidents of domestic violence and PTSD and considering the impact of vicarious trauma on intimate partners and children of ADF members and, in turn, their ability to support the ADF member, which could include undertaking a study that investigates the decompensation of members with PTSD on or around the dates of the traumas experienced by the members.

20. Requiring all ADF psychologists conducting the RtAPS and POPS to:
    a. consider previous psychological screening results to ensure that they have a complete picture when carrying out individual assessments;
    b. be trained to ensure they understand and appreciate the importance of their role in identifying and responding appropriately to combat trauma; and
    c. undertake the assessment in an environment that allows the member to fully participate in the assessment.

21. Providing better education regarding subsyndromal PTSD and undertaking an independent review of health files and a policy developed to guide future reviews in similar situations.

22. That where ADF members are discharging on medical grounds for combat-acquired PTSD, it should be seen as a red flag for others within the unit and should trigger suitable interventions where necessary.

23. Reviewing ADF policies and practices in managing complex psychiatric cases, including clarity on where additional support and when referral to alternative service providers can be requested and ensuring that there is specialised clinical oversight in managing and making decisions regarding the

suitability of activities, duties, and clinical intervention for members in CPL Turner's situation.

24. Amending the ADF's policy*, Army Standing Instruction (Personnel) Part 8 Chapter 8: Delivery of Support to Wounded, Injured and Ill Members in the Australian Army (ASI(P) Part 8 Chapter 8) dated November 2021*, by including the following:
    a. If the member is physically unable to attend the welfare board meeting, the policy is to stipulate who is responsible for providing the member with details of the proceeding and the outcome;
    b. A process of referral in circumstances where the welfare board is not witnessing an expected trajectory of improvement in the member's condition, the Chain of Command can escalate the matter for additional resource support, including additional clinical input for a higher level of care;
    c. Implementing recommendation (d) arising from a Joint After-Action Review conducted by Special Operations Command and Joint Health Command 195 that Director Garrison Operations be included in quarterly Commander Special Forces Welfare Board to ensure that complex cases have the adequate resources at the unit level to deliver appropriate care; and
    d. Coordination of services.

25. Clearly delineating the difference between a medical clearance and a command waiver and ensuring that all documentation including policies and forms used in the process reflect that delineation.

26. Undertaking research regarding the value of a transition period between a member being on operations and returning to a domestic environment and the time required to make such a transition.

27. Providing education for units, in particular male dominated units, regarding the ethical and moral treatment of women and placing greater emphasis on "[p]rotecting the family unit" for a member suffering from ill mental health.

A copy of these Findings is to be provided to the Chief of the Defence Force and the Minister for Defence.

Contents

INTRODUCTION

1. This Inquest concerns the death of CPL Ian Turner who was found deceased in his unit at Waterloo NSW on 15 July 2017.

2. CPL Turner was 35 years old when he died.[1] He had a history of post-traumatic stress disorder (**PTSD**) and substance abuse. Except for a short period when he worked for a private security company in Iraq, CPL Turner had been a member of the Australian Defence Force (**ADF**) since 2000 and had been deployed multiple times to East Timor, Iraq, and Afghanistan. CPL Turner gave much of his life to serving his country through the ADF.

3. It was clear during these proceedings that CPL Turner's death has profoundly affected many. He was greatly loved by his family and fellow soldiers. Tragically, however, the intensity of his journey with PTSD complicated and damaged some of his relationships with those around him and theirs with each other. At the outset I acknowledge the pain and grief of Joanna Turner, Pat and Mike Turner and their family, and all of those who served with or loved CPL Ian Turner. I am acutely aware that the trauma that surrounds his death continues.

THE ROLE OF THE CORONER AND THE SCOPE OF THE INQUEST

4. The role of the coroner is to make findings as to the identity of the deceased person and in relation to the place and date of their death. The coroner is also to address issues concerning the manner and cause of the person's death.[2] A coroner may make recommendations arising from the evidence in relation to matters that have the capacity to improve public health and safety in the future.[3]

5. It is important to acknowledge that this Inquest occurred during a period when there was broad community concern about the prevalence of defence and veteran suicides. Prior to these proceedings commencing, the Commonwealth Government had announced the establishment of a new National Commissioner for Defence and Veteran Suicide Prevention and the terms of reference for the Independent Review of Past Defence and Veteran Suicides. This important inquiry was resourced to examine broad systemic issues. In contrast, these coronial proceedings focussed on the death of a single soldier and the specific issues he faced. Nevertheless, the close

[1] Tab 1 (P79A Report of Death to the Coroner).
[2] *Coroners Act 2009* (NSW) s 81.
[3] *Coroners Act 2009* (NSW) s 82.

examination of CPL Turner's death brought into focus important issues that have a wider significance.

THE EVIDENCE

6. The Court took evidence over 24 hearing days and received documentary material comprising an 11-volume brief of evidence (Exhibit 1) and 66 further exhibits. In total, more than 14,400 pages of evidence were tendered. This material included witness statements, medical records, ADF service records, ADF policies and procedures, and expert reports. The Court heard oral evidence from many witnesses including CPL Turner's fellow soldiers, his treating medical practitioners, ADF officers, his family and friends, and five expert psychiatrists.

7. Notwithstanding the volume of evidence, certain evidentiary gaps were identified by the parties. For example, the Commonwealth submits that it could be inferred that not all messages were recovered from CPL Turner's phone,[4] which "has consequences"[5] for the findings, comments, and recommendations that can now be made. Separately, Counsel Assisting submits that I could not be confident the ADF produced all documents falling within the scope of subpoenas issued in 2019 and 2021. While accepting there was an initial mistaken non-compliance with the 2019 subpoena, the Commonwealth submits in reply that the ADF was not required to produce "all" material within scope, but only make "reasonable searches" and "reasonable enquiries" to find such documents.[6] This issue is explored in further detail at [130]-[134] and [1039]-[1047] below.

8. I have taken into account the extensive evidence before me. The parties also provided very extensive submissions. While I have not been able to refer to every point raised, each has been considered carefully.

9. It is acknowledged that delay has also impacted these proceedings. Difficulties in obtaining relevant material, the effect of COVID 19 on court listings, and various other factors have all played a role. The Court acknowledges the additional stress this has placed on CPL Turner's loved ones and on witnesses awaiting the conclusion of these proceedings.

[4] Submissions of the Commonwealth dated 7 June 2024 at [34]-[37].
[5] Submissions of the Commonwealth dated 7 June 2024 at [37].
[6] Submissions of the Commonwealth dated 7 June 2024 at [38]-[46].

BACKGROUND FACTS

Childhood, Early Life, Family

10. CPL Turner was born on 13 November 1981. CPL Turner's father, Mike Turner, was a reservist in the Army. His mother, Patricia Turner, was a schoolteacher. He also has three sisters (Christine, Karen, and Lisa), and had a brother (Steven) who sadly passed away not long after the close of oral evidence in the Inquest.

11. CPL Turner met his wife, Joanna Turner, in 1994, as they attended the same high school. They commenced a relationship in 2002 and were married in 2006.[7] Joanna Turner had a son from a previous relationship (**XS**), who was born on 26 September 2002.[8] CPL Turner and Joanna Turner subsequently had a daughter (**ET**), born on 2 January 2005.[9]

CPL Turner's Early Service in the ADF and Events Prior to 2013

12. On 4 April 2000, CPL Turner enlisted in the Australian Regular Army (**ARA**).[10] He served with the 2nd Battalion, The Royal Australian Regiment (**RAR**), until October 2003. During this time, he deployed to East Timor on OP TANAGER (2001), from 28 October 2001 to 11 December 2001, and again from 20 December 2001 to 30 April 2002.[11] It appears that during his second deployment, he was convicted of a DUI offence, but did not show any signs of subsequent alcohol dependence and a liver function test showed normal function.[12] Following successful completion of Commando Training and Selection, CPL Turner was posted to the 4th Battalion, RAR (Commando) (**4 RAR (CDO**)).

13. CPL Turner transferred to the Army Reserve on 5 April 2004 and was posted as a rifleman to 12/40th Battalion, The Royal Tasmanian Regiment. He undertook security contract work in Iraq, prior to re-joining the ARA on 1 November 2006 as a 4 RAR (CDO) reinforcement.[13] On 19 June 2009, 4 RAR (CDO) was renamed the 2nd Commando Regiment, or **2CDO**.[14]

14. CPL Turner deployed on Operation SLIPPER (Afghanistan) in 2007, 2009, 2011/2012 and 2013, and Operation OKRA (Iraq) (**OP OKRA)** in 2015 and 2016. He also

[7] Tab 6 (Statement of Joanna Turner) at [3].
[8] Tab 32 (IGADF ROI with Joanna Turner dated 15 August 2018) at 4.
[9] Tab 6 (Statement of Joanna Turner) at [3].
[10] Tab 13 (IGADF Report) at [3].
[11] Tab 43 (ADF Personnel File) at 18.
[12] Tab 49 (ADF Medical Records – Unit copy) at 279.
[13] Tab 13 (IGADF Report) at [3].
[14] Tab 13 (IGADF Report) at [3].

completed other deployments which did not involve active combat or deployment to a warzone.

15. CPL Turner deployed to Afghanistan in 2007 (**2007 Afghanistan Deployment**) and was deployed there on Operation SLIPPER from approximately 24 August 2007 to 4 January 2008.[15] During this deployment, CPL Turner's close friend, PTE Luke Worsley, died during a building clearance operation.[16] Joanna Turner's evidence was to the effect that PTE Worsley's death had a negative impact on CPL Turner, and his alcohol consumption increased noticeably following this deployment. CPL Turner reported (to Dr Sringeri, sometime in 2014) "experiencing symptoms of post-traumatic stress disorder like … frequent flashbacks, intrusive memories of nightmares and panic attacks", and "swings and irritability".[17] He reported using alcohol to cope with his PTSD symptoms.[18]

16. CPL Turner deployed again to Afghanistan in 2009 (**2009 Afghanistan Deployment**), and was deployed there on Operation SLIPPER from approximately 6 March 2009 to 10 July 2009.[19] During this deployment, he applied first aid to PTE Damien Thomlinson, who lost both of his legs when his vehicle was struck by an IED.[20] CAPT MH stated that CPL Turner, in his view, seemed to speak about this incident more than others, talking about being hit with Damien's foot, "the mess, the sound of Damien like in incredible pain".[21]

17. CPL Turner completed a Return to Australia Psychological Screening (**RtAPS**) on 1 July 2009 in which he reported traumatic experiences including one colleague who was killed and another wounded. He reported that an event involving a young child had occurred on this deployment, who was severely injured and that this caused him "some distress" and that he "tries not to think about these events". It was reported that his symptom levels met "PTSD criteria, with high re-experiencing symptoms, a tendency to avoid discussing events and increased hyper-vigilance", and that other people had noted his "jumpiness". The recommendation made was a follow up in two months, and CAPT KH (the psychologist at 2CDO) was contacted and asked to follow up with CPL Turner.[22]

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[15] Tab 43 (ADF Personnel File) at 18.
[16] Tab 13 (IGADF Report) at [7].
[17] Tab 105 (Letter from Dr Sringeri to Meehans Solicitors dated 12 May 2014) at 15.
[18] Tab 105 (Letter from Dr Sringeri to Meehans Solicitors dated 12 May 2014) at 15. See also Tab 32 (IGADF ROI with Joanna Turner dated 15 August 2018) at 8.
[19] Tab 43 (ADF Personnel File) at 18.
[20] Tab 13 (IGADF Report) at [7].
[21] Tab 18 (IGADF ROI with CAPT MH on 5 June 2018) at 24. See also Tab 32 (IGADF ROI with Joanna Turner dated 15 August 2018) at 13.
[22] Tab 48 (ADF medical records psyche file) at 41-42. See also Tab 49 (ADF Medical records – unit copy) at 592- 596.

18. CPL Turner reported (to Dr Sringeri, sometime in 2014) that he experienced an exacerbation of his PTSD symptoms after he returned from the 2009 Afghanistan Deployment, including reliving symptoms (recurrent flashbacks, intrusive memories and nightmares) in a more severe fashion, having "more frequent panic attacks and more intense mood swings", being "increasingly angry for trivial reasons", consuming "excessive alcohol to cope with PTSD symptoms", and alcohol dependence symptoms like tolerance and craving.[23]

19. A Post-Operational Psychological Screening (**POPS**) was conducted with CPL Turner on 22 September 2009 as a result of the RtAPS referral. He recalled during that session the traumatic experiences he had during the 2009 deployment. He reported "no concerns at home". He further reported low psychological distress, but restlessness and an inability to sit still. The conclusion in the POPS was that there were no "immediate concerns" and no reason to recall him for another session/follow up, and that he had "impressed as coping well thus far".[24] CPL Turner deployed again to Afghanistan in 2011-2012 (**2011-2012 Afghanistan Deployment**) and was deployed there on Operation SLIPPER from approximately 27 July 2011 to 1 February 2012.[25] CPL Turner reported (to Dr Sringeri, sometime in 2014), that he experienced "more traumas of his friends getting injured", and continued to have symptoms of PTSD and consume alcohol excessively.[26]

20. CPL Turner underwent an RtAPS on 31 January 2012. During that session, he reported that he had significant exposure to potentially traumatic events but that this was "not an issue for him" and that he would seek support if issues arose. CPL Turner reported that for his "coping skills" he utilises "Beer" as well as "kids missus fitness and watching movies".[27] On 5 July 2012, CPL Turner was seen by a plastic surgeon in relation to lacerations sustained from punching a television screen.[28]

21. CPL Turner underwent a POPS on 28 August 2012. During that screening he reported being restless, difficulty concentrating, hyper-alertness, and jumpiness but stated these were "typical / normal for him".[29] He reported re-experiencing symptoms in relation to him having provided first aid to Damien Thomlinson, stating that the "visual intensity of this scene still intrudes today with vivid images" and "monthly disturbing weird dreams", as well as drinking "4–6 stubbies of beer most nights". The

[23] Tab 105 (Letter from Dr Sringeri to Meehans Solicitors dated 12 May 2014) at 15.
[24] Tab 48 (ADF medical records) at 35-36.
[25] Tab 43 (ADF Personnel File) at 18.
[26] Tab 105 (Letter from Dr Sringeri to Meehans Solicitors dated 12 May 2014) at 16.
[27] Tab 48 (ADF medical records – unit copy) at 27.
[28] Tab 47 (ADF Medical Records – Central Part 2) at 323.
[29] Tab 48 (ADF medical records – unit copy) at 21.

recommendation noted was that the member would benefit from follow up support, but had refused support, and that it therefore seemed "unlikely the member would appropriately engage in therapy or the ADF RESET program", so "no further action is planned".[30]

22. Joanna Turner gave evidence that the first time CPL Turner was violent to her was a few weeks after their daughter was born in 2005. Joanna also gave evidence that excessive alcohol use was a long-term problem for CPL Turner that she started noticing before 2013.[31]

Relevant Events of 2013

23. CPL Turner deployed again to Afghanistan in 2013 (**2013 Afghanistan Deployment**) and was deployed there on Operation SLIPPER from approximately 31 January 2013 to 17 July 2013.[32] He reported (to Dr Sringeri, sometime in 2014) that he experienced "witnessing multiple traumatic experiences like 4 of his friends were shot and 5 blow-ups".[33] Joanna Turner reported that following this deployment, she saw "the most significantly dangerous change in Ian … he was spiralling quick".[34]

24. CPL Cameron Baird lost his life during this deployment. CAPT MH stated that CPL Turner and CPL Baird were "very close mates, and he often talked about Cam … He often said he wished he could change places with Cam".[35] CPL JW stated in his record of interview (**ROI**) that the death of CPL Baird was "a pretty hard one for everyone to take" and that CPL Turner was "blaming himself, but he was really grieving the loss."[36]

25. CPL Turner underwent an RtAPS on 10 July 2013. He reported high psychological distress and reported his alcohol dependence which the psychologist interviewing him attributed to "traumatic grief", seemingly related to the death of CPL Baird. The notes also recorded that CPL Turner had admitted to consuming significant volumes of alcohol, drinking in the workplace, and hiding this behaviour in 2012 but stated that he now had the ability to "stop after 2 drinks."[37]

26. Joanna Turner's evidence was to the effect that when CPL Turner returned from the 2013 Afghanistan Deployment, he was "highly withdrawn", there was an increase in

[30] Tab 48 (ADF medical records – psyche file) at 21-22.
[31] 19/10/2020 T52.26-30 and T53.20-35.
[32] Tab 43 (ADF Personnel File) at 18.
[33] Tab 105 (Letter from Dr Sringeri to Meehans Solicitors dated 12 May 2014) at 16.
[34] Tab 32 (IGADF ROI with Joanna Turner) at 16.
[35] Tab 18 (IGADF ROI with CAPT MH on 5 June 2018) at 25. See also Tab 20 (IGADF ROI with CPL JW on 5 June 2018) at 7.
[36] Tab 20 (IGADF ROI with CPL JW) on 5 June 2018 at 7-8.
[37] Tab 48 (ADF medical records – psych file) at 11-19.

"Army talk" at home and his "pain compliance" towards Joanna and the children increased, as well as his anger towards XS who he would make "do drills".[38] Joanna Turner reported an increase in what I will describe as " coercively controlling" behaviour around this time, whereby she was not allowed to have male friends on Facebook, CPL Turner would check her phone every day, she had to give him a rundown of who she had spoken to, and if he wanted to know at any time where she was, he would send her a message and she would have to take a photo "to prove where I was". If she did not comply, he would choke her, or hold her in pain compliance until she did what CPL Turner asked.[39]

27. During 2013, CPL Turner attended a memorial for CPL Baird, and on the bus ride home CPL Turner became intoxicated. He was subsequently physically abusive towards Joanna Turner, who called a friend of CPL Turner's to come and assist. Joanna Turner's evidence in her ROI was that "everyone at work knew what was happening" but "no one talks about it".[40] Joanna Turner stated that she spoke to Selena Clancy and the padre (who was then Padre M about the issues in her home around 2013.[41]

28. Joanna Turner's evidence was that CPL Turner had told her about things he had done on deployment, including stabbing a man to death, executing someone who he made get on their knees "to see what it was like", that an officer he was with used to "chop hands off" in order to identify a deceased person instead of following proper biometric identification procedures, and that he had "shot a child" and on another incident a "baby had been killed by mistake" which bothered CPL Turner greatly.[42]

29. Padre MP considered that CPL Turner had "moral injury from killing too many people… he was a sniper, so I think he killed a lot of people". Padre MP stated that he had a "big argument" one day with CPL Turner, as he had a "shimar" on his TV, which CPL Turner had taken from his 100th kill. Padre MP stated that he said "that's a trophy, I said you've got to be careful and we got into an argument about having trophies of killing people".[43] Dr Malik reported that in 2017, when CPL Turner was being treated

[38] Tab 7 (Statement of Joanna Turner) at 2 [11]. See also Tab 32 (IGADF ROI with Joanna Turner dated 15 August 2018) at 20.
[39] Tab 32 (IGADF ROI with Joanna Turner dated 15 August 2018) at 21.
[40] Tab 32 (IGADF ROI with Joanna Turner dated 15 August 2018) at 26.
[41] Tab 32 (IGADF ROI with Joanna Turner dated 15 August 2018) at 27-28. See also 19/10/20 at T53-54.
[42] Tab 7 (Statement of Joanna Turner) at 6 [32].
[43] Tab 19 (IGADF ROI with Padre MP on 18 September 2018). It should be noted that Padre MP's evidence to the Inquest was that he was on significant pain medication at the time of his IGADF interview, and that as a result his interview was very "fractured": 03/08/21 T4.7-1.

at St John of God Hospital (**SJoGH**), he stated "I have killed so many people and I cannot live with myself. I have killed innocents".[44]

30. On 16 October 2013, CPL Turner underwent a POPS screening, at which he presented with a high degree of "psychomotor agitation (wringing hands, tapping feet and eye twitch)" and a flat affect. He denied any significant reintegration issues within the domestic, social, or work context. The psychologist, however, noted that he described several symptoms which would suggest some level of functional impairment, including constant restlessness, visual images of deployment scenes, dreams, psychical anxiety, avoidance of crowded places, low frustration tolerance, and feeling hyper-alert, as well as alcohol consumption of 2 beers on weeknights and 6-8 on Friday and Saturday nights. The psychologist reported concern about his reported symptoms and encouraged a review, but CPL Turner "flatly denied the existence of any difficulties" and reported that if things worsened he would "deal with it". The POPS concluded that no further action was stipulated because of CPL Turner's resistance to engage and denial of any current difficulties.[45]

31. On 9 December 2013, the POPS was discussed between medical practitioners and it was noted that CPL Turner was then presenting to a unit welfare board (**UWB**) by reason of physical injuries, and that he would be called in early 2014 to be offered further support. On 5 February 2014, CPL Turner was called and offered further support, and he refused further engagement with psychological support, stating "not trying to be rude, but I don't really like to talk". He was advised that his POPS would be closed off and he would not be contacted but was informed that he could always self-refer.[46]

Relevant events of 2014

(a) Service in the ADF

32. CPL Turner "deployed"[47] on Operation PARAPET, which was the ADF's contribution to supporting the G20 Summit in Brisbane in 2014. He was deployed on this operation between 23 October 2014 and 18 November 2014.[48]

[44] Tab 112 (Statement of Dr Malik) at 4 [27].
[45] Tab 48 (ADF Medical psych file) at 5-6.
[46] Tab 48 (ADF Medical records) at 5-6.
[47] The evidence in the Inquest was to the effect that "deployed" can have different meanings. It appears that the term was used to describe when a member was sent to another location for an extended period of time, whether that was to a conflict zone or not. In some circumstances, it was only used to describe deployment to a conflict zone, such as the MEAO: see, e.g., 21/10/20 T172-173.
[48] Tab 43 (ADF Personnel File) at 18.

(b) 2014 Domestic Violence Charges

33. On 7 April 2014, CPL Turner was charged with stalking or intimidation with intent to cause fear of physical or mental harm, use of a carriage service to threaten to kill, and common assault.

34. The documentary evidence indicates that Joanna Turner reported the domestic violence on 30 March 2014,[49] and then attended Liverpool Police Station on 1 April 2014 to provide an updated statement in relation to the offences. CPL Turner attended Liverpool Police Station at 10am on 7 April 2014 with a support person, Ben Treloar (who was a member of the ADF), and at that time was charged.[50]

35. A provisional domestic violence order was issued by the NSW Police on 1 April 2014 for the protection of Joanna Turner.[51] This was known to the ADF: on 1 April 2014, a copy of the Provisional AVO was emailed from the Adjutant of 2CDO and it was noted that the CSM, WO2 NW, was in location where CPL Turner was then doing a course, to serve the provisional AVO on him.[52] The Adjutant noted that the CSM intended to "seek any required provisions with the NSW Police" in order to allow CPL Turner to complete the course he was doing, with respect to "weapons use".[53]

36. CPL JW noted that while CPL Turner was on course in Singleton, he was getting calls from unit members stating "look, he's drinking a considerable amount". He stated that he and CPL SM were concerned about his wellbeing and went to discuss the issue with the unit psychologist. They were told that if he was to be pulled out of the course, that would be "more detrimental" to his state at that time.[54]

37. On 3 June 2014, the charges were conditionally discharged pursuant to s 32 of the *Mental Health (Forensic Provisions) Act 1990* (NSW) (***MH(FP) Act***) (with the Commonwealth offence similarly discharged under s 20BQ of the *Crimes Act 1914* (Cth) (***Crimes Act***)).[55]

38. The order made under the *MH(FP) Act* was in the following terms:[56]

> "The charge is dismissed and the accused person is discharged
>
> Subject to the following conditions:

[49] Tab 32 (IGADF Investigation, Evidence of Joanna Turner) at 113.
[50] Tab 105 (Police Facts Sheet) at 29.
[51] Exhibit 31 (Tranche 1) at 300.
[52] Exhibit 31 (Tranche 1) at 299.
[53] Exhibit 31 (Tranche 1) at 299. See also Tab 47 (ADF Medical Records Central Part 2) at 48.
[54] Tab 20 (IGADF ROI with CPL JW) on 5 June 2018 at 13.
[55] Tab 105 (Local Cour File – New South Wales Police Force Bail Report) at 36.
[56] Tab 105 (Local Court File) at 12.

TAKE PRESCRIBED MEDICATION/ATTEND

COUNSELLING TREATMENT IN ACCORDANCE WITH

MEDICAL ADVICE/NOMINATED

PSYCHIATRIST/PSYCHOLOGIST CAPTAIN [SG]

& Dr. SUJAYA SRINGERI INCLUDING TREATMENT PLAN

SET OUT ON PAGE 8 OF REPORT OF DR. SRINGERI"

39. The order made under the *Crimes Act* was in the following terms:[57]

> "I, by order, dismiss the charge and discharge the person conditionally upon:
>
> TAKE PRESCRIBED MEDICATION/ATTEND COUNSELLING TREATMENT IN ACCORDANCE WITH MEDICAL ADVICE/NOMINATED PSYCHIATRIST/PSYCHOLOGIST DR. SUJAYA SRINGERI & CAPTAIN [SG] INCLUDING TREATMENT PLAN SET OUT ON PAGE 8 OF DR. SRINGERI'S REPORT.
>
> PERIOD: 12 MONTHS"

40. Additionally, a final Apprehended Violence Order (**AVO**) was made for a period of 6 months which contained an order not to assault, molest, harass, threaten or otherwise interfere with, intimidate, or stalk Joanna Turner or a person with whom Joanna Turner had a domestic relationship. It also provided that CPL Turner was not to approach Joanna Turner or any such premises within which she resided or worked within 6 hours of consuming alcohol or illicit drugs.[58]

41. The facts on which CPL Turner was sentenced record that "over the past few years" CPL Turner had begun to consume large amounts of alcohol on a daily basis, which made him aggressive and hostile towards Joanna Turner, and that he had been both verbally and physically violent towards her. The facts record that CPL Turner had begun to ostracise and control Joanna by taking control of her bank account and disconnecting her phone when she "upset" CPL Turner, and that he had become paranoid about her "trying to find a new boyfriend".[59]

42. The facts sheet recorded an event in November 2013, where CPL Turner had attended a Remembrance Day unveiling for a friend at the Australian War Memorial. Upon returning home, CPL Turner became aggressive and caused a large kitchen window to smash and pulled at Joanna Turner's clothing until it ripped. The facts record further abusive and controlling behaviour over text messages, CPL Turner requiring that

[57] Tab 105 (Local Court File) at 13.
[58] Tab 60 (DVA Medical Records) at 75.
[59] Tab 105 (Police Facts Sheet) at 25.

Joanna Turner delete her Facebook account under threat of "a world of hurt" and "grave trouble", and later threatening to cut off her mobile phone and then doing so. It recorded that CPL Turner later made threats that he would, in relation to another individual, "break his jaw, set him on fire and burn my name into his forehead with a hot knife".[60]

43. The facts record that on 21 March 2014, CPL Turner stated that he had tried to "slit" his wrists but that his "shit fucking knife was too blunt to do the job".[61] On 27 March 2014, CPL Turner travelled with Joanna and their children to Wollongong to watch the football. CPL Turner became aggressive and ordered Joanna to drive home, and later told her he did not think he could cope with the amount of people at the football.[62] The facts further record aggressive behaviour on 28 March and 29 March 2014.[63]

44. Character references were supplied to the Court by members of 2CDO. The first, written by WO2 NW (the CSM of B Company, 2CDO) was written on the letterhead of 2CDO. It is not apparent from the terms of that letter whether WO2 NW was informed of the substance of the charges against CPL Turner. Nonetheless, it is apparent that he was writing a letter of reference in circumstances where CPL Turner required some mitigation in his favour, noting the letter refers to the writer hoping "you take this [CPL Turner's service to the Australian Army] into account during this tough period of his life".[64] The second, written by MAJ JP, was written on the letterhead of the Australian Army. Again, it is not apparent from the terms of this letter whether MAJ JP was informed of the substance of the charges against CPL Turner.[65] Joanna Turner also wrote a letter for reference, noting that CPL Turner's deployments overseas had had an effect on his mental health, caused "problems for both him and our family", and made him "unable to rationally respond to events that occurred in the home".[66] Joanna noted that it was essential that CPL Turner "be provided with necessary mental health care and the opportunity to be rehabilitated".[67]

45. Joanna Turner also gave evidence that at the time of the November 2013 incident, one of his friends got CPL Turner and took him to Holsworthy to sleep at base, and that his "work mates in Bravo company knew what he had done".[68] CAPT MH stated in his ROI that on a "platoon sergeant's course" in 2014, CPL Turner approached him for advice

[60] Tab 105 (Police Facts Sheet) at 27-28.
[61] Tab 105 (Police Facts Sheet) at 28.
[62] Tab 105 (Police Facts Sheet) at 28.
[63] Tab 105 (Police Facts Sheet) at 28.
[64] Tab 105 (Letter of Reference for CPL Turner from WO2 NW dated 29 May 2014) at 33.
[65] Tab 105 (Letter of Reference for CPL Turner from MAJ JP dated 30 May 2014 at 34.
[66] Tab 105 (Letter of Reference for CPL Turner from Joanna Turner dated 29 May 2014) at 35.
[67] Tab 105 (Letter of Reference for CPL Turner from Joanna Turner dated 29 May 2014) at 35.
[68] Tab 7 (Statement of Joanna Turner) at 3 [15].

about an AVO, and relayed to him that he was having "significant issues" with his wife.[69]

46. BRIG Langford (at that time, COL Langford and also referred to in the material as "COL IL"), who was the CO of 2CDO at this time, could not recall being made aware of the AVO other than when Joanna Turner brought it to his attention by way of a letter on 11 June 2014.[70]

47. As noted above, the charges were dismissed on condition that CPL Turner was to take medication and attend counselling/treatment in accordance with medical advice from CAPT SG (the unit psychologist) and Dr Sringeri, including the treatment plan set out on page 8 of the report of Dr Sringeri dated 12 May 2014, for a period of 12 months.[71] That treatment plan was as follows:[72]

I would propose following treatment plan

- [redacted] to take medications as prescribed His current medications are
  - Escitalopram 10mg mane
  - Prozosin (Minipress) 3mgs bid
  - Zopiclone 7.5mg at night
  - Thiamine 100mg bd
- He needs to remain abstinent from alcohol and all illicit substances
- [redacted] to continue to engage in psychotherapy with his Clinical Psychologist
- [redacted] to continue to attend regular consultations at least for 12 months
- I do undertake the responsibility of supervision during this period if Australian Defence Force approves his further psychiatric consultation with me and to report to the Honourable Court regarding any breaches or failure comply with the treatment plan.

(c) Admission to Sydney Southwest Private Hospital in 2014

48. Around the time of the domestic violence charges, CPL Turner was admitted to Sydney Southwest Private Hospital (**SSPH**). He was admitted on 4 April 2014 and discharged on 14 May 2014.[73] He was treated by Dr Sringeri during this time, who authored his discharge summary. He was treated with medication as well as psychotherapy, in both individual and group sessions.[74] After discharge, he was scheduled to attend therapy

[69] Tab 18 (IGADF ROI with CAPT MH on 5 June 2018) at 16.
[70] 21/10/20 T177.20-33.
[71] Tab 18 (IGADF ROI with CAPT MH on 5 June 2018) at 16.
[72] 21/10/20 T177.20-33.
[73] Tab 53 (The Southwest Clinic Discharge Summary dated 14 May 2014) at 2.
[74] Tab 111 (Statement of Dr Sringeri) at 76-77.

twice a week commencing on 19 May 2014,[75] and it appears from the records that he attended therapy with CAPT SG regularly until at least July 2014.[76] He attended a psychiatric review with Dr Sringeri on 27 May 2014, at which time CPL Turner reported he was doing well.[77] He was seen again by Dr Sringeri on 26 June 2014, at which time he reported that he was doing well and that his symptoms were under control.[78] CPL Turner went on exercise for a period of three weeks around August 2014, and subsequently met again with CAPT SG on 8 September 2014.[79]

(d) Joanna Turner's attempts to assist CPL Turner through the ADF

49. Joanna Turner's evidence was to the effect that "during his plan" (that is, the 12-month period of conditional release), CPL Turner began to "drink immediately" and blamed her for ruining his career.[80] She stated that she contacted CAPT SG, the psychologist at 2CDO, but that he stated "what [Joanna] explained wasn't the case" and Joanna felt that "he was just doing what Ian wished him to do".[81]

50. On 11 June 2014, Joanna Turner penned a letter to the then-CO of 2CDO, BRIG Langford, which was emailed to BRIG Langford on 12 June 2014.[82] In that letter, Joanna raised concerns as to the support which had been provided to her, her family, and to CPL Turner by the ADF throughout his deteriorating mental health and in the events which led to her report to the NSW Police. At the conclusion of that letter, Joanna stated that:

> "all I want is for you to make sure Ian is offered every opportunity to heal and move forward in his career, and I expect that the mental health care offered is of the highest possible standard. I want reassurance that he will be cared for and given the respect he deserves as a person who has committed his life to serve to the unit [sic] to a high standard."[83]

51. Joanna Turner gave oral evidence about this letter to the effect that she had raised her concerns and nothing would happen and when she got the AVO she was "harshly criticised and shamed", and instead of "anyone providing my family with any level of

[75] Tab 47 (ADF Medical Records Central Part 2) at 32.
[76] See Tab 47 (ADF Medical Records Central Part 2) at 37-44, 81, 90, 92, 102-103; Tab 48 (ADF Medical Records – Unit Copy) at 65.
[77] Tab 47 (ADF Medical Records Central Part 2) at 87.
[78] Tab 47 (ADF Medical Records Central Part 2) at 93-94.
[79] Tab 49 (ADF Medical Records) at 521.
[80] Tab 7 (Statement of Joanna Turner) at 3-4 [18].
[81] Tab 7 (Statement of Joanna Turner) at 4 [19]. See also Tab 32 (IGADF ROI with Joanna Turner dated 15 August 2018) at 38.
[82] Tab 7 (Statement of Joanna Turner) at 14.
[83] Tab 7 (Supplementary Statement of Joanna Turner) at 17.

support, pretty much I was just cut off, not told anything and then I was blamed. I was left feeling like I was crazy or I was making up lies to get Ian in trouble".[84]

52. Joanna Turner met face to face with BRIG Langford in 2014. Her evidence was that she never heard from him again after this meeting.[85] BRIG Langford also gave oral evidence in relation to the meeting. He accepted that it was an unusual step for him to have taken to meet with the wife of a member.[86]

(e) Treatment during the period of conditional release

53. CPL Turner attended on CAPT SG at Tobruk Clinic on 3 July 2014 and reported that he had "no further significant alcohol related issues" but "is still consuming alcohol socially with his wife over dinner", and that he "has slowly taken himself off anti-depressant medication over the past 3 weeks with no residual affect".[87]

54. Subsequently, on 24 July 2014, Dr Sringeri penned a letter to Dr Matilda Metledge of Tobruk Clinic, stating that he saw CPL Turner on 17 July 2014 for psychiatric review. It reported that CPL Turner had stopped his anti-depressants (Escitalopram) about 6 weeks prior, "which is earlier than our plan to stop medication".[88] It reported that CPL Turner had "consumed alcohol" on one occasion in the prior 4 weeks and reported "having control and he stopped after 2 drinks", and that he and his wife had "been working on improving their relationship".[89]

55. On 8 September 2014, CAPT SG, the unit psychologist, reviewed CPL Turner. The clinical notes report that CPL Turner "continues to show improvement and psychological stability". It reported that he denied "significant alcohol related issues" but noted he was "consuming alcohol occasionally, while socialising without incident". It reported "no foreseeable risk" and concluded that "Ian continues to stabilise and no longer meets PTSD criteria", that a "significant factor in his recovery has been the reduction in alcohol" and that he "responded well to treatment and remains engaged and medication free".[90]

56. On 16 October 2014, Dr Sringeri wrote to Dr Metledge of Tobruk Clinic reporting that he had seen CPL Turner for psychiatric review on 16 October 2014. The report stated

[84] 19/10/20 at T56.28-44.
[85] Tab 7 (Statement of Joanna Turner) at 4 [20]. See also 19/10/20 at T58.30-38.
[86] 21/10/20 T203-204.
[87] Tab 47 (ADF Medical Records) at 37.
[88] Tab 47 (ADF Central Medical Records) at 36.
[89] Tab 47 (ADF Central Medical Records) at 36.
[90] Tab 47 (ADF Central Medical Records) at 34.

that CPL Turner reported he remains "abstinent from alcohol" and that his "marital relationship is good". Dr Sringeri provided the following recommendation:

> "Psychoeducation
> In my opinion Ian is well and stable.
> In my opinion Ian is cleared to attend all duties from a psychiatric point. He does not require any psychiatric follow up for next 6 to 12 months."

57. CPL Turner was conditionally released by the Local Court of NSW on the understanding that he would be following a treatment plan under the care of Dr Sringeri for a period of 12 months. Dr Sringeri was asked about this during his evidence at the hearing and he stated that "usually" with section 32 matters he would "follow for six months", and he did not know why he had originally written "12 months" in the treatment plan he provided to the Local Court. He stated that in his view, he had complied with the order for conditional release because he "followed him for six months" and then he was discharged back to the GP and Dr Sringeri had said he was happy to see him if required, although he acknowledged it was "a breach in some sense".[91]

58. It appears that the 16 October 2014 report from Dr Sringeri was sought in the context of a waiver being sought for CPL Turner to participate in Operation PARAPET, the G20 related "deployment" to Brisbane. A "mental health/psychological report" dated 24 October 2014 for "G20 Waiver" was prepared which stated that CPL Turner "has not been on medication or restriction for over three months and thus is psychologically suitable to deploy on G20".[92] On 4 December 2014, CPL Turner was medically reclassified by the ADF as MEC J23.[93] This classification is explained in a policy document produced by the ADF as follows: "MEC J23 – Restricted Deployment – Defined Limitations and/or Required Material Support and/or Access to Health Support up to Medical Officer support – reviewed at Unit Medical Employment Classification Review (UMECR) at least every two years".[94]

59. Joanna Turner's evidence was that prior to CPL Turner's 2015 Deployment, he was "really, really dangerous", his behaviour was "erratic", he had assaulted Joanna significantly during a family holiday to Thredbo, and he was growing in size from the use of steroids. He was also using alcohol excessively, on a daily basis.[95]

[91] 22/10/20 T346.21-24.
[92] 22/10/20 T347.28-46.
[93] Operation PARAPET was the ADF's contribution to supporting the G20 Summit in Brisbane.
[94] Tab 50 (ADF Medical Records) at 133.
[95] Tab 43 (ADF Personnel File) at 18.

60. On 11 December 2014, CPL Turner was promoted to the rank of Sergeant, with an effective date of 19 January 2015.[96] Joanna Turner stated in her ROI that when CPL Turner was promoted to sergeant, she felt like that was "the biggest insult" because "like I said, they knew – pretty much, he went back to work and never had – never given any mental health care that I was aware of. I think he had to see a psych … It wasn't about him getting well. It was how he could get back into the system and show that, you know, he could come back with no issues". She stated she felt the ADF had viewed her as the "troublemaker", or that she was "making up lies" and that her allegations of domestic violence were "never taken seriously".[97]

Relevant events of 2015

(a) Service in the ADF

61. CPL Turner deployed to Iraq on OP OKRA from approximately 18 February 2015 to 17 June 2015.[98]

62. WO1 EL, who was the Regimental Sergeant Major on SOTG 632 in Iraq in 2015, stated in his ROI that CPL Turner had left the operational area early, he was "sent home" because he had a "marital/domestic impasse or problems with home, with his then wife, Jo Turner".[99]

63. CPL Turner's RtAPS, which was conducted on 16 June 2015, reported that he had a "predominantly frustrating deployment", that he had a medium level of psychological distress "attributed to his current home front problems", and "marital discord and conflict and problems within his family of origin". He declined an offer for a further referral but stated that he would seek further psych support if his situation worsened.[100]

64. CPL Turner was contacted for a follow up on 23 June 2015 by psychologist CAPT KH, who enquired about his well-being. It was reported that CPL Turner "answered the call and engaged well" and that "no follow up" was required at that stage, but a POPS was booked for 3 months' time.[101] A further note from that interaction reported "domestic distress" and that his "wife was threatening self-harm, she keeps denying it". It reported that he had PTSD in 2014. It was noted that they discussed using strategies which

[96] Tab 41 (Career Guidance and related records) at 25.
[97] Tab 32 (IGADF ROI with Joanna Turner dated 15 August 2018) at 42.
[98] Tab 43 (ADF Personnel File) at 18.
[99] Tab 23 (IGADF ROI with WO1 EL on 15 August 2018) at 6.
[100] Tab 50 (Medical records) at 160-168.
[101] Tab 50 (Medical Records) at 57.

CPL Turner had learned in therapy, that he was "very insightful" and was "likely to re-engage [in support] if required".[102]

65. Joanna Turner stated in her ROI that CPL Turner told work he had to come home because of her mental health, but that "wasn't true", and she "got really scared when he was coming home" and contacted the police.[103] Joanna Turner reported that when CPL Turner returned from deployment in 2015, the "violence and alcohol intake increased dramatically".[104]

66. On 21 June 2015, an incident occurred in CPL Turner and Joanna Turner's home whereby they commenced arguing, Joanna Turner pushed food on the floor, and CPL Turner called police and stated that Joanna Turner was threatening self-harm. Joanna Turner denied this.[105] It appears that around 29 June 2015, police applied for an AVO against CPL Turner by reason of the concerns they had for Joanna Turner's welfare.[106] This was reported to the ADF.[107]

67. On 10 July 2015, CPL Turner underwent a mental health assessment. He was referred for assessment after service of the 2015 AVO. He was assessed as being at a "low risk of harming self or others", but an AUDIT assessment indicated a score of 15, which was noted to be "in the harmful use range" and CPL Turner was given "education regarding alcohol and interventions for reducing it as a coping mechanism".[108]

68. On 16 July 2015, CPL Turner attended on Dr Sringeri because "he was feeling stressed and worried from his relationship issues". He reported to Dr Sringeri that Joanna Turner had threatened self-harm with a kitchen knife, that he had called the police and that the police had "charged him with domestic violence". He denied experiencing any current symptoms of PTSD and a response to a PTSD checklist showed a score of 20, "suggestive of him having no or minimum symptoms of PTSD".[109] He was diagnosed by Dr Sringeri as having "Post Traumatic Stress Disorder in remission".[110]

69. On 25 August 2015, an AVO was issued in final terms with the "standard orders" that CPL Turner not assault, intimidate, or stalk Joanna Turner.[111]

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[102] Tab 50 (ADF medical records) at 169-170.
[103] Tab 32 (IGADF ROI with Joanna Turner dated 15 August 2018) at 44.
[104] Tab 6 (Statement of Joanna Turner) at 2 [7].
[105] Tab 32 (IGADF ROI with Joanna Turner dated 15 August 2018) at 122-125.
[106] Tab 32 (IGADF ROI with Joanna Turner dated 15 August 2018) at 126.
[107] See Tab 42 (Conduct & Disciplinary Records) at 100.
[108] Tab 50 (Medical Records) at 171.
[109] Tab 111 (Statement of Dr Sringeri) at [13].
[110] Tab 111 (Letter from Dr Sringeri to Senior Medical Officer, Tobruk Clinic (20 August 2015) at 87.
[111] Tab 60 (DVA Medical Records for TI) (Terms of Final Order) at 72.

70. On 20 August 2015, CPL Turner made a claim for permanent impairment compensation from the Department of Veterans' Affairs (**DVA**) under the *Military Rehabilitation and Compensation Act 2004* (Cth).[112] The listed injuries were "emotional condition" and "alcohol abuse/dependence".[113]

71. On 3 September 2015, CPL Turner underwent the POPS to which CPL Turner was referred following his RtAPS on return from the 2015 Deployment.[114] A mental health progress note was made by a clinical psychologist in the ADF which noted that CPL Turner had an "anxious affect", reported that his moods were "up and down", and noted "some evidence of emotional dysregulation when in domestic conflicts at home that leads to some impulsive, aggressive acts which places him at a low risk of harm to others". It appears the catalyst for CPL Turner seeing the clinical psychologist was a "significant argument" with Joanna Turner the previous evening.[115] The note concludes that the psychologist "will consider referral to an external MHP if internal support cannot adequately address issues without the member being concerned about medical downgrade".[116]

72. CPL Turner reported that he was drinking only two to four times a month during this period, and only had six or more drinks on one occasion "monthly".[117] Joanna Turner's evidence was that he was in fact drinking six or more drinks on a daily basis during this period.[118] She also gave evidence that friends of CPL Turner raised concerns with her that he was drinking at work during the day.[119]

73. On 9 September 2015, CPL Turner sought a medical waiver (signed by the unit Medical Officer, MAJ AM) for deployment on Ex Night Tiger in Malaysia from 4 to 20 October 2015. At the time, CPL Turner was "J22" with restrictions which included "4-5 Fit for deployment with ML2 MO". The waiver stated that CPL Turner had been "unmedicated for almost over 12 months over which time he has deployed on OP Parapet and OP OKRA, neither events required any health intervention".[120]

74. On 18 September 2015, CAPT KH (clinical psychologist) and MAJ SC (then the acting CO of 2CDO) had a teleconference where they discussed that CPL Turner's situation was deteriorating, and he was living in his office when he could not be at home. CAPT

[112] See Tab 58 (DVA Client File) at 242.
[113] Tab 58 (DVA Client File) at 246.
[114] Tab 50 (ADF Medical records) at 117, 192.
[115] Tab 50 (ADF Medical Records) at 190.
[116] Tab 50 (ADF Medical Records) at 190.
[117] Tab 50 (ADF Medical records) at 196.
[118] 19/10/20 at 64.1-14.
[119] 19/10/20 at T71.4-16.
[120] Tab 49 (ADF Medical Records) at 337.

KH also reported "possible drinking alcohol at work" and that he needed a room at the Mess. This was organised, and CAPT KH left a message on CPL Turner's mobile that afternoon indicating that keys had been left for him "at the bar". There were "possible reports" that Joanna Turner had been harmed the previous evening and Selena Clancy, the Welfare Officer, advised that members of the unit indicated Joanna Turner wanted CAPT KH to call her, but CAPT KH "didn't consider this appropriate based on my professional relationship with Ian and reports of her animosity towards me".[121]

75. Joanna Turner's evidence was that she was "curious" about this comment from CAPT KH, because she did not at the time even "really know" who CAPT KH was, or that she was providing CPL Turner with support. She attributed it to CPL Turner telling CAPT KH a mistruth and noted that "no one thought to fact check that with me", and that she did not have any direct contact with CAPT KH at that time.[122]

76. It appears that on that same day (the notes made by CAPT KH state that CPL Turner was called in on "Fri 21 Sep to come in for a consult" in relation to "reports a domestic argument occurred between Ian and his wife last night at their home"; however, it appears the date is intended to be Friday 18 September 2015, noting that is also the date indicated on the notes),[123] CPL Turner was asked to see CAPT KH and he reported to her that Joanna Turner had accused him of cheating earlier in the week, that on Thursday he learned of the death of a friend by suicide and drank alcohol, and that Joanna Turner had "questioned him" about drinking alcohol. He denied hitting Joanna Turner but agreed he had yelled at his daughter, ET.[124]

77. On 19 September 2015, Selena Clancy and CAPT KH spoke and Selena advised that Joanna Turner had reported she had been harmed on the Thursday night (i.e., 17 September 2015) but did not want to call the police because CPL Turner would be in breach of an AVO.[125] Joanna Turner stated in her oral evidence that she was not forthcoming with the extent of the domestic violence she was suffering during this period because she was afraid that CPL Turner would lose his career. She stated that CPL Turner's job was both a barrier to him actually getting well, but also was "potentially keeping my family safe".[126] Selena Clancy's evidence confirmed this in that

[121] Tab 50 (ADF Medical Records) at 212-213.
[122] 20/10/20 T76.18-23.
[123] Tab 50 (ADF Medical Records) at 210.
[124] Tab 50 (ADF Medical Records) at 21.
[125] Tab 50 (ADF Medical Records) at 213.
[126] 20/10/20 T71.32-44.

she was hearing from Joanna Turner that there were events of "attempted assaults, throwing things at her, psychological bulling".[127]

78. On 28 October 2015, CPL Turner attended on Dr Sringeri.[128] Dr Sringeri subsequently wrote a report to the Senior Medical Officer at Tobruk Clinic on 30 October 2015, noting that CPL Turner had denied experiencing any symptoms of PTSD, reported he was functioning well and enjoying work, and that he was consuming alcohol occasionally, only on social occasions and not using illicit substances. The diagnosis was listed as "PTSD in remission".[129] Dr Sringeri's evidence was that PTSD may relapse with future trauma and it is "episodic".[130] Dr Sringeri accepted that there were discrepancies between what CPL Turner was reporting to Selena Clancy and reporting to him, and that "maybe he was under reporting some of his symptoms".[131]

79. In late September 2015, CPL Turner was referred for counselling with the Veterans and Veterans' Families Counselling Service (**VVCS**). The referral noted that it was to assist CPL Turner to "manage any residual anxiety, alcohol use and impulse control issues".[132]

80. Notes of CPL Turner's session with VVCS on 4 November 2015 demonstrate that CPL Turner presented to that psychologist with concerning mental health symptoms. In particular, the presenting issues were listed as:

> "Disrupted sleep, difficulties relaxing and muscle tension, periods of depression (no present suicidal ideation indicated), anxiety, fatigue and agitation, avoidance reactions and isolation, withdrawal from significant others, anger outbursts, relationship issues of trust and intimacy, significant alcohol consumption to help him 'relax and cope', adjustment issues to home circumstances and work pressures/challenges, feeling trapped, frustrated and unsupported at work, trauma reaction from deployment and other events, as well as difficulties with personal interpersonal communication and emotional expression".[133]

81. It was noted that CPL Turner's "issues and tension have not subsided, and symptoms have been reportedly worsening over last 4 to 6 months". CPL Turner's AUDIT alcohol consumption scores reported 10 or more standard drinks 2-3 times per week, depressive reactions, some reported violent incidents in the past, and general high tension levels. It also reported that CPL Turner declined to continue with treatment.[134] Joanna Turner confirmed in her oral evidence that the presenting issues which were

[127] 13/08/21 T15.45-48.
[128] Tab 111 (Statement of Dr Sringeri) at [13].
[129] Tab 111 (Statement of Dr Sringeri) at 88.
[130] 22/10/20 T323.7.
[131] 22/10/20 T325.4-17.
[132] Tab 50 (ADF Medical Records) at 223.
[133] Tab 50 (ADF Medical Records) at 227-228.
[134] Tab 50 (ADF Medical Records) at 227-232.

recorded in the VVCS note were consistent with what she was experiencing with CPL Turner in the 2015 period.[135]

82. In a note made on 11 December 2015, it was noted by "Clin Psych" (author unknown) that CPL Turner indicated that he did not like the psychologist he met with at VVCS. CPL Turner again reported that he had concerns in relation to Joanna Turner's mental health.[136]

83. In a note made in late 2015, psychologist CAPT KH recorded that CPL Turner was "guarded about the prospect of being medically downgraded based on his reported 'hard work' he put in to being upgraded in 2014 post his PTSD diagnosis and inpatient alcohol management". It reported that CPL Turner's symptoms as reported via RtAPS and POPS for OP OKRA were "variable". It also reported that there was an ongoing referral to a psychologist with VVCS for assisting to cope with stress in his relationship, however, "he has chosen not to continue". The report notes that "relationship with wife is a source of volatility leading to change in risk status over the months I've seen Ian, which leads to alcohol use". The purpose of the note was to handover to CAPT KV, the incoming 2CDO psychologist.[137]

84. WO1 EL, the RSM of B Company during 2015, stated that he had "heard rumours at the back end of 2015 that Ian did have previous alcohol issues" but that he "was still performing at work".[138] Minutes of a Welfare Board meeting conducted on 4 September 2015 indicated that the update from CPL Turner was that "things are tracking well … still have ongoing marital issues that we are working through" and that the CO's comments were to "seek legal assistance where require[d], keep COC informed, and unit will provide what assistance it can".[139]

85. SGT NA's evidence was to the effect that CPL Turner was a highly functioning alcoholic, like "just one of those alcoholics who could just work no matter what".[140] When asked if CPL Turner was coping in his job, CPL JW stated: "Yes. Like Ian was extremely intelligent and capable at the job and I guess – and he was probably known for being like that high functioning alcoholic".[141] CPL JW stated that there was no issue

[135] 20/10/20 T73.16-25.
[136] Tab 50 (ADF Medical Records) at 226.
[137] 10/08/21 T53.31-48.
[138] Tab 23 (IGADF ROI with WO1 EL on 15 August 2018) at 8.
[139] Tab 38 (Welfare Board Minutes) at 14.
[140] Tab 14 (IGADF ROI with SGT NA on 14 August 2018) at 10.
[141] Tab 20 (IGADF ROI with CPL JW) on 5 June 2018 at 16.

with performance of his work, but "the thing in the back of everyone's minds was where – what effect that had on his personal health and that sort of thing".[142]

(b) Relationship with Joanna Turner

86. Joanna Turner stated in her ROI that from at least mid-2015 she was experiencing worsening domestic violence at the hands of CPL Turner, who was drinking more and not taking medication.[143] Her children also suffered the effects of domestic violence by witnessing acts of violence and being forced to intervene to protect Joanna Turner from CPL Turner.[144] Joanna Turner stated in her oral evidence that CPL Turner would have nights where he did not sleep very well, have bad nightmares and would sweat a lot, and he would then consume alcohol immediately in the morning. He would also drink when he had a difficult time at work where traumatic memories were relived, and that when he was under the influence of alcohol he would "just rant about his memories, trauma memories".[145]

87. Around the end of 2015, Joanna Turner moved out to a friend's house.[146]

88. Joanna Turner stated in her ROI that until CPL Turner was deployed in mid-2016, she was under the impression that they were still in a relationship, and that they would spend weekends together and she would stay at the Sergeants' Mess with him when he was living there. She reported that CPL Turner assaulted her in his room at the Sergeants' Mess around two days before he deployed.[147]

89. Joanna Turner stated in her ROI in respect of the 2015 period that she felt the unit "protected [CPL Turner] by blaming things on me and by looking at me as if I was crazy … this is how I thought I was treated, like I didn't even mater. No one ever contacted me. No one ever checked on me. No one ever provided my children with any level of, you know, concern or care".[148]

90. Joanna Turner clarified in her oral evidence that she considered Selena Clancy was doing the best she could, but that she would have liked more consideration for her family and collateral information to be provided about his welfare. She thought that the ADF was not "looking outside of the service for information about his welfare".[149]

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[142] Tab 20 (IGADF ROI with CPL JW) on 5 June 2018 at 16.
[143] Tab 32 (IGADF ROI with Joanna Turner dated 15 August 2018) at 48-49.
[144] Tab 32 (IGADF ROI with Joanna Turner dated 15 August 2018) at 50.
[145] 19/10/20 T53.1-11.
[146] Tab 32 (IGADF ROI with Joanna Turner dated 15 August 2018) at 50. See also 20/10/20 T73.27-29.
[147] Tab 32 (IGADF ROI with Joanna Turner dated 15 August 2018) at 52-53.
[148] Tab 32 (IGADF ROI with Joanna Turner dated 15 August 2018) at 48. See also 20/10/20 at T72.43-48.
[149] 20/10/20 T99.1-4.

Relevant events of 2016

(a) Relationship with Joanna Turner

91. At the beginning of 2016, Joanna Turner left the family home with her children and moved to Woronora, whilst CPL Turner moved on base at Holsworthy.[150] Joanna Turner gave evidence that she distanced herself from CPL Turner for her sake, and the sake of her children throughout 2016.[151] However, she stated that the coercive behaviour by CPL Turner towards her continued, for example, contacting a man pictured in a gym photo with her and threatening him, and following her to the shops.[152]

(b) Mental health

92. Joanna Turner's evidence was that during this period CPL Turner's behaviour changed significantly as he was drinking more and had started taking cocaine more frequently.[153] She gave evidence that when she would stay the night with him, he would sweat a lot, never sleep properly, and could become highly agitated and paranoid.[154]

(c) Management of PTSD

93. CAPT KV gave evidence to the effect that when he took over from CAPT KH, he reviewed the VVCS case closure report, the defence electronic health record, and agreed with CPL Turner to close his case. He was asked if he had concerns having regard to what CPL Turner had reported to the VVCS psychologist and not getting any follow-up, and he said "the member was saying he was coping okay, that he could self-manage and that he'll self-refer in the future if required. So that in itself was reassurance that the member would self-refer if required in the future".[155]

94. Minutes of welfare boards conducted in relation to CPL Turner on 3 March 2016, 7 June 2016, and 6 September 2016 were provided to the Inquest. The 3 March 2016 welfare board indicated that the "COC" had "put in waiver to deploy. No response" and that CPL Turner reported he was "going good. no issues".[156]

[150] Tab 6 (Statement of Joanna Turner) at 2 [8].
[151] Tab 6 (Statement of Joanna Turner) at 2 [10].
[152] 20/10/20 T74.9-24.
[153] 20/10/20 T74.26-34.
[154] 20/10/20 T75. 20-29.
[155] 10/08/21 T59.24-29.
[156] Tab 38 (Welfare board Minutes) at 5-9.

95. The minutes of the 7 June 2016 welfare board indicate that the focus of that board was the "waiver" which CPL Turner had sought to deploy to Iraq, and that CPL Turner reported he was "doing well, no issues".[157]

96. CAPT KV gave evidence that he was not the "clinical case coordinator" for CPL Turner at this time despite sitting on the welfare board, and that he did not recall providing an update to the Board about CPL Turner's presentation. He was asked in his evidence whether he should have told the UWB that CPL Turner had been recommended for further psychological follow-up and had declined. He stated there was "no requirement to provide any information on, about what he decided to do" and that he "respected his confidentiality". CAPT KV returned to the theme of confidentiality in his evidence on multiple occasions,[158] and ultimately stated unequivocally that he did not have consent to release CPL Turner's information to the UWB.[159] This is difficult to then square with his own evidence that his role at the UWB was to "help command make decisions with regards to what information was presented at the unit welfare board with regards to the management of personnel's welfare and health".[160] For at least the 6 September 2016 and the 7 July 2017 UWBs, the notes of the welfare board indicate in the "Medical Consent Given" box, "Yes".[161]

Submissions

97. Counsel Assisting submits[162] that what emerges from CAPT KV's evidence about this period is this:

    i. By the end of 2015, there was clear information available to the ADF that CPL Turner was experiencing symptoms of PTSD and was not willing to engage in further psychological treatment. That information was known to CAPT KH and was part of the information which CAPT KV said he read when he took over CAPT KH's role.[163]

    ii. CAPT KV had one conversation with CPL Turner in early 2016, in which CPL Turner declined further psychiatric or psychological support.[164]

    iii. CAPT KV then attended welfare boards and, apparently in reliance on CPL Turner's assurances, did not raise with the UWB any of the information which

[157] Tab 38 (Welfare Board Minutes) at 10-11.
[158] See, e.g., 10/08/21 T65-66.
[159] 10/08/21 T61-T64.
[160] 10/08/21 T66.27-33.
[161] Tab 38 (Welfare Board Minutes) at 1, 15.
[162] Submissions of Counsel Assisting dated 2 November 2023 at [95].
[163] 10/08/21 T59.24-29.
[164] 10/08/21 T56.4-12.

was known to him about CPL Turner's symptoms at the end of 2015 and lack of engagement in any further treatment since that time.

iv. Either CAPT KV did not consider (incorrectly, it appears) that he had "consent" to release information to the UWB (which is objectively unlikely given the point of his presence at the UWB was to provide Command with information to make decisions based on personnel's health and welfare) or CAPT KV did have consent and simply chose not to provide this information to the UWB so it could inform CPL Turner's ongoing management.

98. If the former is correct, Counsel Assisting considers that plainly enough there is a systemic issue in the functioning of UWBs: namely, if the person present at a UWB for the purpose of providing information to Command feels unable to do so because the medical professionals present perceive they have a lack of consent to release health information. If the latter is correct, it demonstrates a failure by CAPT KV to perform the function that he was attending UWBs to perform: to provide Command with information about personnel welfare and health.

99. It is not apparent, in any event, that CAPT KV could have provided the UWBs with relevant and updated information because he did not consider he had any responsibility to continue staying in touch with CPL Turner, as he was no longer in treatment.[165] Nor is it apparent that even if CAPT KV had relevant and updated information, he would have felt it necessary to share that with the UWB: his evidence was to the effect he could not recall whether Padre MP had raised concerns with him about CPL Turner's health in 2016, but even if he had, he would have simply told the Padre to encourage CPL Turner to self-refer and that he would not have told the UWB about those concerns.[166] He was unable to answer what the point in him being at the UWB was in those circumstances, beyond repeating that it was "to help command make decisions … with regards the management of personnel's welfare and health".[167] It is difficult to discern what real substantive purpose the welfare boards in this period had for CPL Turner's welfare: the evidence tends to suggest that these boards were treated as little more than tick-a-box exercises.

100. The Commonwealth submits that the second alternative above at [98] is "not open" on the evidence.[168] In support of its submission in favour of Counsel Assisting's first

[165] 10/08/21 T57.20-23.
[166] 10/08/21 T64-65.
[167] 10/08/21 T66.24-32.
[168] Submissions of the Commonwealth dated 7 June 2024 at [294].

alternative, the Commonwealth refers[169] to (i) the minutes of the unit welfare board indicating CPL Turner had not given the necessary consent[170] and (ii) the fact that, when considered in the context of ADF policy,[171] it is entirely possible that CAPT KV did not have the necessary consent.

101. In reply submissions, Counsel Assisting notes that, in relation to the second alternative, if it is accepted that CAPT KV *did* consider he had consent, then it is difficult to conceive of what other inference can be drawn about his failure to disclose other than "he chose not to do so". While the Commonwealth submits such a finding would be "serious",[172] it does not proffer an alternative explanation on the hypothesis that CAPT KV did have such a state of mind. In any event, despite the extensive submissions the Commonwealth makes about the seriousness of such a finding, Counsel Assisting does not seek a finding one way or another as to CAPT KV's state of mind. The finding that is sought is that, on any hypothesis, it was difficult to discern what real substantive purpose the welfare boards had for CPL Turner's welfare in 2016.[173]

Consideration

102. Having considered all the available evidence on this issue, I have concluded that the UWB process was of no discernible benefit to CPL Turner throughout 2016. While it appears that CAPT KV had little or no useful information to add to any discussions about CPL Turner's health or wellbeing, the fact that CPL Turner had declined further involvement with psychological or psychiatric services was relevant and should have been shared. CAPT KV had reviewed CPL Turner's file and was well aware that he had experienced symptoms of PTSD but refused further psychological engagement. That should have been a red flag. CAPT KV cited "confidentiality" or a lack of consent as the barrier to sharing this information. Whatever the reason, the effect was to render nugatory the value of CAPT KV's participation in the welfare board process.

(d) Deployment on OP OKRA

103. CPL Turner deployed to Iraq on OP OKRA again in 2016 from approximately 30 July 2016 to 14 December 2016.[174] MAJ AF's evidence in relation to this deployment was that it involved "training and capability development for the Iraqi partner force elements", and that it was constrained to designated areas within secured military

[169] Submissions of the Commonwealth dated 7 June 2024 at [285]-[294].
[170] Tab 38 at 6.
[171] Tab 66 at [9]; Tab 63 at [8.8(b)], [8.9(c)] and [8.10(e)(1)].
[172] Submissions of the Commonwealth dated 7 June 2024 at [285].
[173] Submissions in reply of Counsel Assisting dated 22 August 2024 at [209].
[174] Tab 43 (ADF Personnel File) at 18.

bases, and Australian soldiers were not authorised "at any point to leave a designated area".[175]

104. The leadup to this deployment, and the manner in which CPL Turner obtained a medical clearance to deploy on OP OKRA, was the subject of a significant volume of documentary and oral evidence in the Inquest.

Medical clearances and command waivers

105. There was a lack of clarity in the information available as to the nature of the "waiver" which CPL Turner required to deploy on OP OKRA. The ADF ultimately provided the following information to the Inquest:[176]

a. From 4 December 2014, CPL Turner was MEC J23 with a 4-4 Employment Deployment Restriction, which meant that he required pre-deployment medical officer review.

b. Being MEC J23, CPL Turner did not need a "command waiver" to deploy. A "command waiver", would ordinarily be considered in respect of an ADF member who is "mission-critical". The granting of a command waiver rests with the Deputy Chief of Joint Operations. It is a Command decision, although ADF medical officers would have input into the decision-making process.

c. The policies in place for OP OKRA in 2016 required that all ADF members with a MEC J23 classification or a 4-4 Employment/Deployment restriction obtain a medical clearance from J07 HQJOC (the Director Health, Joint Operations Headquarters). A medical clearance, by contrast to a command waiver, is a medical decision. The ADF indicated to the Inquest that the "chain of command may have input into the decision-making process". It was not clear from the evidence in the Inquest what that "input" was supposed to be directed to (i.e. whether the "medical" decision was nevertheless intended to be influenced by Command needs, or whether Command was intended to provide medical information to inform the medical decision, or something else). There is an ability to appeal a decision not to grant a medical clearance by presenting J07 HQJOC with additional material.

106. Ultimately, the "medical clearance" which CPL Turner required to deploy on OP OKRA in 2016 came to be described in the Inquest as a "waiver" (including because the

[175] Exhibit 11 at 1 [5]-[7].
[176] Tab 116 (Letter from AGS re medical waiver granted to TI in 2016).

witnesses who gave evidence about it tended to refer to it in this way). There was a significant degree of confusion in the evidence given by relevant witnesses as to the nature of a "medical clearance", the appropriateness of Command input or "influence" on that decision, and the distinction between a medical clearance and a command waiver.

The risks of the deployment to Iraq on OP OKRA in 2016

107. The deployment to Iraq involved the potential exposure to traumatic events. BRIG Langford, for example, accepted that even if the primary purpose of the deployment was to train Iraqi soldiers, deployment to a conflict zone was "inherently potentially traumatic".[177] COL MF similarly accepted that the nature of the deployment was inherently potentially traumatic.[178] However, he stated his view was that there was "little to no risk that any personnel would be exposed to a personal combat trauma incident".[179] MAJ AF maintained in his oral evidence that the deployment was the "lowest risk of trauma of any of his deployments", commenting that "you can find trauma in Sydney".[180] MAJ AM accepted the potential for trauma, noting that on his own rotation into Iraq he had experienced the rocketing of the compound in which he was located, and seeing wounded individuals.[181]

108. What emerged as a whole from the oral evidence of those involved in the medical clearance (except GPCAPT Ross) was that they all accepted there was the potential for exposure to traumatic events but viewed that potential risk by reference to the trauma to which CPL Turner had already been exposed on his many deployments to Afghanistan, thus diminishing the significance of the risk. GPCAPT Ross, by contrast, accepted with no hesitation that the deployment was on OP OKRA was inherently potentially traumatic.[182]

109. This accorded with the view of the expert witnesses, who generally agreed that there was a probability of events in Iraq triggering a recurrence of PTSD.[183]

The initial discussions around CPL Turner's deployment on OP OKRA in 2016

110. In relation to the original decision made within 2CDO for CPL Turner to deploy on OP OKRA, MAJ AF gave evidence that "it went to the board, to the unit welfare

[177] 21/10/20 T169.1-20.
[178] 21/10/20 T36-39.
[179] Exhibit 11 at 1 [8].
[180] 4/08/21 T32.15-17.
[181] 05/08/21 T27.18-26.
[182] 06/08/21 T37.29-32.
[183] See 08/02/23 T47-48.

board".[184] He stated that he went and saw the CO, and that "my outlook was that I wanted to deploy him. My decision was made because I saw him remaining back home whilst the company was deployed as being more detrimental for his mental health than deploying".[185] He additionally stated that CPL Turner had come to see him and said "Look, I want to deploy" and they had talked about it on numerous occasions.[186] He stated that "I saw him deploying and that being the moment (1) he could get some money to come back from his separation, but (2) I think it was going to be the break he needed, separating from, I don't know, life at home … So I made the decision for him to deploy", and "Went to the board, the board agreed, psych agreed, everybody agreed".[187] (It is noted that this evidence relates to the decision initially to put CPL Turner forward for deployment, and not the subsequent decision to seek a reconsideration of the decision of GPCAPT Ross about his clearance given no "board" was conducted between the time GPCAPT Ross made his initial decision and when he ultimately reversed that decision and granted the clearance).

111. In his ROI, WO2 DP stated that initially, when he was coming up with the manning, he "actually suggested that we probably shouldn't take Ian", which Ian "didn't like", so he "enlisted some – because he's quite influential, he then enlisted support from some of the platoon commanders within the company" and that the "OC" (who was MAJ AF) was initially on WO2 DP's side, but then the decision "was turned around and he ended up on the trip".[188]

112. CAPT BJ was involved in preparing the paperwork around CPL Turner's medical clearance to deploy. His evidence was that he supported CPL Turner's deployment and that he did not observe any significant mental health concerns in CPL Turner's presentation in late 2015 and early 2016. He accepted, with the benefit of hindsight, that CPL Turner was not presenting an accurate description of his mental health to him at the time.[189]

113. On 2 June 2016, CPL Turner underwent a pre-deployment health screen. He was assessed as fit to deploy, but as noted above, because CPL Turner was MEC J23, he required a medical clearance from J07 HQJOC to deploy.[190] On or around 8 July 2016,

[184] Tab 16 (IGADF ROI with MAJ AF on 24 July 2018) at 6.
[185] Tab 16 (IGADF ROI with MAJ AF on 24 July 2018) at 13.
[186] Tab 16 (IGADF ROI with MAJ AF on 24 July 2018) at 13-14.
[187] Tab 16 (IGADF ROI with MAJ AF on 24 July 2018) at 14.
[188] Tab 24 (IGADF ROI with WO2 DP on 5 July 2018) at 11.
[189] 01/02/23 T63-66.
[190] Tab 49 (ADF medical records) at 325-329; Tab 50 (ADF Medical Records) at 108-111, 264-268.

J07 HQJOC (which position was then filled by GPCAPT Ross) refused to grant CPL Turner a medical clearance to deploy.[191]

(e) The medical clearance / "waiver"

114. MAJ AM, who was the unit RMO, stated in his statement to the Inquest that he was informed on 8 July 2016 that the J07 HQJOC had refused to grant a medical clearance to CPL Turner. He stated that he had a conversation with MAJ AF, who he knew would be concerned about the decision, because CPL Turner had a "pivotal role in MAJ AF's company for the imminent deployment". MAJ AM's evidence was that MAJ AF was "intensely keen for the situation to be 'fixed'" and he was "adamant that [CPL Turner] had to deploy". MAJ AF wanted to know how the decision could be influenced and in fact overturned. He stated that MAJ AF said "What the fuck? [CPL Turner] …. must deploy with us. No one can replace him or his knowledge of the team this close to deployment".[192] MAJ AM's evidence was to the effect that MAJ AF had made it explicit to him, "in no uncertain terms" that "there was a significant mission risk if Ian was unable to deploy".[193]

115. This evidence was put to MAJ AF, who stated that he considered the "tone" was aggressive and suggests that he was more invested in CPL Turner's deployment than he actually was, and he did not believe that the words MAJ AM attributed to him were his words.[194]

Submissions on the conversation between MAJ AM and MAJ AF

116. It is submitted by Counsel Assisting that I would accept MAJ AM's version of what MAJ AF said.[195] *First*, MAJ AF admitted that he was concerned about CPL Turner not being deployed, because he wanted to "firm up" the personnel who were deploying.[196] *Second*, MAJ AF admitted that he formed the view that GPCAPT Ross' decision was the "wrong decision" without having seen the terms of the decision that were made nor having any idea what had or had not been taken into account by GPCAPT Ross.[197] *Third*, there was no apparent motive for MAJ AM to exaggerate the terms of his discussion with MAJ AF in his evidence. *Fourth*, the evidence which ultimately emerged from MAJ AF over the course of a number of years was that he was unshaken (and remained unshaken) in his view that it was preferable for CPL Turner to deploy

[191] Tab 50 (ADF Medical records) at 108.
[192] Tab 115 (Statement of MAJ AM dated 2 October 2020) at 3-4.
[193] 06/08/21 T6.41-46.
[194] 04/08/21 T23.5-10.
[195] Note also that MAJ AM maintained this version under cross-examination: see 05/08/21 T56-57.
[196] 04/08.21 T23.17-24.
[197] 04/08/21 T23.39-T24.5.

to Iraq in 2016. He stated that he "believed and still believe[s] it was in Ian's best interest to deploy" and that he was seeking a review hoping the decision would be changed.[198] It is submitted that this firm view sits comfortably with the version of the conversation which MAJ AM gave. MAJ AF's professed indifference in his oral evidence to whether CPL Turner deployed or not, as he sought to downplay this conversation with MAJ AM, sits uncomfortably with the balance of his evidence in this regard, which was largely to the effect that he wanted CPL Turner to deploy.[199]

Consideration

117. Having considered all the evidence, I have no trouble accepting the account given by MAJ AM of his conversation with MAJ AF. To be clear, where his account of the conversation differs to the account given by MAJ AF, I accept MAJ AM's version. Further, I have no trouble accepting MAJ AM's description of the intensity of MAJ AF's desire to have the situation "fixed". I accept Counsel Assisting's submission that there was no reason for him to exaggerate MAJ AF's response to the news that CPL Turner's medical clearance had been refused.

118. I had the opportunity of watching MAJ AF give evidence. In my view, he appeared defensive and tried to downplay his displeasure with what had occurred and recast his reaction as measured and focussed only on ensuring that the decision was reconsidered with all the available material. This is particularly implausible given the steps later taken by MAJ AM and his contemporaneous email that stated "My CoC, to CO level, is VERY keen to have this decision reviewed".[200] I do not accept MAJ AF's evidence on this issue.

119. Returning to the evidence, MAJ AM spoke to COL MF, who was supportive of preparing additional information to submit to the J07 HQJOC for consideration. MAJ AM subsequently called GPCAPT Ross, outlined the "intent of MAJ AF and [COL MF]", and MAJ AM outlined verbally why he thought that MAJ AF's "arguments had merit". GPCAPT Ross agreed to review a written submission from MAJ AM.[201]

120. MAJ AM subsequently prepared a document titled "Clinical Perspective to Support Request to Reconsider Waiver for Deployment of [CPL Turner]" (**Clinical Perspective**

[198] 04/08/21 T26.30-39.
[199] 04/08/21 T25.5-6.
[200] Tab 115 (Statement of MAJ AM dated 2 October 2020) at 49.
[201] Tab 115 (Statement of MAJ AM dated 2 October 2020) at 5.

Document).[202] That document assumed some significance in the Inquest. It is extracted below in full.

SENSITIVE: PERSONAL
HEALTH INFORMATION

AM-2

Australian Army
2nd Commando Regiment

CLINICAL PERSPECTIVE TO SUPPORT REQUEST TO RECONSIDER WAIVER FOR DEPLOYMENT OF 8253608 [redacted] - JUL 2016–FEB 2017

REFERENCES:

A. DI(G) PERS 159-1—*The Application of the Medical Employment Classification System and PULHEEMS Employment Standards in the Australian Army*

B. Health Directive (HD) 264—*Management of Post-traumatic Stress Disorder and Acute Stress Disorder in the Australian Defence Force for Primary Care Providers*

1. A contracted MO conducted a UMECR and pre-deployment medical consult with 8253608 [redacted] on 02 Jun 2016 and consequently submitted a waiver to JOC Health Br supporting deployment to the Middle-East Region (MER) despite his current MEC P3S3J23. In contrast to the relevant HSO, on my recommendation, a full waiver process was undertaken due the complexity of [redacted]'s history and the lack of availability of home RAP MOs to answer requests for confirmation of detail between the consult and deployment date. Being aware of his circumstances but not being his treating MO, I was cognisant that his history can look superficially of greater risk than it actually represents when the available details are carefully reviewed. Today, the unit was informed that his waiver was not supported by the incumbent JOC J07 on the basis that [redacted] represents a high risk of recurrence of mental health problems. Therefore, below I have attempted to display the more subtle detail of [redacted]'s case that may inform reconsideration aligned to his OC & CO's intent.

2. **Background.** [redacted] was diagnosed with Major Depression, PTSD and alcohol dependence in Apr 2014 during an in-patient admission. He was at that time a veteran of five warlike deployments during which he was witness to significant combat trauma. At that time, he was psychiatrically assessed, managed with clinical psychologist counselling including psycho-education and CBT teaching him self-management techniques; and mood stabilised with escitalopram that continued until early Jun 2014. His MEC was downgraded to J31 over this period, but after three months of his symptoms being in remission off medication; good insight; rapid progress more than five months of alcohol abstinence, his treating MO recommended his MEC be upgraded to P3S3J21in Oct 2014. The confirming authority added restriction 4-5 making [redacted] P3S3J23. Although he engaged with psychology staff approximately monthly over this period, the purpose was monitoring rather than active therapy. His psychiatry reviews on Oct 2014 noted he was low risk of self-harm and cleared for all duties with no requirement for follow-up for 12 months.

3. **Waivered deployments.** Subsequently, [redacted] has deployed under waivers twice on operations, including four months warlike in the MER, and another two occasions on international engagement (IE) activities. During these deployments he has been fully functional and has not engaged MOs for mental health related problems, indeed on the IE activities he was under care of an AMT only.

SENSITIVE: PERSONAL

[202] Tab 115 (Statement of MAJ AM dated 2 October 2020) at 45-47.

4. **Early RTA.** His early return to Australia (RTA) from his MER deployment in Jun 2015 was administratively related to his social situation (which had been deteriorating for some time and was probably a trigger for the initial episode of de-compensation that led to his diagnoses in Apr 2014). His RTAPS did not identify a need for follow-up but noted the reason for his early RTA in context of his history, leading to a psychiatric review that stated he was low risk and not for resumption of medication. However, his relationship stress and resumption of problematic alcohol use led to re-engagement with psychology staff regularly between Jun-Dec 2015 during which his self-management strategies were re-affirmed. This period did appear superficially to be a recurrence of his mental health problems, but throughout this period his anxiety and mood remained stable with mental health professionals assessing him as low risk of self-harm, his social stress being his main concern as noted in his Sep 2015 POPS. Importantly, his treating clinicians note that while he was task-focussed on deployments, away from the social stress of his deteriorating relationship and easy alcohol availability, he was the most stable/functional and least anxious/stressed. This may seem paradoxical in a soldier previously suffering PTSD/Depression consequent to deployment experiences, but the observation highlights the lack of relevance of his prior diagnoses to risk.

5. **Conclusion of relationship stress.** [redacted]'s relationship conclusively ended in late Oct 2015. He attended one VVCS psychologist session in early Nov 2015, but discontinued follow-up in Dec 2015 for two stated reasons: firstly, revision of CBT techniques he had previously learned and had continuously been actively self-administering to good effect; and secondly, the practitioner appeared to [redacted] to have difficulty believing the reality of his candidly recalled combat experiences, which undermined the integrity of their therapeutic relationship. [redacted]'s stress had significantly abated with the cessation of his relationship and he was self-managing his alcohol dependence effectively by this stage, so he saw no tangible benefit to further counselling under those circumstances.

6. **Current status.** [redacted] has not suffered PTSD or Major Depression symptoms for over 2 years since at least Jun 2014 and has not taken SSRIs since then. He self-administers CBT-type techniques to control stress and has a self-regulating alcohol management regime: never drink alone; never drink on "school-nights"; never drink before 1800; never drink more than a six pack of beer on any one night. He has never tested positive to random/targeted alcohol testing. He has never presented or been seen to exhibit any signs of withdrawal on exercises/operations in the absence of alcohol including under the supervision of myself over the last two weeks on Ex Hamel. Clinically, he does not currently appear to be dependent on alcohol. He has not required psychology review or psychiatric assessment since last year.

7. **MECR.** Having been J31 Apr-Oct 2014 and upgraded to J23 Oct 2014, [redacted] was noted as clinically suitable for P2S2J11 by his treating MO in Mar 2016, but in accordance with the references, was counselled to wait until Jun 2016 so that two years of remission from PTSD/Major Depression symptoms had elapsed. The Jun 2016 UMECR/pre-deployment consult that led to the topical waiver identified [redacted] continuing to appear low risk, but also the previous MECR directed review in Oct 2016 (in the middle of the scheduled deployment) and recommended preceding psychiatric assessment (which had not yet occurred). The treating MO consulted with military clinical staff and decided to institute the waiver, delaying expected upgrade until Feb 2017. However, it should be noted again the ref A criteria having been met for two years and the ref B para 24-25 criteria being met would have enabled consideration of upgrade to P1S1J11 as at Jun 2016.

SENSITIVE: PERSONAL HEALTH INFORMATION

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8. **Factor summary for consideration:**

a. Each treating MO, psychologist and continuing psychiatrist have identified [redacted] as low risk for over two years.

b. His apparent episode of recurrence around his early RTA in Jun 2015 can be attributed to the social stress of his relationship breakdown, which having now been resolved, is not an active stressor.

c. Since the confirming authority added the 4-5 restriction to make him J23 rather than J21 in Oct 2014, he has not required acute management by an MO on any of four deployments, one of which was to the MER for four months.

d. [redacted] has demonstrated insight and has learned consistently applied effective self-management, including of his previous alcohol problem. His discontinuity of VVCS sessions may be attributable to the lack of usefulness and poor rapport he perceived, rather than a casual disregard for his own mental health.

e. Under the references he has met criteria to be considered for upgrade to a MEC that wouldn't have necessitated a waiver or JOC approval.

f. A referral to his previously managing psychiatrist has been raised, and should be undertaken in the next week, the report of which will be forwarded in support of this submission when available.

MAJ AM [redacted]

MAJ AM [redacted]

Senior RMO

[redacted]

08 Jul 2016

Enclosures:

1. PM615-Consent for the Release of Health Information – 8253608 [redacted] of 8 Jul 16

121. The document does not present a balanced or measured consideration of CPL Turner's mental state at the relevant time, having regard to the medical records which have been referred to above. MAJ AM accepted this to some degree and stated that he did not think it was important to ensure his document conveyed a balanced review of the medical information available: rather, his role was to "trigger the J07 to have a

comprehensive review", and he accepted that he instead prepared a document "selling the idea that CPL Turner was sufficiently fit to deploy".[203]

122. MAJ AM stated that he considered that GPCAPT Ross would review all of the medical records in making a decision, so it was not necessary for him to include material indicative of the risks to CPL Turner's health.[204] MAJ AM did not consult with CPL Turner in putting together the document, but rather conducted it "on the basis of a medical record review."[205]

123. MAJ AM accepted, having been taken through a number of medical records in the period between June and December 2016, that those records would have changed what he wrote in his summary document.[206] He considered that his role involved advocating for "defence" and "his commanders wanted to deploy him" which he tried to balance with his "responsibility to protect" his patients.[207] He accepted that Command's requirements were a significant factor in considering the appropriateness of CPL Turner's deployment.[208] He ultimately described the clearance process as a "command-driven process informed by the medical system", that he understood the CO's "intent", and that he enacted the CO's "intent" in "doing what I did".[209]

124. MAJ AM's evidence in relation to the nature of the decision to be made by GPCAPT Ross was to the effect that, in his view, it was part of the J07's role to consider CPL Turner's importance to the "mission" in deciding whether he should make a different decision about deployment.[210] MAJ AF accepted that the request he made was a clinical summary emphasising the points he considered had been "overlooked", and that MAJ AM's document was "well written and it achieved its aim".[211]

125. The Clinical Perspective Document was sent by MAJ AM to MAJ2 LK[212] and MAJ AF, with MAJ AM noting that he had "compiled a clinical summary emphasising the points I think were overlooked by the JOC J07 when considering" CPL Turner's deployment.[213] It was then sent from MAJ AM to LTCOL NB, who was working with CPCAPT Ross at the time.[214] The email noted that "My CoC, to CO level is VERY keen

[203] 05/08/21 T58.39-50.
[204] 05/08/21 T59.10-13.
[205] 05/08/21 T65.49-66.13.
[206] 05/08/21 T72.13-17.
[207] 05/08/21 T77.43-50.
[208] 05/08/21 T86.25-34.
[209] 06/08/21 T7.11-21.
[210] 05/08/21 T61.11-19.
[211] 04/08/21 T28.12-18.
[212] Who was the acting CO of 2CDO at the time: see 05/08/21 T78.14-17.
[213] Tab 115 (Statement of MAJ AM dated 2 October 2020) at 50.
[214] 05/08/21 T78.50.

to have this decision reviewed".[215] The email further noted that "The soldier in question, in my opinion, is LESS risk to himself deployed than he will be if he is left behind at this point. Paradoxical, I know, and deployment shouldn't be a therapy, but it is what it is".[216]

126. MAJ AM's evidence about his comment commencing with "Paradoxical" in the email was that CPL Turner was "very functionable in the deployed environment", that he had "some psychosocial welfare issues whilst he'd been in barracks", and that if he was "rejected from a deployment" it was "probably not something that he would, would like to face".[217] This opinion was reflected in the substance of the Clinical Perspective Document, which similarly stated:[218]

> "Importantly, his treating clinicians note that while he was task-focussed on deployments, away from the social stress of his deteriorating relationship and easy alcohol availability, he was the most stable/functional and least anxious/stressed. This may seem paradoxical in a soldier previously suffering PTSD/Depression consequent to deployment experiences, but the observation highlights the lack of relevance of his prior diagnoses to risk."

127. MAJ AM's oral evidence was that he could not recall which treating clinicians he consulted in order to inform the above comment but he accepted he did not speak to any psychologist before preparing that document.[219]

128. Subsequent to MAJ AM's oral evidence, a further document was produced by the ADF which included an email from MAJ AM to LTCOL NB stating "I was holding off sending this until I had the specialist report, but last night the CoC was getting anxious".[220] The "this" referred to in that email was the Clinical Perspective Document.[221] MAJ AM was asked to put on a statement in relation to this document. He stated he could not recall to whom in the Chain of Command he was referring to when he typed "getting anxious", and all he could recall was that the "general feel from the chain of command was that they needed to know, one way or another, whether CPL Turner was waivered to deploy".[222] In his oral evidence, MAJ AM stated he could not recall who in the Chain of Command was "anxious", that he had an "impression" about what the anxiety of "all the stakeholders in the unit was about that situation", but that he could not say conclusively what they were anxious about.[223] MAJ AF's evidence was that it was

[215] Tab 115 (Statement of MAJ AM dated 2 October 2020) at 49.
[216] Tab 115 (Statement of MAJ AM dated 2 October 2020) at 49.
[217] 05/08/21 T81.27-34.
[218] Tab 115 (Statement of MAJ AM dated 2 October 2020) at 46.
[219] 06/08/21 T26.39.
[220] Exhibit 45 (Further Statement of MAJ AM dated 31 August 2022) at 4.
[221] Exhibit 45 (Further Statement of MAJ AM dated 31 August 2022) at 2.
[222] Exhibit 45 (Further Statement of MAJ AM dated 31 August 2022) at 2.
[223] 06/09/22 T57.8-11.

highly likely that it was he (MAJ AF) who was being referred to in this email, because he "definitely wanted to get this moving".[224]

129. MAJ AM could offer no explanation why this email was not attached to his initial statement to the Inquest.[225] At one point he suggested he did not have access to it. His evidence ultimately tended to suggest that he did likely have access to the email but that his legal representatives decided it should not be included in his first statement and that is why it would not have been attached.[226] He was asked whether he should have reviewed the emails himself to ensure that a "full and complete picture of events as represented in those emails was included". He answered that "I wouldn't have known that it was my duty to ensure it was full and complete … I was prepared to trust my legal counsel to determine what was and what was not relevant".[227]

Submissions on the email from MAJ AM to LTCOL NB

Submissions of Counsel Assisting

130. It is submitted by Counsel Assisting that it is open, in those circumstances, to find that this email was deliberately excluded from the evidence of MAJ AM. The only available inference is that it was done to avoid the suggestion that the Chain of Command was involved in influencing GPCAPT Ross' medical decision. Ultimately, the full picture was made available to the Inquest. The sequence of events leading to its full revelation reflects poorly on the conduct and attitude of the ADF's witnesses in the Inquest. In particular, it is submitted that I would be concerned that: (a) a witness from the ADF was not apparently aware it was his own obligation to ensure that his evidence presented the full picture to me of the events concerning the medical clearance; and (b) a decision was made on behalf of MAJ AM not to include an email in his evidence which plainly enough is relevant to how the medical clearance decision was made.

Submissions of the Commonwealth

131. The Commonwealth does not accept this submission and it requested that it be withdrawn.[228] In addition to submitting that MAJ AM's answers were an insufficient basis to draw the asserted inference,[229] the Commonwealth submits that the unchallenged evidence of COL Cochbain discloses that there was a mistaken interpretation of the 2019 subpoena which resulted in various databases not being

[224] 03/02/23 at T159.3-12.
[225] 06/09/33 T47.4.
[226] 06/09/22 T47-48.
[227] 06/09/22 T49.1-13.
[228] Submissions of the Commonwealth dated 7 June 2024 at [343]-[346].
[229] Submissions of the Commonwealth dated 7 June 2024 at [347]-[353].

searched until September 2021, which was after the finalisation of the first statement of MAJ AM's statement in October 2020. Following discussions between the ADF and those assisting in January-February 2022, searches were done on various ADF email databases and in April 2022 the email from MAJ AM was produced. Accordingly, the Commonwealth submits that the email was located after MAJ AM's statement was finalised and so could not have been included in his first statement and was, therefore, not "deliberately excluded" from the statement.[230] It was further submitted no adverse finding could now be made without affording the ADF the opportunity to seek further evidence be admitted to rebut the proposed finding.[231]

Submissions in reply of Counsel Assisting

132. Notwithstanding that explanation, Counsel Assisting does not accept that the submission made at [130] should be withdrawn. It is contended that MAJ AM's evidence did not proffer any cogent explanation for the exclusion of the particular email. MAJ AM accepted that he carried out the searches of his email accounts using "Ian's name [and] PMKeyS number"[232] and gave evidence that he was able to produce every other email in the chain in his original statement.[233] The 12 July 2016 email had the same subject line (being both CPL Turner's surname *and* his PMKeyS number). MAJ AM's evidence on this point made the submission above available, and that proposed finding was put to the parties in Counsel Assisting's submission as a matter of fairness.[234]

133. Counsel Assisting notes that they did not make a submission that a finding should be made that it was the ADF's legal representatives who had excluded the 12 July 2016 email. Nor did Counsel Assisting make any submission that any legal practitioner acting for the ADF breached their duties to the Court by deceiving or misleading the Court. No such submission was expressly made (as the Commonwealth appreciates, by submitting there is an "implication" from Counsel Assisting's submissions). Counsel Assisting does not contend that I should make any finding as to the conduct of the legal representatives of the ADF in respect of the 12 July 2016 email, either expressly or by implication.[235]

[230] Submissions of the Commonwealth dated 7 June 2024 at [355]-[358].
[231] Submissions of the Commonwealth dated 7 June 2024 at [361]-[362].
[232] 6/09/2022 T47.37-38.
[233] Exhibit 45 at [9].
[234] Submissions in reply of Counsel Assisting dated 22 August 2024 at [216].
[235] Submissions in reply of Counsel Assisting dated 22 August 2024 at [217].

Consideration

134. I was greatly troubled by MAJ AM's evidence on this issue. I accept Counsel Assisting's submission that he did not give a cogent explanation for the exclusion of this email. In circumstances where every other email in the chain was produced in his original statement, any purported confusion about the terms of the subpoena seems unlikely to be relevant to his initial decision. On balance, I find that a decision was made to exclude it, and I accept that it is most likely to have been excluded to avoid disclosing the extent of the Chain of Command's attempt to influence the medical decision. MAJ AM's evidence was particularly concerning because it was an example of an occasion where an ADF member appeared to see his loyalty to the organisation as more compelling than his duty to provide the Court with a full and frank account. I was deeply troubled that he did not see that it was his duty to provide "a full and complete" account.[236] I make no finding in relation to the legal advice he received.

135. Returning to the evidence, MAJ AF accepted in his oral evidence that he did not in fact have an accurate understanding of the extent of CPL Turner's alcohol use, or "domestic difficulties", in mid-2016 when he made the decision to have him deploy.[237] He further accepted that he did not have any of the detail of CPL Turner's medical history or his medical notes.[238] However, he accepted that he knew that CPL Turner had ongoing symptoms of PTSD as at June 2016 and still thought it was in his best interests to deploy.[239] His view was that CPL Turner had a "fractured and compartmentalised personal life and problems with alcohol" and that the deployment would give him a "break" with his "support network around him that the Company provided while deployed".[240]

136. COL MF did not have specific training in PTSD.[241] COL MF's view was that the deployment would give CPL Turner "time and space" from his marital difficulties to focus on work. He did not recall taking any psychiatric or psychological advice as to whether deployment would be good or bad for CPL Turner's mental health.[242]

137. In his ROI, COL MF stated that his recollection of why a medical clearance or waiver was required, was "related to medication that he was taking" (which was not the case) and that he supported the waiver, "based off the fact that he was performing, all

[236] 06/09/22 T49.1-13.
[237] 4/08/21 T8-9.
[238] 4/08/21 T29.18-25.
[239] 4/08/21 T34.44-49.
[240] 04/08/21 T39.13-16.
[241] 21/10/20 T227.20-23.
[242] 21/10/20 T243.1-26.

reports, well in his role" and that "clinically, the recommendation was that he was fine to support".[243] He stated he had "no reservations about recommending him to go back, based off what I'd observed" but ultimately recognised he had only seen CPL Turner a "few times".[244] He went on to explain:[245]

> "And, to be honest, at that point, he was almost a good news story with regard to members that had seen a lot of action as a result of that service… So from a regiment's perspective and my viewpoint, it was really quite positive for him personally to be able to continue to soldier on … organisationally as well, to display that just because you did put your hand up and say you had an issue, it wasn't a one-way ticket to medical discharge."

138. COL MF stated that he was aware of CPL Turner's alcohol issues and that, as a result, CPL Turner was "on the radar" but that in his view "he had sort of turned that around".[246] COL MF indicated that he did not consider there was a real risk that in 2016 CPL Turner was not fully disclosing his mental health conditions because of a concern that it would reduce deployability, because of the "trust that goes with being a senior NCO" and because he had "received treatment beforehand".[247] He could not recall speaking to any psychologist prior to making the decision about whether CPL Turner should deploy in 2016.[248]

139. COL MF stated that the decision to deploy CPL Turner did not rest with him because he required a medical clearance to deploy.[249] However, he ultimately accepted that within the Chain of Command, he had the ultimate responsibility for the recommendation that CPL Turner be deployed.[250]

140. WO1 EL, the RSM of B Company at this time, stated that "to be honest … [he] appeared to be, for [want of] a better word, a good news story for a member that had previous alcohol issues, you know, ongoing trauma he had seen on operations in Afghanistan … and he'd come out at the other side".[251]

141. Subsequent to MAJ AF's first evidence in relation to this matter, a document was produced by the ADF which was a minute prepared by MAJ AF for the CO, to ultimately be provided to the J07 (GPCAPT Ross).[252] The document was amended before it was provided to GPCAPT Ross. In its draft form, it was as follows:

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[243] Tab 17 (IGADF ROI with COL MF on 22 August 2018) at 8-9.
[244] Tab 17 (IGADF ROI with COL MF on 22 August 2018) at 10.
[245] Tab 17 (IGADF ROI with COL MF on 22 August 2018) at 9.
[246] Tab 17 (IGADF ROI with COL MF on 22 August 2018) at 12.
[247] 21/10/20 T229-230.
[248] 21/10/20 T231.24-37.
[249] 06/02/23 T203.
[250] 06/02/23 T206.
[251] Tab 23 (IGADF ROI with WO1 EL on 15 August 2018) at 10.
[252] Exhibit 31 (Tranche 7) at 25.

AUSTRALIAN ARMY
2nd Commando Regiment
MINUTE

Reference Number

HQ JOC (Attn: J07)

MEDICAL WAIVER REGARDING 8253608 SGT I TURNER

1. SGT I Turner has been fulfilling his role as the Senior Section Commander within Bravo Commando Company while medically classified J23 for PTSD and associated alcohol misuse. Despite SGT Turner's medical downgrading, he has maintained operational responsibilities and a continual commitment to rehabilitation.

2. In 2014 SGT Turner was granted a medical waiver to deploy on OP PARAPET and OP OKRA Rotation II. Earlier this year he was granted a medical waiver to participate in EX BALIKATAN, Philippines. In each of these occasions, SGT Turner was able to perform his function to a high standard.

3. SGT Turner experienced a relationship breakdown in 2015 which required an early RTA from OP OKRA II. This early RTA facilitated the administrative requirements associated with his relationship breakdown which has now been finalised.

4. SGT Turner is scheduled to assume the role of Senior Advisor within Special Forces Advisory Team Two during Operation OKRA Rotation V. The decision to deploy SGT Turner was determined by the CoC based on SGT Turner's current personal situation and his positive rehabilitation progress highlighted through the ongoing Unit Welfare Board. Regt Rehabilitation staff and the RMO have indicated that SGT Turner is mentally fit to deploy. Further, it has been highlighted that a deployment of this nature would be beneficial to his rehabilitation.

5. SGT Turner's rehabilitation will be best managed by maintaining the level of operational readiness associated with his position. While deployed, SGT Turner will have access to Coalition medical support and be accompanied by his current CoC and team members. Following the deployment, SGT Turner will commence a month post deployment leave, then clear leave throughout Apr – May 17 IAW his Company endorsed leave plan. Each of these mitigation measures are designed to ensure SGT Turner is on track to complete his medical classification upgrade to J11 in Dec 16.

6. SGT Turner's excellent professional performance over the last 18 months, coupled with his highly successful rehabilitation, were critical factors in determining SGT Turner's suitability to deploy in Jul 16. All personnel consulted prior to completing the medical waiver are in agreeance that the final phase of SGT Turner's rehabilitation would be best managed by his Company staff and peers who are deploying on Op OKRA Rotation V.

Consulted: RMO
Drafted By: OC B Coy

142. The document stated that the RMO (MAJ AM) had been consulted in its drafting. MAJ AM's evidence was that he was not verbally consulted although he may have had a "brief discussion" with MAJ AF about CPL Turner.[253] MAJ AF accepted that it was likely that he had drafted this document.[254]

143. MAJ AF did not accept that he ought not to have drafted the brief which ultimately came to be provided to the CO, amended, and then provided to GPCAPT Ross. He was asked whether he "should never have drafted this document because you should never have sought to interfere with the decision-making process of the JO7".[255] He responded that "that's incorrect. The role of the Chain of Command is purposely separated from the medical decision making process" and concluded that if "CPL Turner wasn't medically or psychologically cleared to deploy, then he wouldn't have", but "[t]his is a mechanism for the army to – to communicate with decision makers"[256] ("this", being the draft of the Brief for the CO which was ultimately sent to the J07 albeit with amendments).

144. The brief which he prepared strikes me as a piece of written advocacy aimed at achieving a specific outcome: the deployment of CPL Turner, and to seek to demonstrate that his deployment would be "beneficial" to his rehabilitation (which is quintessentially, a medical question and not a command one). It stated expressly the CO's apparent view that CPL Turner's "rehabilitation will be best managed by maintaining the level of operational readiness associated with his position" and sought to provide an assurance that CPL Turner would have access to medical support and his team members as a "mitigation measure".[257]

145. I accept Counsel Assisting's submission that this is not a document which conveys information to a medical professional for that medical professional to make an independent-minded decision. Rather, it is a document designed to persuade and, therefore, seeks to present a particular view about CPL Turner's mental state. MAJ AF did not accept this characterisation of the document and, in my view, this affected the integrity of his evidence as a whole. It was another example where I had reason to doubt the veracity of MAJ AF's account of the events in question.

[253] Exhibit 31 (Tranche 7) at 25.
[254] 03/02/23 T150.14-17.
[255] 03/02/23 T157.46-48.
[256] 03/02/23 T157.49-158.2.
[257] Exhibit 31 (Tranche 7) at 25.

146. An amended version of this document was then sent on to GPCAPT Ross, under the hand of COL MF, in the following form:[258]

Australian Army
2nd Commando Regiment

Brief

AN6236811

J07 (Through: CO 2 Cdo Regt)

MEDICAL WAIVER – 8253608, SGT I TURNER – TG632 ROT V

1. **Purpose of brief**. This brief informs the process taken to determine SGT Turner's suitability for deployment and the management plan that has been put in place to support him during deployment if required, during his final phase of rehabilitation.

Background.

2. In Apr 14, SGT Turner presented with symptoms of PTSD and alcohol misuse. He was subsequently medically downgraded to J23 following medical treatment.

3. Since being downgraded medically to J23, SGT I Turner has been successfully fulfilling his role as the Senior Section Commander within Bravo Commando Company.

4. SGT Turner has maintained operational responsibilities and a continual commitment to rehabilitation since being downgraded to J23. This is clearly articulated in Enclosure 1.

5. In Oct 14, SGT Turner was granted a medical waiver to deploy on Operation PARAPET. He was granted a subsequent waiver in Dec 14 to deploy on Operation OKRA Rotation II, and again in Feb 16 for Exercise BALIKATAN in the Philippines. On each of these occasions, SGT Turner was able to perform his function without displaying indicators warranting medical intervention.

Main body

6. SGT Turner is to assume the role of Senior Advisor within Special Forces Advisory Team Two for Rotation V. The decision to place SGT Turner in this role was not made lightly, and was determined after considerable discussion between his Company chain of command and his rehabilitation coordinators. SGT Turner's current personal situation, coupled with positive rehabilitation progress highlighted by the 2 Cdo Regt RMO at the recent Unit Welfare Board, indicate he is mentally fit to fulfil his role as indicated on the Operation OKRA Rotation V OMD.

7. The following management strategies and mitigations have been developed by SGT Turner's chain of command, in consultation with rehabilitation staff and psychologists IOT ensure SGT Turner's welfare is managed appropriately and successfully whilst deployed:

a. The personnel best able to monitor, asses and manage his mental health are his regular team members, who he will be deployed with;

b. During the deployment, SGT Turner will have ready access to coalition medical

[258] Exhibit 31, Tranche 1 at 4-5. See also Exhibit 35 (Statement of Brig MF dated 26 August 2022) at 4.

support, including PII psychologists;

c. Post deployment, SGT Turner will immediately commence a month of post deployment leave; and

d. SGT Turner will then take leave again during April and May 17, IAW his Commando Company approved leave plan.

8. Each of these mitigation measures are designed to ensure SGT Turner is healthy and able to upgrade to J11 in Dec 16, as agreed in the Unit Welfare Board.

9. SGT Turner's peers and hierarchy believe his rehabilitation is best managed by maintaining the level of operational readiness associated with his position. During the last 18 months, SGT Turner's excellent professional performance, coupled with his highly successful rehabilitation, were critical factors in determining his suitability for deployment in Jul 16. All personnel consulted prior to completing the medical waiver agree the final phase of SGT Turner's rehabilitation would best be managed by his Company staff and peers, all of whom are deploying on Operation OKRA Rotation V.

CONCLUSION

10. SGT Turner's deployment suitability is a mature and considered determination. A management plan has been determined to support him should it be required during deployment. He is in his final stages of rehabilitation and would be best served to complete this stage by being able to perform his professional duties whi9lst deployed with his regular chain of command and peers.

RECOMMENDATION

11. It is recommended SGT Turner's waiver be granted and he deploy to Operation OKRA Rotation V.

PS_COL MF
CO
2 CDO REGT

Contact details
PS_COL MF @defence.gov.au

Jul 16

Enclosures:
1. Clinical Perspective to Support Request to Reconsider Waiver for Deployment of 8253608 SGT I Turner, 08 Jul 16
2. Psychiatrist Recommendation, 13 Jul 161

147. COL MF's evidence was that he recalled reading this brief and the two enclosures, that he did not have an actual recollection of signing and dating the brief but is confident that he would have done so.[259] COL MF's evidence in relation to this document was that he was "providing additional context that GP CAPT Ross did not have previously about the decision".[260] He accepted, however, that he did not actually know what information GPCAPT Ross had available to him when he made his initial decision.[261]

[259] Exhibit 35 (Statement of COL MF dated 26 August 2022) at 5.
[260] 06/02/23 T240.
[261] 06/02/23 T300-301.

This makes it difficult to understand how he could have formed the view that he was only providing additional information which GPCAPT Ross did not have to begin with.

148. COL MF accepted that he was relying on the information provided to him that CPL Turner's domestic circumstances had stabilised. He did not make any investigations himself as to CPL Turner's personal situation and he did not accept he should have made any inquiries or investigations himself (including of Joanna Turner).[262]

149. Although the document stated that the personnel best able to monitor, assess, and manage CPL Turner's mental health were his team members, he accepted he did not check which of CPL Turner's team members had training in PTSD.[263] He expressed confidence that his team members would know the symptoms of PTSD because he thought that was how CPL Turner's first incidence of severe PTSD in 2014 had been identified. He was not aware it was in fact Joanna Turner who reported his symptoms to the ADF in 2014.[264] It is also not apparent why he assumed that those team members who had identified it in 2014 were necessarily the same members who would be deploying with him on this deployment.

150. COL MF accepted that based on what in fact subsequently happened, it was not the case that the personnel best able to monitor, assess and manage CPL Turner's mental health were his regular team members in Iraq.[265]

151. COL MF accepted that he intended this brief to influence GPCAPT Ross in his reconsideration of whether or not CPL Turner should be granted a clearance. He accepted that it would be given weight by GPCAPT Ross. He did not accept that doing so was inappropriate.[266] COL MF specifically rejected the proposition that his Brief constituted "intervention by the chain of command". He stated "what the chain of command did was provide additional supplementary information that was not provided in the initial form which was pushed forward" and there was "no chain of command leaning in on anybody to seek to get them to change their decision".[267] He stated that the purpose of the document, and by him signing off as CO, was to provide assurance that the "issue was significant enough to be raised" and to show "we had done the background behind it to get to a point where we were seeking to get the decisions sort of changed".[268] It appeared that COL MF made a distinction between "influencing" and

[262] 06/02/23 T244.
[263] 06/02/23 T245.
[264] 06/02/23 T246.
[265] 06/02/23 T249.
[266] 06/02/23 T240.
[267] 06/02/23 T255.
[268] 06/02/23 T256.

leaning on or pressuring GPCAPT Ross. He accepted he was trying to do the former and he rejected that he was doing the latter.[269]

(f) Dr Sringeri's letter

152. Enclosed within COL MF's brief to the J07 was a letter from Dr Sringeri (listed under "Enclosures" and titled "Psychiatrist Recommendation"). The background to that letter is as follows.

153. On 11 July 2016, a referral request was penned by Dr Aftab Ahmed to Dr Sringeri.[270] It stated that:

> "Member has history PTSD and alcohol dependence in 2014 and that time CPL Turner was admitted to Sydney Southwest Private Hospital for substance abuse control and PTSD treatment for over 5 weeks. He was diagnosed with PTSD and Alcohol use Disorder - He was seen by the psychologist your self. Memebr [sic] is stable now. He no longer requires psychological treatment for PTSD. His symptoms are in remission. Recently member was up graded to MEC J23. I need your opinion about his deployment is member is fit to Deploy? Regards . Dr Aftab Ahmed".[271]

154. Dr Sringeri penned a letter on 13 July 2016 to MAJ AM, the RMO. In that letter, Dr Sringeri stated (emphasis in original):[272]

> "**Diagnosis: Post Traumatic Stress Disorder in remission**
> **Alcohol Dependence Syndrome in remission**
>
> I saw Ian 13th July 2016 for her [sic] psychiatric review. Ian remains symptom free and denied having any symptoms of PTSD. Ian is not on any medication since 28th August 2014. He has attended 2 operational deployments and 2 international engagements successfully. He denied experiencing any anxiety symptoms or PTSD symptoms during stressful situations.
>
> He consumes alcohol only on the weekends and special occasions and monitors his alcohol intake. He was proud and positive about his progress.
> On examination he was found to be pleasant cooperative and relaxed. His psychomotor activity was normal. His speech was normal. He described his mood as fine and his affect was reactive. He was found to be positive and hopeful. He denied having any ideas of self-harm or experiencing any psychotic symptoms. He had good insight.
>
> **Impression: In my opinion Mr Turner is free of symptoms of anxiety and PTSD. In my opinion his chances of recurrence of his PTSD symptoms are very low. His risk of self and harm to others also very low.**
> **Recommendation**:
> Psychoeducation
> In my opinion Mr Turner is well and stable.
> In my opinion Ian is cleared to attend all duties from a psychiatric point.
> He does not require any psychiatric follow up. However, I am happy to review him if required.

[269] 06/02/23 T256.
[270] Tab 116 (Letter from AGS re medical waiver) at 12.
[271] Tab 50 (ADF Medical Records) at 9.
[272] Exhibit 26.

If you need any further information please do not hesitate to contact me"

155. Dr Sringeri's contemporaneous note from that consult recorded that "Ian wanted to go for a deployment to Iraq and needed psychiatric clearance".[273]

156. Dr Sringeri's (and GPCAPT Ross') oral evidence was taken without the benefit of this letter, which was belatedly produced by the ADF to the Inquest (an issue which is dealt with below at [1039]-[1047]). However, Dr Sringeri later answered questions via letter from his solicitors in relation to this letter. He stated that he did consider the risks associated with deployment to Iraq when he penned the letter and discussed those during the consultation. He stated in response to the question "whether he considered Sgt Turner should be cleared for deployment" that "[t]he clearance for deployment was not a matter for me, it was a matter for the ADF medical board and the chains of command".[274]

157. In his ROI, COL MF stated that after CPL Turner's first suicide attempt, he revealed that he had previously told the Chain of Command, and also the "specialist" (which would be inferred to mean Dr Sringeri), "whatever they wanted to hear" to enable him to do what he wanted to do next, two deployments was one of those".[275] Joanna Turner gave similar evidence, to the effect that CPL Turner had said openly to her that he could "manipulate" Dr Sringeri.[276] Joanna Turner gave evidence that she had been present in conversations where CPL Turner would speak with colleagues who would share or compare notes on how to "get Sringeri to do" certain things,[277] and that CPL Turner had "implied" to her that his understanding with Dr Sringeri was that CPL Turner would be open and honest, but not at the risk of damaging his career, and that he could "get the result that he wanted, like on paper" from Dr Sringeri.[278] Dr Sringeri denied this in his oral evidence. [279]

158. COL MF's evidence in relation to the letter from Dr Sringeri was that he made no decision about CPL Turner's deployment prior to getting Dr Sringeri's report, although he had a brief prepared before he received that report because it "started getting tight with regard to timelines".[280] He stated that he relied in particular on Dr Sringeri's opinion that CPL Turner's chances of recurrence of his PTSD symptoms were very low.[281] COL MF recalled reading Dr Sringeri's opinion that CPL Turner was "cleared to

[273] Tab 11 (Statement of Dr Sringeri) at 90.
[274] Exhibit 19.
[275] Tab 17 (IGADF ROI with COL MF on 22 August 2018) at 24.
[276] Tab 32 (IGADF ROI with Joanna Turner dated 15 August 2018) at 33.
[277] 19/10/20 T54.43-49.
[278] 19/10/20 T55.1-16.
[279] 22/10/20 T320.42-45.
[280] 06/02/23 T223-224.
[281] 06/02/23 T228.

attend all duties from a psychiatric point" and that he took it to mean that CPL Turner was fit psychiatrically to be deployed on OP OKRA.[282] He did not think to question whether Dr Sringeri intended to state that CPL Turner was fit for active deployment with the Special Forces in Iraq because he assumed that the letter had been procured for a specific purpose, namely, the response to go back to the J07.[283] COL MF did not consider at the time the possibility that CPL Turner might have had symptoms of PTSD which he did not disclose to Dr Sringeri.[284]

159. MAJ AM's evidence in relation to the significance placed on treatment received from an external psychiatrist was that "it's not the only decision-making tool" because "civilian psychiatrists often don't necessarily understand the context and so one of my roles is not to counter their advice … but to interpret that advice for the military context". His view was that external psychiatrists "don't necessarily have a background" for "specific military contextual advice".[285] He stated that he would not expect a consultant psychiatrist who is not military to make an assessment about deployment.[286] This sits at odds with the fact that Dr Ahmed, a medical officer working at Tobruk Clinic, asked Dr Sringeri "I need your opinion about his deployment…is member fit to Deploy?".[287]

(g) GPCAPT Ross' decision

160. On 8 June 2016, GPCAPT Ross refused CPL Turner's medical clearance to deploy on OP OKRA. The reasons for the refusal were recorded as follows: [288]

> "Pre-deployment medical reviewed by HQJOC J07 – member has been deemed unfit to deploy based on medical history. Extensive psychological and alcohol dependence history, ongoing stressors, and failure to continue psych support as recommended places member at high risk of deterioration whilst deployed. Tobruk Lines Health Centre notified, and member is to be recalled to receive feedback from MO".

161. GPCAPT Ross gave a statement to the Inquest[289] and gave oral evidence during the second tranche of hearings. While he stated that he could not remember the precise reasoning behind his refusal to grant a clearance to CPL Turner in the first place, having regard to the notes available in the brief of evidence, he stated that his particular concern was that CPL Turner had been recommended for ongoing psychological support (but had unilaterally discontinued treatment) and GPCAPT Ross considered

[282] 06/02/23 T230.
[283] 06/02/23 T232.
[284] 06/02/23 T227.
[285] 06/08/21 T20.48-21.11.
[286] 06/09/22 T71.30-32.
[287] Tab 50 (ADF Medical Records) at 9.
[288] Tab 50 (ADF Medical Records) at 108.
[289] Tab 114A (Statement of CPCAPT James Ross dated 28 September 2020).

that this suggested CPL Turner had poor insight into his situation.[290] The notes which were available to GPCAPT Ross from which he refreshed his memory were as follows:[291]

> "History of significant mental health issues from 2013/14, with further problems identified in late 2015. Recommendation of continuing psych support was not taken up by member. Issues around stress/agitation, interpersonal relationships, alcohol use. Member at high risk of deterioration if deploys to Middle East."

162. In GPCAPT Ross' oral evidence, he accepted that there were three matters which led to his original refusal decision: (1) the history of significant mental health issues from 2013/2014 with further problems identified in late 2015; (2) the recommendation of continuing psychological support which was not taken up; and (3) issues around stress/agitation, interpersonal relationships, and alcohol use.[292]

163. When asked as to whether CPL Turner might have been seeking to avoid detection of his symptoms, CPCAPT Ross gave evidence that:[293]

> "That was the concern that I had. It was either that he was well aware of his poor psychological health and was trying to hide it or he had poor insight and that he, although he was unwell, he was in denial and was avoiding because he didn't think there was anything wrong so they were the two options but there's the same outcome essentially. That I was concerned that ongoing symptoms were not being adequately dealt with."

164. On 20 July 2016, GPCAPT Ross reversed his original decision. GPCAPT Ross' evidence was that he relied on the Clinical Perspective Document in making his decision. He stated the level of involvement demonstrated in that document from an RMO was unusual and he expected that was a "large part of why I reversed my original decision" and that he expected (though he could not actually recall) that he considered that document contained "adequate justification for [CPL Turner's] deployment on operation from a medical officer who had direct clinical knowledge of him."[294]

165. In his oral evidence, GPCAPT Ross stated that to the best of his recollection the Clinical Perspective Document was the one document he considered before he reversed his decision.[295]

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[290] Tab 114A (Statement of GPCAPT James Ross dated 28 September 2020) at 6-7.
[291] Exhibit 3 (Letter from AGS re additional medical waiver issue documents) at 5.
[292] 06/08/21 T42-43.
[293] 06/08/21 T43.8-13.
[294] Tab 114A (Statement of GPCAPT James Ross dated 28 September 2020) at 7.
[295] 06/08/21 T36.26-27.

166. GPCAPT Ross later suggested that his revised decision would have "been based on all of the documentation available" and that he "would have re-familiarised" himself with the other documentation, being the documentation he had originally looked at when making the decision not to grant a clearance (although he could not, at the time of giving evidence, recall what documentation that was).[296]

Submissions on GPCAPT Ross' evidence regarding the reversal/review decision

Submissions of Counsel Assisting

167. Counsel Assisting submits that, plainly enough, there is an inconsistency between these two versions and that there would be cogent reasons to prefer GPCAPT Ross' first version of events, namely, that he only considered the Clinical Perspective Document.

168. *First*, that was his first answer given in evidence in an apparently forthright and honest response to questioning. His second answer, by contrast, emerged after an objection was taken by Senior Counsel for the ADF who suggested, as part of that objection, that GPCAPT Ross had not given the evidence he did in fact give (that the Clinical Perspective Document was the only document he considered in his reconsideration).[297]

169. *Second*, when GPCAPT Ross was taken through the medical records, he accepted there was an inconsistency between the medical records and what was being presented in the Clinical Perspective Document.[298] It is exceedingly unlikely that a doctor of GPCAPT Ross' experience and rank would have read the medical records again contemporaneously and not have noticed this inconsistency at the time.

170. *Third*, GPCAPT Ross' evidence was that he considered an RMO would have direct knowledge of the members in the regiment,[299] and his statement indicated that he considered the level of involvement of an RMO in the Clinic Perspective Document was "unusual to the point of being unique", that it "addressed the issues mentioned in the record of my original decision, including [CPL Turner]'s discontinuation of psychological treatment", and that, in GPCAPT Ross' view, it contained "adequate justification for [CPL Turner's] deployment on operation from a medical officer who had direct clinical knowledge of [CPL Turner]". That is, GPCAPT Ross viewed the Clinical Perspective Document as an important document which had been written by someone

[296] 06/08/21 T48.50-49.11.
[297] 06/08/21 T48.26-27.
[298] 06/08/21 T51.1-18.
[299] 06/08/21 T36.34-37.

with medical qualifications who he considered would have an awareness of CPL Turner's clinical history.

171. *Finally*, the written reasons which were provided by HQJOC in relation to the decision stated that "Based on new evidence sent to the J07 by MAJ AM this Member has been cleared to deploy on Okra by the J07 HQJOC".[300] That is, the contemporaneous reasons given for the change in GP CAPT Ross' decision identified MAJ AM's document as the reason for the change in decision.

172. On the other hand, if it is to be accepted that GPCAPT Ross did reconsider all of the medical records he had considered in the first place, and assuming he followed his usual practice and considered the documents which are contained in Exhibit 3 (which included the VVCS case closure summary), it is unclear how GPCAPT Ross did not identify the glaring inconsistency between the medical records and what was being put forward in the Clinical Perspective Document, and take some step to investigate this issue before overturning his original decision. That is, if GPCAPT Ross did not consider any further medical records, he should have done so. That is what, on his own evidence, he would ordinarily have done. If he did consider the medical records, his evidence offered no cogent explanation for why he made the clearance decision he did.

173. That is because his evidence, ultimately, was that having regard to the medical records which were available to him, none of the three concerns which he had raised in his original decision had in fact been alleviated or addressed,[301] and in fact, CPL Turner was still experiencing three issues that he had relied on in his original clearance decision, when he had reached the conclusion that deployment presented an unacceptable risk of deterioration.[302] GPCAPT Ross further accepted that if he had picked up on the inconsistency between the Clinical Perspective Document and the medical records at the time, he would have "done more about it"[303] and that his reliance on the Clinical Perspective Document led him to the view that CPL Turner had a sufficiently low risk to be able to deploy but, in retrospect, the "risk profile was higher".[304]

[300] Tab 49 (ADF Medical Records) at 330.
[301] 06/08/21 T50.46-48.
[302] 06/08/21 T52.34-43.
[303] 06/08/21 T51.17-19.
[304] 06/08/21 T53.8-21.

174. GPCAPT Ross accepted that he could have granted a clearance that was subject to a condition that there be regular psychological reviews of CPL Turner,[305] although he considered that this would have been an unusual thing to do.[306]

175. GPCAPT Ross' evidence revealed similar confusion to MAJ AM's evidence in terms of what he was supposed to be considering as part of his decision-making process. At one point, GPCAPT Ross stated that the medical clearance process is "intended to be a medical decision" because there is a "command process" (the command waiver process), which could be implemented if the Chain of Command was not satisfied with the outcome of the clearance process.[307] However, at another point in his evidence, he stated that he had to "walk a tightrope" where "there's the interests of the individual, the interests of the organisation, the interests of the operation, are considered on balance".[308] Again, by contrast, he later considered that it was "no part" of his consideration to consider what the operational significance of the particular individual was to the deployment.[309]

176. GPCAPT Ross' evidence was that he had "no reason" to think that the Chain of Command had been involved in the process of preparation of the Clinical Perspective Document.[310] However, he accepted that it was clear from the face of the Clinical Perspective Document that CPL Turner's Chain of Command wanted to have the decision reversed: it stated in terms that it was "aligned to his OC and CO's intent". GPCAPT Ross suggested in evidence he might not have taken particular note of this at the time of making his reconsideration decision.[311] This is again difficult to reconcile with the fact that the Clinical Perspective Document was provided to GPCAPT Ross under cover of a brief under the hand of the CO, COL MF.

Submissions of the Commonwealth

177. The Commonwealth accepts that Counsel Assisting's submission that GPCAPT Ross' evidence revealed "confusion" as to "what he was supposed to be considering as part of his decision-making process" has force.[312]

[305] 06/08/21 T36.45-50.
[306] 06/08/21 T23.21-23.
[307] 06/08/21 T38.33-35.
[308] 06.08/21 T38.20-26.
[309] 06/08/21 T38.50-39.1-2.
[310] 06/08/21 T49.34-35.
[311] 06/08/21 T49.44-49.
[312] Submissions of the Commonwealth dated 7 June 2024 at [316]-[317], [386].

Submissions of GPCAPT Ross

178. GPCAPT Ross makes a number of submissions in relation to the matters above.

179. *First*, GPCAPT Ross disagrees with the contention that he was suffering from any confusion as to his role as J07 HQJOC. He submits that his evidence was clear about: when Command seeks that an individual deploy because it suits an organisational imperative, yet that person is not medically cleared to deploy, the appropriate process is a command waiver; at all times he understood the difference between medical clearances and command waivers; the role of an occupational physician; and the matters that an occupational physician might permissibly consider in the medical clearance process. He maintains that: the medical clearance decision involved only medical considerations; those medical issues have impacts on the individual and on the organisation; an occupational physician can validly take into account both of those perspectives; and the appropriate course for the Chain of Command to influence a decision is through the command waiver process. [313]

180. *Second,* GPCAPT Ross disagrees with Counsel Assisting's contention that he *only* had regard to the Clinical Perspective Document when making the "reversal decision" and submits that he also considered the report of Dr Sringeri, which was enclosed in the brief to GPCAPT Ross containing the Clinical Perspective Document.[314] In support of this submission, GPCAPT Ross refers to: his evidence of having a "very limited recollection"[315] of CPL Turner's case generally (which was understandable considering the passage of time and volume of cases GPCAPT Ross reviewed as J07 HQJOC); he had not indicated in his written statement that he *only* had regard to the Clinical Perspective Document;[316] his oral evidence suggested that he reviewed other documents in making his appeal decision;[317] and the evidence of Professor Hopwood.[318] GPCAPT Ross considers that a finding ought to be made that he did consider all of the material before him in first refusing and then granting the clearance.

181. In submissions in reply, Counsel Assisting accepts GPCAPT Ross' submission on this point.[319]

[313] Submissions of GPCAPT Ross dated 5 June 2024 at [100]-[103]; Submissions in reply of GPCAPT Ross dated 22 July 2024 at [9]-[12]
[314] Submissions of GPCAPT Ross dated 5 June 2024 at [36]-[44].
[315] Exhibit 114 at [18]; 06.08.21 T35.47-48 and T41.36-37.
[316] Exhibit 114 at [25].
[317] 06.08.21 T35.9-11, T40.7-9, T41.38-42, T42.1-2; 10.08.21 T19.22-24.
[318] 08.02.23 T35.21-27.
[319] Submissions in reply of Counsel Assisting dated 22 August 2024 at [177].

182. GPCAPT Ross submits that the Clinical Perspective Document addressed his concerns as to CPL Turner's history of mental illness, his alcohol consumption, and his interpersonal relationships, and why CPL Turner had discontinued his psychological treatment, which were the matters in CPL Turner's health record that had caused GPCAPT Ross to make his initial decision. However, he also submits that on the basis that the Clinical Perspective Document was not the only new evidence available to him at the time of making the reversal decision, the question of whether that document answered every concern he had expressed at the time of the initial decision to refuse the clearance "becomes much less significant".[320]

183. In relation to Counsel Assisting's submission that the Clinical Perspective Document led GPCAPT Ross to the view that CPL Turner had a sufficiently low risk to be able to deploy but in retrospect "the risk profile was higher", GPCAPT Ross submits that this was evidence given prior to the production of Dr Sringeri's letter (which independently addresses CPL Turner's risk profile and expressly states that CPL Turner was at low risk of a recurrence of PTSD).[321]

184. GPCAPT Ross also considers that the fact that a document such as the Clinical Perspective Document advocates a position which its author is convinced does not necessarily mean that it is unbalanced or that it does not accurately reflect the true position and, accordingly, GPCAPT Ross was entitled to approach the document on the basis that MAJ AM's conviction was based on the medical information known to MAJ AM.[322]

185. GPCAPT Ross is of the view that he was entitled to place the reliance he did on the Clinical Perspective Document and he ought not be criticised for this. He considers that there was nothing on the face of the Clinical Perspective Document that put GPCAPT Ross on notice as to any limitations on the opinion that MAJ AM expressed in it (i.e., there was no reference to MAJ AM being deployed on a significant operational exercise at the time he wrote it; there was no reference to the document being written out-of-hours at which time MAJ AM lacked access to CPL Turner's treating clinicians; there was no reference that MAJ AM had not in fact consulted with the clinicians) and that, in fact, the document expressly referred to the opinion of CPL Turner's clinicians in support of its contentions. GPCAPT Ross considers that it was incumbent on MAJ

[320] Submissions of GPCAPT Ross dated 5 June 2024 at [55]-[56].
[321] Submissions of GPCAPT Ross dated 5 June 2024 at [57].
[322] Submissions of GPCAPT Ross dated 5 June 2024 at [59].

AM to make clear any matter that might have affected the veracity or reliability of the opinions he expressed in the document.[323]

186. GPCAPT Ross submits that while he approached the document with his usual caution, he ought not to have been expected to have approached a document from a professional colleague holding the senior role of RMO with scepticism or suspicion, nor to second-guess the information it contained.[324]

187. GPCAPT Ross also rejects any contention that his "second version" of events (referred to at [166] above) was influenced by the content of Senior Counsel for the Commonwealth's objection and was not true.[325]

188. *Third,* GPCAPT Ross submits that a finding ought to be made that he "had no reason" to interrogate the medical records to test what was being put to him in the Clinical Perspective Document. It is further submitted that GPCAPT Ross was "likely to have done so".[326]

189. On this point, Counsel Assisting submits that it is difficult to reconcile GP CAPT Ross' submission that he had no reason to interrogate the records with the further submission that he was likely to have done so. Counsel Assisting maintains that it is open to make a finding that GPCAPT Ross did not subsequently interrogate the medical records which had led him to make his first refusal decision.[327]

190. *Fourth,* GPCAPT Ross submits that on the premise that Dr Sringeri's letter was before him, that letter provides an independent answer to the concerns that he held as to CPL Turner's fitness to deploy.[328]

191. *Fifth,* in relation to the contention that the reference to "new evidence" was the basis for appeal/reversal decision (referred to at [171] above), GPCAPT Ross submits that there is no cogent reason to read this narrowly as a reference to the Clinical Perspective Document given that it has become clear that GPCAPT Ross most likely also had the benefit of Dr Sringeri's letter at the time of the appeal/reversal decision. For similar reasons, GPCAPT Ross rejects Counsel Assisting's submission above at [172] that there is "no cogent reason" why GPCAPT Ross could have made the appeal

[323] Submissions of GPCAPT Ross dated 5 June 2024 at [60]-[62].
[324] Submission of GPCAPT Ross dated 5 June 2024 at [66].
[325] Submissions of GPCAPT Ross dated 5 June 2024 at [42].
[326] Submissions of GPCAPT Ross dated 5 June 2024 at [88(b)].
[327] Submissions in reply of Counsel Assisting dated 22 August 2024 at [177].
[328] Submissions of GPCAPT Ross dated 5 June 2024 at [96]-[97].

decision if he had taken into account the medical records (given that Dr Sringeri's letter addressed his concerns as to CPL Turner's fitness to deploy). [329]

Consideration

192. At the conclusion of all the evidence I was not persuaded that GCAPT Ross' "reversal" decision was not infected by some confusion in relation to his understanding of his role as J07 HQJOC. While he may have understood the theoretical difference between a medical clearance and a command waiver, his evidence demonstrated he was affected by competing concerns. He spoke of "walking a tightrope" where he had to balance the interests of the individual, the organisation, and the operation. While he appeared to see that balancing task as part of his role as an occupational physician, it demonstrated to me the extent to which Chain of Command interests weighed upon him. It is important to note that GPCAPT Ross was not alone in this confusion and it is an issue to which I will return.

193. I was persuaded that GPCAPT Ross placed great emphasis on the Clinical Perspective Document in coming to his second decision. He accepted that there were significant inconsistencies between the medical records and the Clinical Perspective Document. In my view, this was compelling evidence which demonstrated that it was most unlikely that he reviewed the medical records again at the time of his second decision. While he originally gave evidence that to the best of his recollection the Clinical Perspective Document was the only document he relied upon, I accept that it is now clear he may well have had the Dr Sringeri report. I have some sympathy for the submission that he was entitled to give significant weight to Dr Sringeri's opinion that CPL Turner was at "low risk" for a recurrence of PTSD. However, he was not entitled to accept that opinion without placing it in context and having regard to all the material available to him. He was not entitled to substitute Dr Sringeri's opinion for his own.

194. I also have some sympathy for GPCAPT Ross' contention that he was entitled to place reliance on the Clinical Perspective Document. It had been prepared by a RMO and made expansive claims about CPL Turner's wellbeing. GPCAPT Ross believed MAJ AM had a clinical role in CPL Turner's care, which added to the weight he gave the document. Nevertheless, GPCAPT Ross was not entitled to abrogate his own decision to the opinion of MAJ AM. Even a cursory re-examination of the medical records would

[329] Submissions of GPCAPT Ross dated 5 June 2024 at [94]-[95].

have alerted GPCAPT Ross to areas of concern and caused him to question the accuracy of the Clinical Perspective Document.

195. There is another issue which should have alerted GPCAPT Ross to the need for caution when asked to re-consider his original decision. Given that GPCAPT Ross considered the level of involvement of an RMO in the Clinical Perspective Document as "unusual to the point of being unique", one wonders why he did not at least consider whether he was being pressured to change his decision. GPCAPT Ross' original decision makes it clear that he was aware of CPL Turner's extensive psychological and alcohol dependence history, his failure to continue psychological support as recommended, and his risk of deterioration whilst deployed. In my view, on receipt of new information he was obliged to reconsider the original material, particularly where the new material conflicted with matters set out in his original written decision. There was real need for curiosity.

196. In my view, there were significant deficits in the second decision.

(h) Deployment to Iraq on OP OKRA in 2016

197. Ultimately, CPL Turner did deploy on OP OKRA in late July 2016. He arrived at Al Taqqadum Air Base (**TQ**) on 30 July 2016.

(i) Disciplinary proceedings and reduction in rank

198. The incident which became known in the Inquest as the "cock-carding" incident occurred on 30 July 2016. At this time, CPL Turner was on a Royal New Zealand Airforce aircraft, travelling into Iraq. He placed a pornographic playing card displaying a photograph of a naked male on a cargo pallet, which was scheduled for offload at Al Assad Air Base. The card was discovered by a member of the aircrew and when discovered, the flight was briefed on the cargo inspection processes used by Iraqi customs officers and the possible consequences if the card had been found by Iraqi officials.[330]

199. It is not the role of a coroner to review the decision to charge CPL Turner, the severity of his punishment, or the outcome of his ultimate petition for review. The disciplinary proceedings were the subject of an investigation by the IGADF, the report of which was tendered in evidence in the Inquest.[331] Rather, the relevance of the disciplinary proceedings to the issues in the Inquest are as follows:

[330] Tab 40 (Military Charge Papers) at 12.
[331] Tab 125 (IGADF Report of investigation into disciplinary proceedings).

(a) first, the causal link (if any) between CPL Turner's mental state and his participation in the cock-carding incident;

(b) second, the ADF's management of CPL Turner's mental health throughout the disciplinary proceedings and their aftermath; and

(c) third, the effect of the disciplinary proceedings on CPL Turner's mental health during the Iraq deployment and subsequently.

200. MAJ AF's evidence was to the effect that the incident became "bigger than Ben Hur", and that one of the "key things that all come out when we talk about his charge, he was charged for an international incident that never took place".[332] He gave evidence that prior to the charge the vibe was "it's not a big deal, let us know who these people are", and that his impression was "I'll charge a couple of diggers and move on".[333] However, it became an "integrity issue" for the Commander of Joint Task Force (**JTF**) 633.

201. CAPT MH stated in his ROI that "at the time we were told that there would be no further action with regards to what had occurred, they simply wanted to get the names of the individuals who were responsible so they could pass those on to 633, and that would be it". This came to be described as the promise of an "amnesty". He stated that CPL Turner put his hand up and said "I'm responsible for the one that was found in the package".[334] He stated that shortly thereafter, CPL Turner was told he would likely be facing disciplinary action and CAPT MH was told he would be the Defending Officer.[335] CPL TJ stated that the amnesty was given by LTCOL NJ, that the group who had been on the flight was brought in together (with those who were not in Baghdad on a video conference) and that they were told you "have amnesty".[336]

202. WO2 DP stated that it "really put a rocket through the company", because his view was that they were told that if people came forward, nothing would happen, and the "next thing they see is a sergeant is getting charged after putting his hand up".[337]

203. The summary hearing in relation to the cock-carding incident occurred on 16 August 2016.

[332] Tab 16 (IGADF ROI with MAJ AF on 24 July 2018) at 19.
[333] Tab 16 (IGADF ROI with MAJ AF on 24 July 2018) at 19.
[334] Tab 18 (IGADF ROI with CAPT MH on 5 June 2018) at 7-8.
[335] Tab 18 (IGADF ROI with CAPT MH on 5 June 2018) at 5.
[336] Tab 27 (IGADF ROI with CPL TJ on 14 August 2018) at 7.
[337] Tab 24 (IGADF ROI with WO2 DP on 5 July 2018) at 15.

204. CPL Turner was charged with prejudicial conduct contrary to s 60(1) of the *Defence Force Discipline Act 1982* (Cth),[338] pleaded guilty, and was sentenced to a reduction in rank (from SGT) to CPL.[339] The reasons for judgment stated that the officer trying the charge assessed CPL Turner's judgment as "incredibly poor" but noted that he did not believe that his intent was to cause damage.[340] It also noted that the behaviour of concern was "your inability to understand or foresee the potential outcome of your behaviour and how poor this decision was in the circumstances in which you chose to perform the act".[341]

205. It is notable that the reasons do not record any consideration being given to CPL Turner's diagnosis with PTSD or mental health in the sentencing consideration. That being said, neither CPL Turner's mitigation statement, which was prepared with the assistance of CAPT MH, nor the character references supplied in support of his plea in mitigation, referenced these issues.[342]

206. LTCOL SW, who wrote a letter of reference for CPL Turner, stated that (subjectively speaking) he was surprised at the severity of the punishment, and that his statement did not appear to be "actually given any credence".[343] WO2 DP stated that he considered it to be a "very harsh punishment" for something that was "not an actual incident".[344]

207. MAJ AF's evidence was that he was worried about the "guys who were going back" to Al Minhad Air Base (**AMAB**), because "AMAB is cancerous … its institutionalised fraud".[345] His evidence was that he was "quite worried about them", they were "treated like lepers", and that "we tried to look after them as much as we can".[346] MAJ AF's evidence was to the effect that it was then decided that CPL Turner "would be in Baghdad" after the charge and the decision to allow him to stay in country.[347] It is not clear that this in fact was the case. Following his return from AMAB after the charge process was complete, CPL Turner remained in BDSC for around 6 days before returning to TQ for over 6 weeks (as set out in **Annexure C**).[348]

[338] Tab 40 (Military charge papers) at 35.
[339] Tab 40 (Military charge papers) at 39.
[340] Tab 40 (Military charge papers) at 38.
[341] Tab 40 (Military charge papers) at 38.
[342] See Tab 40 (Military charge papers) at 69-77.
[343] Tab 22 (IGADF ROI with LTCOL SW on 11 December 2018) at 10-11.
[344] Tab 24 (IGADF ROI with WO2 DP dated 5 July 2018) at 22.
[345] Tab 16 (IGADF ROI with MAJ AF on 24 July 2018) at 20.
[346] Tab 16 (IGADF ROI with MAJ AF on 24 July 2018) at 20.
[347] Tab 16 (IGADF ROI with MAJ AF on 24 July 2018) at 21.
[348] Exhibit 67 (Agreed Fact: CPL Turner's movements during the 2016 Iraq Deployment).

208. A further issue which arose in relation to the disciplinary proceedings related to an incident involving COL L, who was standing near the front gate of the accommodation on the morning of the disciplinary proceedings. WO2 DP's evidence was that it was strange that he was there at the time, early in the morning and in full uniform. He stopped CPL Turner to talk, and WO2 DP stated that CPL Turner later said to him (WO2 DP) that COL L had said "Hey, I heard you're getting charged today. Good luck with that, mate". Neither WO2 DP nor CAPT MH, who were with CPL Turner, were in fact privy to the conversation. CPL Turner then told WO2 DP that he had a sexual relationship with COL L's wife, and COL L was aware that had happened.[349] CPL TJ stated in her ROI that CPL Turner considered there was a person who was "out to get him" involved in the disciplinary proceedings. CPL TJ's evidence was that CPL Turner considered that this person "took the opportunity to seek maximum damage on Ian. So he kind of had that mindset that everything was just turning against him".[350]

209. Joanna Turner similarly stated that CPL Turner believed that a woman who he had been sexually involved with had a father who was somehow involved in the disciplinary proceedings and was out to get him. Joanna Turner indicated she did not know if this was true and said "to be honest, CPL Turner was that paranoid that you couldn't believe – I couldn't believe a word that he said".[351]

210. This issue was canvassed in the IGADF investigation into the disciplinary proceedings, which found no evidence to substantiate the allegations.[352] The issue was not dealt with in any significant detail in oral evidence in the Inquest. The relevance of it is simply to understand CPL Turner's response to the disciplinary proceedings. That is, it is evident that CPL Turner had a sense of grievance about the disciplinary proceedings. One way in which this manifested was in his belief that there had been collusion and/or bias involved in his disciplinary proceedings, which had affected their outcome.

211. Evidence was also given during the hearing that CPL Turner's mental health was also affected by the fact that "cock-carding" was a widespread practice within 2CDO and the wider special forces community and he felt he had been unfairly singled out for punishment. In his oral evidence, MAJ AF said he was aware of the practice of cock-carding prior to the 2016 deployment to Iraq.[353] MAJ AF also said he would have taken a different view as to the seriousness of the incident had it occurred in Australia.[354] In

[349] Tab 24 (IGADF ROI with WO2 DP dated 5 July 2018) at 19-21.
[350] Tab 27 (IGADF ROI with CPL TJ on 14 August 2018) at 8.
[351] Tab 32 (IGADF ROI with Joanna Turner dated 15 August 2018) at 53.
[352] Tab 125 (IGADF Report of investigation into disciplinary proceedings) at 6.
[353] 03/02/23 T189.10-12.
[354] 03/02/23 T189.24-26.

his written answers to questions posed to him, CAPT MH said that he was aware of cock-carding being a widespread practice in the unit when he joined in 2015; that he had had cock cards placed on and in his equipment; that he had placed cock cards on others and their equipment; and that he was aware that the OC (MAJ AF) had been cock-carded in the lead-up to the deployment to Iraq in August 2016. CAPT MH also said he had taken no action to curtail the practice of cock-carding and justified this by saying he did not think it was a problem and understood the practice to be an accepted one within the unit, including up to the OC, and in the international special forces community.[355] Although CAPT MH said he did not have any concerns for CPL Turner's mental health after the outcome of the disciplinary proceedings were known, he did observe him to be "angry, frustrated and disillusioned".[356]

(j) Care of CPL Turner's mental health in Iraq

212. COL MF was asked if he took any step upon CPL Turner being charged to provide him with psychological support. He stated he did not because "him being deemed fit to deployment in the context of the mission that they were going to deploy on, I took to mean that he was physically and mentally in a position to cope with the activities with that mission… I did not see that as a red flag".[357] However, he also stated that because CPL Turner was "force assigned" to a different Chain of Command, "we are very conscious that once the members are force assigned we sort of stay out of it".[358]

213. CAPT MH described CPL Turner's mental state during the time they were in AMAB as "angry", "devastated", and "disillusioned".[359] CAPT MH stated that following the return from AMAB into Iraq, CPL Turner's work performance "never suffered" but it was evident from the conversations he was having with him that he was "angry, and he was getting more angry…and he was getting more frustrated and disillusioned".[360]

214. LTCOL SW had been asked by CPL Turner to provide a reference for him in his disciplinary proceedings. He stated in his ROI that CPL Turner had written to him after the outcome of the proceedings and expressed "dismay" at the lack of support the organisation had shown him, saying that the army had been a "fair-weather friend" to him, and that he was going to look for a job with an employer that would value him. LTCOL SW said he wrote back and said he was sorry it had turned out that way but

[355] Exhibit 66 at 2 [3].
[356] Exhibit 66 at 6 [15].
[357] 21/10/20 T232.40-233.3.
[358] Tab 17 (IGADF ROI with COL MF on 22 August 2018) at 13.
[359] Tab 18 (IGADF ROI with CAPT MH on 5 June 2018) at 9.
[360] Tab 18 (IGADF ROI with CAPT MH on 5 June 2018) at 11.

not to rush to any conclusions about his future and that "command needed people like him".[361]

215. LTCOL SW also stated in his ROI that he had a discussion with BRIG GD (who was, at that time, Commander Special Forces) and stated that as CPL Turner was clearly upset, he might appreciate an email from him (BRIG GD) stating something like "Listen I know you've done the wrong thing, but I know you've owned up to it", and "we still value you … you're going to bounce back and you'll get your rank back". LTCOL SW stated he was "pretty sure" he even drafted an email and sent it to BRIG GD to consider, just in case he wanted to do it. No such email was produced to the Inquest (noting it would have fallen well within the scope of the subpoenas issued to the ADF), and LTCOL SW stated in his ROI that he had looked for it and could not find it.[362] BRIG GD's evidence to the Inquest was that he could not recall receiving this, but he did not deny that it took place and, in any event, he would have thought it was "not the right thing to do" because the investigation was happening overseas and the punishment was being awarded overseas.[363]

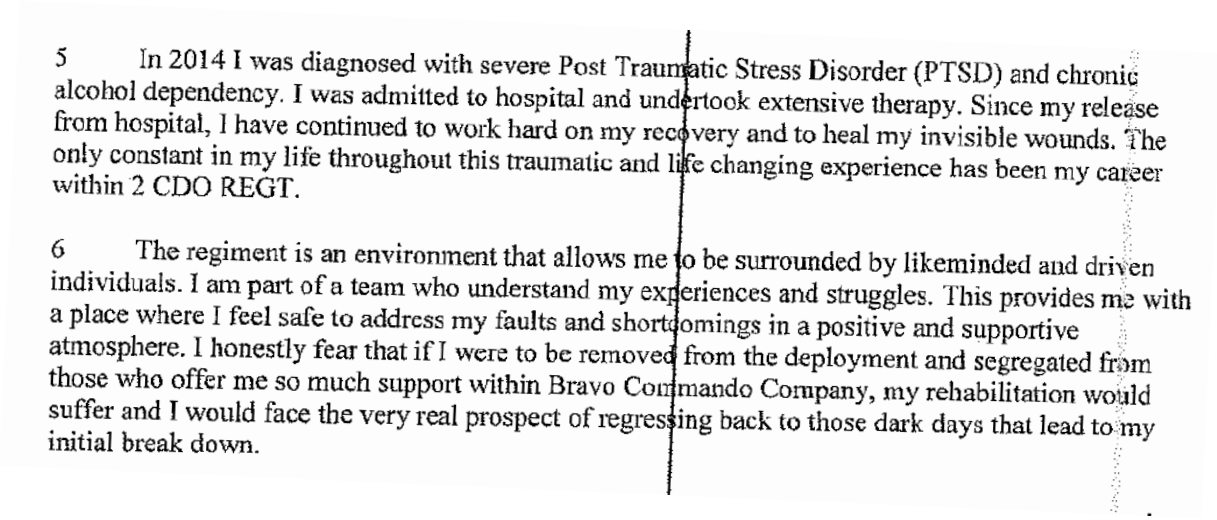
216. On 18 August 2016, CPL Turner lodged a petition for review of the conviction. The decision made at first instance was upheld.[364] The petition which was submitted by CPL Turner did not refer to his history of mental health issues as a potentially mitigating factor.[365]

217. CAPT MH was unavailable to give evidence to the Inquest but provided a number of written statements at the request of Counsel Assisting. He was asked why CPL Turner's mental health was not raised during the summary authority hearing. In a letter dated 31 July 2021, CAPT MH stated that this was because "it was not raised by Ian Turner with me and it was not something that I was aware of at the time". He further stated that "nothing was raised by Ian in the course of preparing for the hearing that indicated his mental health was a relevant matter", and that he was not instructed by CPL Turner to raise any issues regarding his mental health.[366] He clarified in a later letter responding to further questions that "at the time" meant at the time of the summary proceedings.[367]

[361] Tab 22 (IGADF ROI with LTCOL SW on 11 December 2018) at 9.
[362] Tab 22 (IGADF ROI with LTCOL SW on 11 December 2018) at 22.
[363] 01/02/23 T44-45.
[364] Tab 40 (Military Charge Papers) at 9.
[365] Tab 40 (Military Charge Papers) at 20-24.
[366] Exhibit 13.
[367] Exhibit 66 at 5-6.

(k) The Notice to Show Cause (NTSC)

218. Following the disciplinary action, on 17 August 2016, CPL Turner was issued with a Notice to Show Cause (**NTSC**) as to why he should not be returned to Australia.[368] The NTSC required a response within 2 days. CAPT MH assisted CPL Turner with responding to the NTSC.[369] The response to the NTSC referred to CPL Turner's PTSD diagnosis, stating as follows:[370]



5 In 2014 I was diagnosed with severe Post Traumatic Stress Disorder (PTSD) and chronic alcohol dependency. I was admitted to hospital and undertook extensive therapy. Since my release from hospital, I have continued to work hard on my recovery and to heal my invisible wounds. The only constant in my life throughout this traumatic and life changing experience has been my career within 2 CDO REGT.

6 The regiment is an environment that allows me to be surrounded by likeminded and driven individuals. I am part of a team who understand my experiences and struggles. This provides me with a place where I feel safe to address my faults and shortcomings in a positive and supportive atmosphere. I honestly fear that if I were to be removed from the deployment and segregated from those who offer me so much support within Bravo Commando Company, my rehabilitation would suffer and I would face the very real prospect of regressing back to those dark days that lead to my initial break down.

219. It appears that there was a policy in the ADF that a NTSC as to why a member should not be returned to Australia followed the institution of any disciplinary proceedings on deployment. MAJ AF's evidence in relation to the NTSC was that he put CPL Turner under administrative action himself because then "I have done it", and not some "random deputy commander". He did not personally agree with the policy that administrative action should automatically follow DFDA Action,[371] and his view was "He's mine, and I'll decide whether he goes home or not".[372]

(l) Deteriorating mental health in Iraq and available supports

220. The text and WhatsApp messages available from CPL Turner to various individuals during this period evidence that CPL Turner experienced significant disillusionment in respect of the disciplinary action and then in relation to his move from B Company and as a result of an incident known as the "body recovery" (both of which are discussed

[368] Exhibit 31 at 57-59.
[369] Exhibit 66 (Response to Questions posed to CAPT MH) at 5.
[370] Exhibit 31, Tranche 8 at 42.
[371] Tab 16 (IGADF ROI with MAJ AF on 24 July 2018) at 25.
[372] Tab 16 (IGADF ROI with MAJ AF on 24 July 2018) at 24.

further below).[373] At this juncture, however, it is useful to consider the available mental health supports in Iraq for CPL Turner.

221. The brief sent from the CO of 2CDO to the J07 specifically stated that "the following management strategies and mitigations have been developed by SGT Turner's chain of command, in consultation with rehabilitation staff and psychologists [in order to] ensure SGT Turner's welfare is managed appropriately and successfully whilst deployed", and then stated:

> "a. The personnel best able to monitor, asses [sic] and manage his mental health are his regular team members, who he will be deployed with;
>
> b. During the deployment, SGT Turner will have ready access to coalition medical support, including… psychologists;"

222. MAJ AF's oral evidence was that there was no specific mental health plan designed for CPL Turner once he had deployed. The only steps he took to determine if there was a deterioration in his mental health condition was "routine engagement by the chain of command".[374] This would have been CAPT MH whilst CPL Turner was in TQ, and then later MAJ AF when CPL Turner returned to BDSC.[375] WO2 DP stated in his ROI that because CPL Turner was "such a high performer, we put him into a position where it's fairly isolated" (talking about TQ).[376] The evidence revealed that CPL Turner himself felt lonely and isolated whilst he was in TQ.[377] (Set out in **Annexure C** to these findings is a timeline which constituted an agreed fact of CPL Turner's movements in Iraq).

223. COL MF's evidence was that once CPL Turner was deemed "fit to deploy", no "caveats" were put on that deployment, and he therefore did not take any steps to reduce the risk of any relapse by CPL Turner of his PTSD.[378] His view was that "his being deemed medically fit to deploy meant that he was capable of, you know, completing the physical and psychological taskings that he was going to encounter".[379] His understanding of PTSD was that, essentially, he could "rule a line" underneath it, he was "better", and his PTSD was not something that needed to be monitored unless he was informed by a doctor that something had changed.[380] COL MF did not, in 2016, hold an understanding that when someone has had PTSD the risk of further ongoing

[373] See, e.g., Exhibit 57 (WhatsApp and SMS messages) at 257-258.
[374] 04/08/21 T44.9-21.
[375] 04.08.21 T44.29-32.
[376] Tab 24 (IGADF ROI with WO2 DP on 5 July 2018) at 11.
[377] See, e.g., Exhibit 57 (WhatsApp and SMS Messages) at 739, 1051, 1289.
[378] 21/10/20 T232.1-20.
[379] 21/10/20 T26-28.
[380] 22/10/20 T290.47-50.

exposure carries a substantial risk of relapse.[381] He was not aware that alcohol abuse can manifest as a form of self-medication in individuals with PTSD, or can be a symptom of PTSD.[382] At the time of recommending that CPL Turner be deployed, he did not think he was at risk of recurrence of PTSD in Iraq, even if exposed to traumatic events.[383]

224. MAJ BJ's evidence was that he could not recall seeing the 2CDO CO's brief to the J07 (notwithstanding he sent it to CAPT MH for his awareness because CPL Turner was deploying with CAPT MH as his immediate superior).[384] His evidence was later that although he forwarded it (because he thought it was important that CAPT MH have the information in the brief), he could not in fact recall whether he had read it, skimmed it, or forwarded it – he just did not recall having "read it in detail".[385] He stated that he did not "feel at that stage that Ian was under a rehabilitation, yeah, management plan" and that "we felt that him going on that deployment was in his best interests, being around his teammates…and not being at home by himself".[386] He could not recall if a psychologist was available at BSDC.[387] He could not recall whether either of the two mitigation strategies extracted above at [221] were put into place but stated the "decision making around that would have been through administrative lines, so I'm not sure".[388] CAPT BJ's evidence was that he was aware of the disciplinary proceedings concerning CPL Turner but did not raise any concern with the Chain of Command about CPL Turner's mental health going through that process.[389] His explanation for not having done so was that CPL Turner was not his direct reporting line at this stage, and other people in the Company were aware of his mental health difficulties and that he had been granted a "waiver" to deploy.[390]

225. MAJ BJ received an email from CPL Turner on around 14 October 2016, in which CPL Turner noted that he was experiencing a "minor relapse at the minute" from "that body recovery thing", "not as in the drinking piece, but the other stuff". CPL Turner stated "[n]ot sure why, but it has just had a bit of an impact on me" and it was impacting his sleep and his decision-making processes.[391] MAJ BJ stated that he did not really track

[381] 06/02/23 T211.
[382] 06/02/23 T212-213.
[383] 06.02/23 T215-216.
[384] 01/02/23 T69.46-48.
[385] 03/02/23 T144-145.
[386] 01/02/23 T70.44-47.
[387] 01/02/23 T71.24-28.
[388] 01/02/23 T72.20-23.
[389] 01/02/23 T74.
[390] 01/02/23 T75.9-28.
[391] Exhibit 31, Tranche 9 at 55.

this issue or try to understand what had occurred and he did not think it warranted any further lines of enquiry.[392]

226. MAJ BJ's evidence highlighted that his deployment on OP OKRA was turbulent in an operational sense and he had a lot of responsibilities. He was also remotely located around 350km away from where CPL Turner was located.[393]

227. CAPT MH was CPL Turner's immediate supervisor. He was responsible for the "west of Iraq" during 2016, including TQ.[394] CAPT MH was excused from giving oral evidence in the Inquest but he gave a statement answering some questions in relation to disclosures that CPL Turner made to him about his declining mental health in Iraq via text and WhatsApp messages.[395] CAPT MH's answer given in writing to the Inquest explained that he did not have a good recollection of the events of 2016 but that he did not recall doing anything formal in respect of the disclosures which CPL Turner made about his relapse. He stated:[396]

> "Having reviewed the messages, I note that when CPL Turner did disclose to me that he had had a relapse of his PTSD, he also said to me: "I'm being honest with you so you are aware. Don't use it against me please." to which I replied "I would never use it against you mate. You know you can trust me." I also note that the messages reveal amongst the frequent communications I had with CPL Turner, interspersed with messages about work, I checked on his welfare and tried to give him moral support. By way of illustration, (at DEF.2002.0024.0141) I said to him "More importantly, what's going on with your sleep or lack of it! I'm out on a work party til lunch but let's talk this arvo."
>
> I also recall having a conversation with MAJ AF about CPL Turner being relocated from where he was to BDSC. I felt BDSC would be better place for him because CPL TJ and I would be there with him and the facilities, including the gym, were much better."

228. MAJ AF gave evidence that CPL Turner was returned to BDSC in order to provide better oversight of him.[397] MAJ AF accepted, having regard to the messages from CPL Turner's phone during his deployment, that he was shocked by the content of the messages and that he was "not tracking" the issues which it appeared from the messages were affecting CPL Turner.[398] He accepted that it appeared CPL Turner did not bring the concerns about his mental health he had to MAJ AF as the officer in command and that he had assumed that he would come forward in that way.[399]

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[392] 01/02/23 T79.41-46.
[393] 01/02/23 T79.
[394] Tab 18 (IGADF ROI with CAPT MH on 5 June 2018) at 5.
[395] See Exhibit 57 at 346.
[396] Exhibit 66 (Response to questions posed to MAJ MH) at 11.
[397] 04/08/21 T47-48.
[398] 03/02.23 T101-T104.
[399] 03/02/23 T105.

229. MAJ AF's evidence was that he never discussed with CPL Turner the opportunity for CPL Turner to put his hands up about his declining mental health, but that he "was aware in the community that was the company at the time that there was people he could reach out to, and one of them was me".[400] He accepted that he could not recall asking any particular person to look out for CPL Turner's mental health and any relapse in PTSD whilst he was deployed in Iraq.[401] He accepted he did not task any person in TQ to monitor CPL Turner personally.[402] He accepted he did not know what CPL Turner's process of continued psychological support was during the Iraq deployment and that he did not require him to have any sort of program of psychiatric or psychological support.[403] He accepted, with the benefit of hindsight, that CPL Turner was not open with his Chain of Command as to his psychiatric or psychological difficulties in Iraq.[404]

230. MAJ AF accepted that there was evidence that each of CPL TJ, MAJ BJ, and CAPT MH knew about CPL Turner's relapse and none of those individuals reported it to him. He refused to accept that he could not therefore rely on those who are serving with a soldier to report to the Chain of Command whether those soldiers have suffered from relapses of mental health conditions. It is useful to extract his entire answer:

> "Q. And does that suggest to you now that you cannot rely upon those who are serving with soldiers to report to you whether those soldiers have suffered from relapses of mental health conditions?
>
> No. I don't want to speak for the decision process that MH and BJ or TJ went through. They have been nothing but reliable for me in the past. They have made a decision here. I'm sure they went through a process."

Submissions on MAJ AF's evidence regarding reliance on soldiers to report relapses of mental health conditions of other soldiers

Submissions of Counsel Assisting

231. Counsel Assisting submits that I would have difficulty in accepting this evidence. That is, having been shown documentary evidence that each of the people to whom CPL Turner disclosed his relapse in Iraq (including two officers who were superior to him) did not report it to MAJ AF, he was unwilling to accept what is plainly obvious: it is not sufficient for the Chain of Command to rely on a soldier's peers or even immediate

[400] 03/02/23 T107.1-4.
[401] 03/02/23 T109.4-7.
[402] 03/02/23 T119.21-23.
[403] 03/02/023 T121.
[404] 03/02/23 T123.39-41.

superiors to report a decline in their psychological well-being to the Chain of Command.

Submissions of the Commonwealth

232. The Commonwealth does not consider that such a finding is open for me to make. Rather, it submits that it is an obvious conclusion that "it is not sufficient for the chain of command to rely on a soldier's peers" to monitor their well-being. The basis for the objection on this point is that it purportedly seeks to "universalise from one case".[405]

Submissions of CAPT MH

233. CAPT MH submits[406] that the factors as to why he did not disclose CPL Turner's relapse to MAJ AF were that CPL Turner had sent him text messages asking him not to "use it against" him; CAPT MH took steps to have CPL Turner moved from his location shortly after the disclosure; CAPT MH knew CPL Turner felt a sense of betrayal by the Chain of Command; CAPT MH felt more vulnerable to being influenced by CPL Turner to keep his relapse confidential due to the disparity in rank; the text messages sent by CPL Turner after the disclosure indicated he was in a better frame of mind; CAPT MH made specific enquiries to monitor CPL Turner's welfare after the disclosure; and CAPT MH had no specific training in dealing with and understanding PTSD. While CAPT MH acknowledges that, with the benefit of hindsight, he may have acted differently, in 2016 he responded to CPL Turner's mental health issues to the best of his ability in what he honestly and reasonably believed were CPL Turner's best interests and that it was not unreasonable for him to have adopted the course that he did.

Submissions in reply of Counsel Assisting

234. In reply submissions, Counsel Assisting submits that the focus in this respect is on the deficiencies in CPL Turner's case, and the Commonwealth accepts that "the system of reporting matters up the chain of command did not work in this case". But that is not to say the matter is *irrelevant* for the broader practice of ensuring appropriate monitoring of the well-being of ADF members, in circumstances where a medical clearance for deployment has been obtained.[407]

235. Counsel Assisting submits that the assertion of CAPT MH that he was more "vulnerable" to being influenced by CPL Turner lacks a strong evidentiary foundation.

[405] Submissions of the Commonwealth dated 7 June 2024 at [444].
[406] Submissions of CAPT MH dated 7 June 2024 at [31]-[45].
[407] Submissions in reply of Counsel Assisting dated 22 August 2024 at [220].

Nevertheless, Counsel Assisting does not seek any particular adverse finding against CAPT MH for his conduct; rather, Counsel Assisting submits that CAPT MH was inadequately trained to deal with CPL Turner's mental health issues and provide an appropriate response. It is emphasised that there was no system put in place at this time to monitor CPL Turner's condition notwithstanding the knowledge of his medical history.[408]

Consideration

236. It is clear that the Chain of Command cannot rely solely on a soldier's peers or immediate superiors to monitor their mental health. CPL Turner's case shows how a variety of factors including misplaced loyalty, lack of knowledge and skills in mental health, and a reluctance to get involved in a "private" matter can influence a decision to feed information up the line.

237. I make no adverse finding in relation to CAPT MH who was inadequately trained to assist CPL Turner. CAPT MH was in a difficult position and I understand the pressures on him to "keep information confidential."

238. To gain insight from examining CPL Turner's case is not to "universalise" impermissibly. The evidence shows that CPL Turner's peers were not able to meaningfully monitor his mental health. His relationship with CAPT MH is a case in point. No matter how well meaning CAPT MH was, his desire to help was impacted by the rank disparity and the need not to appear to "use information against" CPL Turner.

239. Returning to the evidence, the welfare board minutes for 6 September 2016[409] indicate that very little was discussed at the meeting, with most entries listed "N/A" because CPL Turner was deployed.

240. On 17 September 2016, CPL Turner contacted the health facility at BDSC. He reported continued sleep deprivation. He was prescribed temazepam.[410] MAJ AF's evidence was that he was not aware of this, and it was something that he would have liked to have been made aware of. He did not ask CPL Turner to report to him if he had sleeplessness or anxiety.[411]

241. CPL TJ stated in her ROI that during CPL Turner's time in Iraq, he was "extremely frustrated" and he "would go through waves". There would be "a day where he would

[408] Submissions in reply of Counsel Assisting dated 22 August 2024 at [141].
[409] Tab 38 (Welfare Board Minutes) at 1-4.
[410] Tab 49 (ADF Medical Records – unit copy) at 56.
[411] 13/08/21 T60.

be okay, this is it, I just cop it on the chin" and "there would be days where he was just inconsolable and just angry and become very volatile towards just being around the rank, the chain of command". She stated that there was a day she did not see CPL Turner at breakfast and she found him in his room shaving down a bullet, and he said that he was going to drive himself to HRT (where he was working at the time), lock himself in the armoured car, and pull the trigger with one of his shaved down rounds.[412]

(m) Availability of alcohol in Iraq

242. A major factor in MAJ AF's reasoning that it was "better" for CPL Turner to deploy to Iraq than remain in Australia in mid-2016 was that Australian soldiers were not permitted to drink alcohol during the Iraq deployment and, thus, deployment would give CPL Turner a break from alcohol. Counsel Assisting considers that that opinion was (at best) naïve, and at worst, wilfully blind to the true nature of alcohol consumption by Australian soldiers in Iraq. I accept that submission.

243. CPL TJ's evidence in her ROI was that "even on deployment like he would find a way of getting alcohol to have alcohol on deployment".[413] She stated the Chain of Command was not aware of his alcohol consumption on deployment but "they were definitely aware prior to him going on this trip".[414] Her evidence was that CPL Turner obtained alcohol from the pizza shop, and that at least two of the nights that CPL TJ was with him a week (which was about four nights a week), he would have alcohol.[415] Notwithstanding this, CPL TJ gave evidence that "I believe it was effective because you [could] only get a limited amount of alcohol…[I]t was an effective measure because it did reduce the amount and when he was drinking".[416]

244. The messages to and from CPL Turner demonstrated that CPL Turner was regularly accessing alcohol in Iraq and that other soldiers he was deployed with were also doing so, both in BDSC and in TQ.[417]

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[412] Tab 27 (IGADF ROI with CPL TJ on 14 August 2018) at 13.
[413] Tab 27 (IGADF ROI with CPL TJ on 14 August 2018) at 30.
[414] Tab 27 (IGADF ROI with CPL TJ on 14 August 2018) at 30.
[415] 12/08/21 T19-50.
[416] 12/08/21 T12.36-44.
[417] Exhibit 57 (WhatsApp and SMS messages) at 544 "That's the only thing I miss about not being in BDSC. Is the easy access to alcohol and the parties"; 878 "Just cracked a bottle of piss that we scored today"; 1108 "then after an hour or so, his guys came in and they had alcohol with them"; 1530 "I have drinks and we can order pizza"; 1543: "I scored alcohol and Valium and took a little too much"; 1567 "I'll have a beer; 1571 "Just having a beer"; 1572 "Ill drop you a beer off"; 1627 "drinking wine alone; 1566 "I just dropped into the pizza shop for a sneaky beer"; 1635 [picture of a bottle of vodka]; 1638: "I'm drunk still"; 1729 "I'm going to go to the bottle shop"; 1758 "I'm about to drink more and knock myself out"; 1815 "I might try a thing I heard about called beer" - where you getting the beers from - pizza man"; 219 "I do have a bottle to sneak back with me"; 222 "got you a bottle of pinot"; 227 "I still have two beers and an entire bottle of rum"; 320 "I just had drinks with the Polish"; 359 "there is a full bottle sitting above by bed"; 398 "I heard you were drunk texting and raising the flag at BDSC – yeah it true"; 43 "I could easily get you Captain Morgan's from there".

245. MAJ AF indicated in a statement dated 2 August 2021 in relation to this issue that "[t]here was to be no alcohol consumed on this deployment" and that he was "not aware of any person consuming alcohol while deployed within this rotation/deployment".[418] However, he acknowledged later in his oral evidence that alcohol was available in BDSC it was simply that Australian soldiers were not permitted to drink alcohol on the deployment.[419] MAJ AF was subsequently recalled to give evidence in circumstances where he had reviewed the text and WhatsApp messages on CPL Turner's phone during the Iraq deployment in 2016. He accepted that, having regard to those messages, it was not possible to simply rely on orders restricting access to alcohol being complied with.[420] Overall, I found his evidence on the issue of the availability and use of alcohol less than convincing. I was not persuaded that he was trying to assist the Court by providing a full and honest account. The only alternative, given that he was "not aware of any person consuming alcohol", is that he was completely out of touch with daily life in BDSC.

246. MAJ AM's evidence was that he was aware alcohol was not permitted to be used by Australian soldiers on OP OKRA and that alcohol was available for purchase, and when asked whether alcohol was used by Australian soldiers he responded that "Australian soldiers have an uncanny way of finding alcohol wherever they are".[421] He stated that his "experience in multiple theatres with the Australian Army is that soldiers manage to find alcohol somehow in every environment", so he would not be surprised if they found alcohol in Iraq on OP OKRA (although he did not see evidence of that himself).[422] He accepted that he knew that CPL Turner would be able to access alcohol in Iraq when he prepared the Clinical Perspective Document.[423]

(n) The body recovery

247. CPL Turner had attributed his declining mental health (in his RtAPS, to Dr Sringeri and to CPL TJ) partly to his involvement in a mission to recover the body of a US Airman during the 2016 deployment as well as the involvement in a ramp ceremony after that incident. CPL TJ stated in her ROI that when they were in TQ, there was a body recovery by the US which "Ian had went to (sic) and helped put it on the chopper and

[418] Exhibit 11 at [10].
[419] 13/08/21 T61.18-20.
[420] 03/02/23 T99.40.
[421] 06/09/22 T66.49-50.
[422] 06/09/22 T22-26.
[423] 06/09/22 T68.28-33.

stuff which caused a bit of stress for him because it just triggered some PTSD".[424] The evidence was to the effect that this incident occurred on 31 September 2016.[425]

248. During the first tranche of the hearings of the Inquest, Senior Counsel for the ADF cross-examined Dr Sringeri as to whether it was possible that the body recovery only happened in "CPL Turner's mind". Senior Counsel indicated that the ADF could not say that "it did not happen" but would be submitting "it would be very unlikely that it did happen", seemingly because if the event had happened, CPL Turner would have had to have "gone outside the wire" and he had no authority to do so.[426] Senior Counsel for the ADF subsequently asked Dr Sringeri whether "people can have quite detailed memories where they give you detail about something that's quite distinct and it didn't happen".[427]

249. As became apparent throughout the Inquest, the body recovery did happen, and CPL Turner was involved in it. It is regrettable that court time was wasted in proving that this event did occur, having regard to what must always have been known to the ADF about the incident and the possibility that CPL Turner could have been involved in it whilst remaining *inside* the wire at TQ.

250. It is also regrettable that MAJ AF's evidence originally suggested to the Court that CPL Turner had not participated in the body recovery mission. His evidence did this by suggesting that CPL Turner was not permitted to go outside the wire.[428] As became apparent, whether or not CPL Turner was permitted to go outside the wire was irrelevant to the likelihood that he had participated in the mission. There was an attempt to explain that evidence in re-examination by asking MAJ AF whether the information he was "permitted to disclose" in the proceedings changed between a statement he made on 2 August 2021 and a statement he made on 12 August 2021 and that he had understood when he wrote his 2 August 2021 statement that he was not allowed to disclose that the mission had occurred inside the wire.[429] That was similarly what emerged from his cross-examination by then Senior Counsel Assisting: that "the context behind that answer was in regards to the fallacy that this activity took place outside the wire".[430]

[424] Tab 27 (IGADF ROI with CPL TJ on 14 August 2018) at 12.
[425] 05/08/21 T20.39-41.
[426] 22/10/20 T342.50
[427] 22/10/20 T343.
[428] See, e.g., Exhibit 11 (Statement of MAJ AF dated 2 August 2021) at [15]. See also 05/08/21 T45.
[429] 13/08/21 T77.43-78.9.
[430] 13/08/21 T58.11-23.

251. That fallacy was again one which was within the capacity of the ADF to correct and it is not to the point that MAJ AF had been apparently "instructed" not to reveal the whole truth because of some nebulous and ill-defined concept of the "public interest". In that regard, it ought to be noted that the interests of the Commonwealth in public interest immunity were amply protected by the presence of senior counsel, including on occasion by separate senior counsel (Mr Berger KC), and the questioning proceeded by asking MAJ AF to pause before answering questions so that the Commonwealth had a proper opportunity to consider whether an objection on the basis of public interest immunity would be taken. It is not for a witness to withhold evidence on the basis of public interest immunity: it is for the Commonwealth to take an appropriate objection. Witnesses are under an obligation, by the oath or affirmation which they take at the commencement of their evidence, to simply tell the truth.

252. Counsel Assisting submits that there are two matters which should not have occurred in relation to MAJ AF's evidence about the body recovery. The first is that MAJ AF ought not to have provided a statement and answered questions in a way which suggested to the Court that it was unlikely CPL Turner participated in the body recovery because he did not have permission to go outside the wire. The second is that MAJ AF ought not to have been instructed that there were matters he was not permitted to disclose in his evidence: that was a matter for a claim for public interest immunity. MAJ AF was under an obligation to tell the whole truth. An obligation, in my view, that he did not appear to understand or take seriously.

253. I was deeply troubled by the evidence of MAJ AF in relation to this issue. He should not have provided a statement which was designed to suggest that CPL Turner did not participate in a body recovery because he was not allowed outside the wire. It was misleading and eventually caused me to treat all his evidence in this Inquest with extreme caution. If there were matters which warranted a public interest immunity claim, it should have been made. I was particularly disturbed by his evidence that he had been told he was not permitted to disclose information to these coronial proceedings.

254. The associated line of questioning to Dr Sringeri about the possibility of CPL Turner's mind inventing the body recovery is also concerning. It was either highly inappropriate or occurred because the Commonwealth's own counsel was kept in the dark about this issue for a considerable time.

255. The messages recovered from CPL Turner's phone appear to unequivocally demonstrate that CPL Turner suffered a serious decline in his mental health which he attributed to that incident and the bagpipes and ramp ceremony which followed it.[431]

256. CPL TJ's evidence was that CPL Turner suffered a mental health episode after the body recovery. She said that CPL Turner stated to her that he had helped put the body onto a helicopter, that he was disturbed by seeing the body, and that he was distressed by the incident.[432] CPL TJ stated he was just "quite nervous and couldn't sit still. He kept sitting down, standing back up. He kept putting his head in his hands. He was just talking a lot about it … And then he was just getting real worked up".[433] She stated that CPL Turner was saying "it kind of brought up memories that he had from Afghanistan".[434]

257. Professor McFarlane was asked about the body recovery in his oral evidence. He stated that "simply seeing another ramp ceremony is likely to be a very significant trigger to his distress" about the death of colleagues in the past.[435]

258. It is apparent that CPL Turner suffered a serious decline in his mental health consequent on that incident. He reported to each of CPL TJ,[436] CAPT MH[437] and MAJ BJ[438] that he had relapsed, the major symptoms of which appeared to be drinking, anxiety, and insomnia.

(o) Relationship with CPL TJ

259. CPL Turner's relationship with CPL TJ appears to have commenced around July 2016. CPL TJ's evidence was that it was just a few days prior to their deployment on OP OKRA.[439] Her evidence was that their relationship was kept private for a while and after some time, people began to realise they were in a relationship.[440]

260. It appears from a review of the whole of the messages between CPL Turner and CPL TJ that for a significant period of time CPL Turner's relationship with CPL TJ was relatively positive. It is evident that towards the end of 2016 and in the early part of 2017, the relationship was marked by significant domestic violence, primarily by what I would describe as coercive controlling behaviour by CPL Turner of CPL TJ. CPL

[431] See, e.g., Exhibit 57 (WhatsApp and SMS messages) at 346, 1074, 1288, 1343.
[432] 12/07/21 T6.
[433] 12/08/21 T7.46-50.
[434] 12/08/21 T8.1-7.
[435] 08/02/23 T47.
[436] Exhibit 57 (WhatsApp and SMS messages) at 1318.
[437] Exhibit 57 (WhatsApp and SMS messages) at 346.
[438] Exhibit 31, Tranche 9 at 55.
[439] 11/08/21 T57.45-47.
[440] 11/08/21 T64.35-36.

Turner became increasingly jealous, suspicious, and agitated at CPL TJ. As is apparent from the expert evidence (discussed below), these behaviours can be associated with PTSD and coincided with the decline in CPL Turner's mental health following his return to Australia at the end of 2016.

(p) Steroid use

261. The issue of steroid use by CPL Turner was raised by Joanna Turner in evidence, who stated that CPL Turner had "taken steroids to gain size", which the "ADF was aware of". She stated that he had begun taking steroids in 2015 following a shoulder reconstruction in order to regain strength.[441] Joanna Turner's evidence was to the effect that CPL Turner had said to her that the Commandos were "informed of when drug tests would happen and to stop taking what they were taking for a clean sample".[442]

262. Joanna Turner's evidence in relation to CPL Turner's steroid use was borne out by the evidence in CPL Turner's messages, which demonstrated CPL Turner [redacted] had used steroids prior to the OP OKRA deployment[444] and used it throughout that deployment.[445] It also appears that he was able to access it in Iraq through his interpreter in Iraq whom he identified as "Big Hassan".[446]

263. Joanna Turner's evidence in relation to commandos having advance notice of when drug tests would occur was also borne out by the evidence, which demonstrated that on at least three occasions in 2016, CPL Turner had advance notice of a drug test.[447]

264. The evidence concerned me and I hope it is carefully reviewed by the Chain of Command.

(q) End of the Iraq deployment and return to Australia

265. On 9 December 2016, an RtAPS was conducted by CAPT KV. CAPT KV reported the following in a referral following that psychological screen:[448]

> "CPL Turner deployed to Iraq for 4.5 months with SOTG 632 Rot V in a training and advising role. He reported a neutral experience overall for his seventh deployment … He noted that whilst deployed he helped recover a body and that the RAMP ceremony

[441] Tab 7 (Statement of Joanna Turner) at 2 [8].
[442] Tab 6 (Statement of Joanna Turner) at 2 [9].
[redacted]
[444] Exhibit 57 (WhatsApp and SMS messages) at 951.
[445] Exhibit 57 (WhatsApp and SMS messages) at 952, 1904.
[446] Exhibit 31, Tranche 1 at 262, 267.
[447] Exhibit 57 (WhatsApp and SMS messages) at 951 (20 September 2016); 1792 (30 November 2016); 1856 (11 December 2016).
[448] Tab 50 (ADF medical records) at 267-283.

> for the deceased triggered disturbing memories of past trauma. He said he had a relapse of PTSD symptoms (previously treated for PTSD) and has since had greater difficulties with sleep because of nightmares of previous trauma. He reported no critical incidents on this deployment."

266. The recommendations made were as follows:

> "RtAPS referral upon RtA to set up support resources while he is on leave. Assessment by MO at TLHC to provide medical support if required. POPs with Psych at 3 months."

267. CAPT KV's notes of that RtAPS indicate that CPL Turner had reported he had planned to suicide during Iraq but denied current suicidal ideation.[449] COL MF's evidence was that this was not reported to him as CPL Turner's commanding officer and that he should have been made aware of it.[450]

268. CAPT KV's evidence was that it was not a "requirement" to pass this information on, he repeated the need for "individual confidentiality", and stated that his recommendation was to have CPL Turner assessed upon his return to Australia, to "go through a comprehensive risk assessment" and "then make recommendations with regards to any command involvement".[451] CAPT KV's evidence in this regard repeatedly sought to justify his actions by reference to the "policy" and "procedure" and the need for "comprehensive assessment".[452] He was adamant it was not necessary to report CPL Turner's previous suicidal ideation because it was not a current ideation.[453] CAPT KV was not able to identify the particular policy he was relying on in this regard. Nor was he able to cogently articulate why he did not report this back to the command structure beyond that he thought he had not done a "full assessment".[454]

269. On 16 December 2016, CPL Turner was called for an RtAPS follow up, and it was noted that he declined a referral for ongoing psychological support, felt he could self-manage, and that past psychological support was not helpful, he declined information on a PTSD treatment trial, and declined being on the RAP monitoring service.[455]

270. In late December 2016, CPL Turner moved to Waterloo into an apartment on his own.

[449] Tab 50 (ADF medical records) at 273-274.
[450] 21/10/20 T237.13-14.
[451] 10/08/21 T67.3-10
[452] 10/08/21 T68.
[453] 10/08/21 T68.1-11.
[454] 11/08/21 T50.28-37.
[455] Tab 50 (ADF medical records) at 107. See also Tab 50A at 156-163.

Submissions regarding CAPT KV's decision not to pass on information about CPL Turner's disclosure of suicidal ideations while deployed

Submissions of Counsel Assisting

271. It is submitted by Counsel Assisting that CAPT KV's evidence, as a whole, was designed to avoid accepting any individual responsibility for decisions he had made in the course of CPL Turner's treatment. It is further submitted that I would not accept that the need for a "comprehensive assessment" was an adequate reason for failing to report CPL Turner's previous suicidal ideation.

Submissions of the Commonwealth

272. The Commonwealth notes[456] that Counsel Assisting's submission on this point should be rejected as the report "did not cross the threshold for non-consensual mandatory reporting". This appears to be a reference to the Defence Health Manual (**DHM**) which permits disclosure of health information to "prevent a serious threat to life, health or safety or any individual."[457] This was a topic raised by the Commonwealth as an introductory matter in its submissions where it was noted that the ADF's privacy policies attempted to strike a balance between a member's right to privacy/confidentiality in respect of his or her health information and the needs of the Chain of Command to be aware of information relevant to "employability/deployability" of a member.[458]

273. As for criticism of CAPT KV's role for the period between January and June 2016, the Commonwealth submits that CAPT KV, relying on CPL Turner's clinical records, could not compel CPL Turner to have treatment and encouraged him to self-refer – the suggestion that the fact that he did not do so was itself a "red flag" is submitted to be "a clear manifestation of hindsight bias".[459]

Submissions in reply of Counsel Assisting

274. In reply submissions,[460] Counsel Assisting notes that an account to CAPT KV was given on 9 December 2016 and a note was made that CPL Turner "planned to suicide on his birthday last month after his daughter did not send him a birthday message" but that he denied current suicidal ideation.[461] If CAPT KV had in mind the confidentiality

[456] Submissions of the Commonwealth dated 7 June 2024 at [461].
[457] Tab 50 at 96.
[458] Submissions of the Commonwealth dated 7 June 2024 at [63]-[73].
[459] Submissions of the Commonwealth dated 7 June 2024 at [295]-[299].
[460] Submissions in reply of Counsel Assisting dated 22 August 2024 at [210]-[211].
[461] Tab 50 at 273.

restrictions at this time, then a report of suicidal ideation within the previous *month* (along with the reports to CAPT KV of a relapse of PTSD as a result of trauma, and that CPL Turner was "unsure if he will experience reintegration difficulties") would arguably meet the definition of "serious threat" in the DHM. Counsel Assisting accepts that CAPT KV's evidence was that he did not consider he could disclose this ideation due to ADF policy and that it is a reasonable inference that he was referring to, but could not recall, that part of the DHM to which the Commonwealth refers to. Counsel Assisting notes that COL MF's evidence was that he should have been made aware of the ideation.

Consideration

275. While I accept that minds may differ about exactly where the threshold for non-consensual mandatory reporting may lie, it appears to me that this was a situation which necessitated very serious consideration of a report. CAPT KV was aware CPL Turner had relapsed with his PTSD and was questioning whether he "will experience reintegration difficulties," in other words a further deterioration of his condition was possible. CPL Turner's planned suicide the previous month needed to be given some weight, even when he apparently denied suicidal ideation during the consultation. Once again, there is a distinct lack of curiosity in the care CPL Turner received.

Relevant events of January to July 2017

(a) Transfer from Bravo to Charlie Company

276. In around January 2017, CPL Turner was transferred from Bravo Company (**B Company**) to Charlie Company (**C Company**).

277. SGT NA's evidence was that the posting out of B Company "angered him". His view, however, was that CPL Turner had an "autocratic leadership style" and that "it just wouldn't have worked" for him to stay in B Company, to have a "junior corporal" told to "Go tell Turns, you know he's your 2IC now … Turns would tear him apart. It wouldn't work".[462]

278. MAJ AF's evidence was that there was a "variety" of reasons for the move from B Company to C Company, including that there were too many NCOs in B Company and not enough in C Company and that it was considered that CPL Turner would undermine the senior NCOs and Chain of Command in B Company when he returned

[462] Tab 14 (IGADF ROI with SGT NA on 14 August 2018) at 114.

(as a Corporal) because he was "so influential".[463] MAJ AF's evidence was that he did not want CPL Turner moved, but it was the CO's decision along with the RSM, and in hindsight, he agreed it was a good decision.[464]

279. COL MF (i.e., the CO) stated in his ROI in response to being asked to explain his reasons for moving CPL Turner from B Company (where his support network was) to C Company, "as the CO I have to look at – I have obligations to the individuals. I also have obligations to the organisation, and also very much to the capabilities that I am mandated to maintain".[465] COL MF also considered that it was "untenable" that CPL Turner, who was considered an "extremely influential member of that [B] Company", to then be reduced in rank and have a sergeant, "in effect, command him", being a sergeant who would have previously been more junior than CPL Turner.[466] Additionally, COL MF considered that B Company was "going to go back onto war roles" (a "very demanding component of their cycle") whereas C Company was going to be in "supporting courses" and other supporting roles.[467] COL MF considered that this would "give [CPL Turner] a bit more time to sort himself out".[468] COL MF stated in his ROI that he stood by his decision: "every decision that I made with regard to Turner along the way, and I've had plenty of time to think about. My responsibility is not only [sic] to the balancing act between the individual and organisation ... I did everything I could in both sense for him, particularly a decision to move him out of that company".[469] He noted that towards the end of the year there were "positive reflections through the Chain of Command about what his move had actually done", allowing "capability to advance".[470]

280. COL MF's oral evidence to the Inquest was substantially aligned with his statements to the IGADF. What emerged from the lengthy oral evidence was that the decision to move CPL Turner from B Company to C Company was based solely on the "effective delivery of capability".[471]

281. It is difficult to discern from COL MF's oral evidence that any particular consideration was given to CPL Turner's mental health history, the experiences he had in Iraq and the potential impact of those experiences on his mental health, and the potential impact on his mental health of the move from B Company to C Company. There was no

[463] Tab 16 (IGADF ROI with MAJ AF on 24 July 2018) at 28.
[464] Tab 16 (IGADF ROI with MAJ AF on 24 July 2018) at 29.
[465] Tab 17 (IGADF ROI with COL MF on 22 August 2018) at 14.
[466] Tab 17 (IGADF ROI with COL MF on 22 August 2018) at 17.
[467] Tab 17 (IGADF ROI with COL MF on 22 August 2018) at 18.
[468] Tab 17 (IGADF ROI with COL MF on 22 August 2018) at 18.
[469] Tab 17 (IGADF ROI with COL MF on 22 August 2018) at 33.
[470] Tab 17 (IGADF ROI with COL MF on 22 August 2018) at 33.
[471] 22/10/20 T253.20-21.

evidence that COL MF had inquired about CPL Turner's mental health subsequent to the disciplinary proceedings, either with CPL Turner directly or with anyone deployed with him. COL MF admitted that he did not even turn his mind to whether the decision would have an adverse impact on CPL Turner's mental health.[472] At base, the decision was made with "capability" at the front of mind, not the interests of CPL Turner.

282. WO1 EL gave a slightly different explanation of the process of moving CPL Turner from B Company to C Company. He stated that he worked "as a command team" with COL MF, and that COL MF was: [473]

> "obviously very distressed about the reputation damage that had been caused not only to B Company but 2 Commando Regiment, Special Operations Command and the whole of army. It was not a good look. COL MF questioned whether now CPL Turner had been protected within B Company …. And whether it would be best for him to be moved to another Company for a fresh set of eyes, some supervision and to be honest the CO, COL MF, was also concerned that perhaps Ian had a stifling effect on the other NCOs within Bravo."

283. He concluded, however, that it was "very complicated" and that was "the decision we came to and I backed the commanding officer a hundred per cent, as is my job".[474] He did not recall any other NCOs being moved at the same time.[475]

284. WO2 DP stated that he spoke to WO1 EL at the time the decision was being made and said that this will be seen as "another punishment", and that the RSM "initially sort of agreed with me" that CPL Turner should not be moved from B Company. The decision was ultimately made to move CPL Turner. WO2 DP stated that he believed the "CO and RSM had the best intentions …and wanted to remove Ian from Bravo Company to try and alleviate some of that influence he had on us because now – Ian was very jaded at this point about the whole process and his dealings".[476]

285. Mr Nick Hill, who had previously served alongside CPL Turner (but subsequently discharged) stated that, in his view, "moving one person from a company to another, is one of the worst things you can do to them" because when you "get moved to another company, it's like you're taken away from your home".[477] He explained:[478]

> "Guys like [CPL Turner] who did four or five tours overseas and deployments, who trained as private soldier and worked his way up to a sergeant, you know, in the one company that's a long time, and then if you take them away from that it doesn't do them any good, especially if they have things going on, because they need to be part of their home and the company is their home, because that's where they feel the

[472] 22/10/20 T257.7-9.
[473] Tab 23 (IGADF ROI with WO1 EL on 15 August 2018) at 16.
[474] Tab 23 (IGADF ROI with WO1 EL on 15 August 2018) at 17.
[475] Tab 23 (IGADF ROI with WO1 EL on 15 August 2018) at 17.
[476] Tab 24 (IGADF ROI with WO2 DP dated 5 July 2018) at 27.
[477] Tab 28 (IGADF ROI with Nick Hill dated 18 September 2018) at 19.
[478] Tab 28 (IGADF ROI with Nick Hill dated 18 September 2018) at 20.

> safest. You know, you're talking about guys who have done some pretty horrific things in their time and taking them away from that, they've got nothing. They might know guys in that company that they go to, but they don't have the same experience."

286. Hannah Steele described the effect of the move on CPL Turner as "[d]emotivating, definitely made him more and more depressed; his self-worth was destroyed". She said CPL Turner said that he felt he was being punished by the ADF.[479]

287. The decision to move CPL Turner was made while he was posted overseas. It was notified to him via his Chain of Command whilst he was overseas.[480] MAJ AF's evidence was that he had the conversation about the transfer and that he gave CPL Turner the "context as to why it was taking place, reaffirming with him that it was not a continuation of a punishment, it was a cultural and organisation decision being made by the regimental leadership about how we manage NCOs across the regiment, and that it wasn't about him in particular". [481]

288. CPL TJ's evidence was that CPL Turner very much connected the move from B Company to C Company to the charge, and that he believed it was "part of the unit's reaction to the charge".[482]

(b) Effect of the company move on CPL Turner's mental health

289. It is readily apparent that CPL Turner viewed the movement from B Company to C Company as a form of further punishment for the cock-carding incident. For example, LCPL DL stated in his ROI that "I think he thought it was a continuation of punishment…he went downhill pretty quick after this charge and I think he was disillusioned and probably a bit upset with an organisation he'd given his youth to and he'd worked so hard to be a leader in, all of a sudden he's a subordinate to people who are nowhere on his level as an operator, as a commander".[483]

290. LTCOL SW, who visited CPL Turner after his second suicide attempt, stated that CPL Turner talked about the night that Damien Thomlinson lost his legs, his loss of rank, and the fact he had been moved companies when he returned back to Australia.[484]

291. CPL JW gave evidence in his ROI that it appeared that "once he got sort of taken away from that support system [B Company] and what he knows he started to decline".[485]

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[479] 19/10/20 at T34.4-10.
[480] 21/10/20 T241.37-38.
[481] 05/08/21 T39.38-42.
[482] 12/08/21 T23.8-14.
[483] Tab 21 (IGADF ROI with LCPL DL on 14 August 2018) at 9-10.
[484] Tab 22 (IGADF ROI with LTCOL SW on 11 December 2018) at 14.
[485] Tab 20 (IGADF ROI with CPL JW on 5 June 2018) at 16.

292. CPL TJ stated that CPL Turner "didn't appreciate the no warning about this move and it just trifled with his emotions again…he just was conspiring against this ultimate meltdown of the hierarchy because they didn't give him any respect, to tell him…he felt he was getting double-tapped not only from what happened with 633 [i.e. the disciplinary proceedings] but also back here in Australia at the unit and that just broke him, it broke him".[486] CPL TJ stated CPL Turner did not get any "forewarning that the change was going to happen, not from his CO or his OC who had made the decision".[487]

293. COL MF's evidence was to the effect that if he had been made aware of the resumption of symptoms in CPL Turner in December 2016, and January 2017, it would not have impacted on his decision to move CPL Turner from B Company to C Company. However, he would have provided more "mental health scaffolding around him".[488]

294. The evidence demonstrated that CPL Turner's reaction to being informed about the move out of B Company (whilst he was deployed in Iraq, around October 2016) was to send an email expressing his grievances to CAPT MH and asking him to proofread it. CPL Turner described himself in the email as a "10 consecutive year veteran of BCC".[489]

295. CAPT MH was asked about this by way of questions in writing. He responded in writing that he did not recall who CPL Turner intended to send the email to, but his best guess is that it was either the OC (MAJ AF) or the CSM.[490] CPL Turner submitted discharge paperwork the next day[491] but subsequently withdrew the paperwork the following day.[492] His text messages during this period indicate that someone called CPL Turner to inform him he would be moving to C Company and that he laughed at them and told them he would be discharging.[493] MAJ AF stated that at this stage he was not tracking CPL Turner's reduction in mental health. He knew CPL Turner was frustrated but he "really thought" he was doing "pretty well".[494]

(c) Relationship with Joanna Turner and the children

296. Joanna Turner stated in her ROI with the IGADF that after the deployment, ET was upset with CPL Turner and became anxious around him and wanted to stop seeing

[486] Tab 27 (IGADF ROI with CPL TJ on 14 August 2018) at 16.
[487] Tab 27 (IGADF ROI with CPL TJ on 14 August 2018) at 17.
[488] 22/10/20 T257.9-21.
[489] Exhibit 31, Tranche 9 at 23.
[490] Exhibit 66 (Response to questions posed to MAJ MH) at 7.
[491] Exhibit 31, Tranche 9 at 37.
[492] Exhibit 31, Tranche 9 at 50.
[493] Exhibit 57 (WhatsApp and SMS messages) at 136.
[494] 03/02/23 T163. 5-14.

him. CPL Turner blamed Joanna Turner for that and attempted to see ET at school. ET was frightened and the family moved to the Sutherland Shire and ET changed schools in the hope that CPL Turner would be unable to find them.[495]

(d) Mental health in early 2017

297. On 9 January 2017, CPL Turner was called by Ms Sullivan from Tobruk Clinic for a telephone review. He reported a difficult Christmas with no access to his daughter, anger at the SOCOMD 2CDO hierarchy's treatment of him, that he planned to undertake a PhD in Canberra and have respite from SOCOMD and deployments, that he had "continuing fleeting thoughts of suicide" mostly when he had arguments with his ex-wife but had "no intent or plan", and that he requested a referral to Dr Sringeri.[496]

298. COL MF stated in his ROI that when CPL Turner returned from Iraq just before Christmas, although he was tracking "the disciplinary issues", he was not "tracking mental health issues at that point", because CPL Turner had "got a waiver to deploy and there'd been no sort of significant red flags".[497]

299. CAPT MH stated that he had developed a "close relationship" with CPL Turner from 2014 and that he "knew that he wasn't coping with what had occurred in Iraq". He stated that CPL Turner was viewing everything that happened after the disciplinary proceedings as punishment.[498]

300. On 23 January 2017, CPL Turner was contacted again by Ms Sullivan from Tobruk Clinic for a telephone review. CPL Turner reported that he had been to Canberra for a PhD interview at ANU and had been offered a spot, but he needed to discuss study approval with his Chain of Command. He stated that he had booked psychiatric review with Dr Sringeri and that the earliest appointment was 4 May but he was on the cancellation list. CPL Turner stated that he did not want to engage in psychological counselling at the time and that he felt he was "well enough".[499]

301. Christine Turner stated that CPL Turner sent her a message on 18 February 2017 stating:[500]

> "It just hurts that my lifelong dream and my dream job was the very thing that destroyed me. I tried to take on too much pain and protect my guys too much. I should've shared the pain more but with my PTSD, anxiety, depression and alcohol

[495] Tab 32 (IGADF ROI with Joanna Turner dated 15 August 2018) at 55-56. See also 20/10/20 at T84.
[496] Tab 50 (ADF Medical records) at 107.
[497] Tab 17 (IGADF ROI with COL MF on 22 August 2018) at 18.
[498] Tab 18 (IGADF ROI with CAPT MH on 5 June 2018) at 13.
[499] Tab 50 (ADF Medical records) at 106.
[500] Tab 34 (IGADF ROI with Christine Turner on 21 August 2018) at 13.

> dependency I've just had enough. I spent seven years of my life overseas fighting cunts. I've had enough."

302. Sometime in February 2017, CPL TJ met with Padre MP to raise her concerns about CPL Turner's mental health. He stated that he would raise it with the CO and RSM. CPL TJ's evidence was that she was never contacted about that meeting by either the CO or RSM.[501]

303. CPL Turner attended on Dr Sringeri on 22 February 2017 for an urgent review with an apparent relapse of PTSD symptoms.[502] On 27 February 2017, Dr Hale saw CPL Turner and recorded that CPL Turner would require close supervision and crosschecking for tasks requiring high focus such as parachute packing. A letter from Dr Sringeri to Dr Hale at Tobruk Clinic reported significant and serious PTSD symptoms.[503]

304. On 2 March 2017, CPL Turner attended a follow-up review by Dr Hale, and admitted to suicidal thoughts over a long period of time. He was prescribed diazepam and Dr Hale reported putting in place "crisis counselling" which involved calling the padre or going to St Vincent's Hospital. A psychiatrist appointment was booked for the following day.[504]

305. On 3 March 2017, Dr Hale saw the letter from Dr Sringeri dated 24 February 2017.[505] On that day, Dr Reppas emailed Ms Cantwell, recommending that CPL Turner be downgraded to MEC J31 and stating he assumed the unit will conduct daily welfare checks.[506]

306. A medical note made by CAPT KV on 3 March 2017 indicated that the COC would be informed of the change in CPL Turner's risk status.[507] COL MF gave evidence that he was not informed on that day of any change in CPL Turner's risk.[508] The evidence was ultimately that the information was passed on to the acting OC at the time and he did not pass it on to COL MF because there was a UWB on the following Tuesday. The acting OC was issued with a NTSC in relation to this incident. COL MF's evidence was therefore that the lack of communication has been "identified by the ADF and dealt with".[509]

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[501] 12/08/21 T29-30.
[502] Tab 111 (Statement of Dr Sringeri dated 25 September 2020) at 10.
[503] Tab 111 (Statement of Dr Sringeri dated 25 September 2020) at 92-93.
[504] Tab 50 (ADF Medical records) at 103.
[505] Tab 50 (ADF Medical records) at 304.
[506] Tab 50 (ADF Medical records) at 102.
[507] Tab 50 (ADF Medical records) at 102.
[508] 22/10/20 T265.19-23.
[509] 22/10/20 T305.40-43.

307. He agreed that there were numerous identifications by medical professionals within the ADF of the resumption of CPL Turner's symptoms between 16 December 2016 and 3 March 2017 and that it was a problem that he, as the CO, was not aware of any of them.[510]

(e) The PhD proposal

308. The Inquest heard evidence in relation to a proposal by CPL Turner to undertake a PhD, along with a placement at a government Department. Hannah Steele gave evidence that the PhD proposal was "the one thing" that CPL Turner got excited about and that CPL Turner had planned to do the PhD out of a university in Canberra.[511]

309. Hannah Steele gave evidence that the PhD proposal was raised at a "welfare meeting", which she later described as a welfare board,[512] at which the CO, Matthew Cardinaels, Carmel Poulter, the RSM, and CAPT KC as well as some doctors were present. She described the CO as "scoffing" at the PhD proposal and that it was "mentioned and it was just – whether he said, yeah, we'll think about it, we'll talk about it later, it was given no air time".[513]

310. MAJ JP spoke to the IGADF and confirmed that he was involved in a proposal for CPL Turner to undertake a PhD. He stated he had discussions with CPL Turner regarding a PhD at the end of 2016 to "give him something to look into for his future and give him options". MAJ JP arranged for CPL Turner to speak with a potential supervisor and discussed the matter with CPL Turner's Chain of Command. He stated his understanding was that the proposal was not supported by 2CDO.[514] CPL TJ confirmed in her ROI that MAJ JP had been in touch with CPL Turner, that they took the proposal to Mr Cardinaels who supported it, but then the "CO turned around and said no, because of his admin infraction that he wasn't going to support it".[515] CPL TJ indicated that the CO "shut it down" and then CPL Turner pretty much gave up on it.[516]

311. COL MF stated in his ROI that he could not recall how the issue of CPL Turner wanting to study had come to him, but he "was aware of his intention to conduct study" early in 2017. COL MF stated that he did not support the PhD proposal "by virtue of the disciplinary issues that were associated with Turner" and he was concerned about "reputation damage for army" because the proposal came up as part of an out-

[510] 22/10/20 T25-30.
[511] 19/10/20 T32.6-9.
[512] 19/10/20 T43.45-49.
[513] 19/10.20 T32.18-23.
[514] Tab 25 (IGADF ROI with MAJ JP on 17 December 2018) at 1.
[515] Tab 27 (IGADF ROI with CPL TJ on 14 August 2018) at 21.
[516] Tab 27 (IGADF ROI with CPL TJ on 14 August 2018) at 21-22.

placement with another government agency.[517] He also maintained it was not a "formal" proposal to do study and it was the "out-placement component" which he was not supportive of which was "pitched as part of the concept".[518] He accepted he did not make any inquires as to CPL Turner's mental state or psychiatric well-being at the time he made this decision.[519] He placed this decision as being made before CPL Turner's first suicide attempt.[520] There was no evidence to suggest that COL MF had indicated to CPL Turner that he *was* supportive of the PhD proposal on its own (just not the outplacement). CPL TJ's evidence was that if CPL MF had done so, that would have been something they could have worked towards.[521]

312. CAPT KV stated that he was aware of the PhD proposal and said he was supportive of it but could not identify any concrete step he took to assist CPL Turner in realising this beyond saying that he "encouraged him to follow his dreams and goals".[522]

(f) First suicide attempt and March 2017 admission

313. On 6 March 2017, CPL Turner was reviewed by psychologist Andrea Cantwell following a psychiatric consultation on 2 March 2017.[523] He denied thoughts of suicide and declined hospital admission.[524]

314. It is apparent from the text messages between CPL Turner and CPL TJ that he was in a heightened emotional state and took this out in various ways on CPL TJ throughout the course of the evening by way of text messages which were aggressive, manipulative, and demeaning of her. Towards the conclusion of a long series of messages between CPL Turner and CPL TJ, he stated "I'm going to be unconscious very Soon. Hopefully I don't wake us [sic] I wish you had called Goodbye".[525] CPL TJ was outside his house at the time trying the buzzer and, ultimately, he let her up into the apartment.[526]

315. CPL Turner had attempted suicide by consuming a large amount of alcohol and overdosing on prescription medication. He was admitted to St Vincent's Hospital.[527]

[517] Tab 17 (IGADF ROI with COL MF on 22 August 2018) at 30.
[518] Tab 17 (IGADF ROI with COL MF on 22 August 2018) at 31.
[519] 22/10/20 T261.50-T262.2,
[520] 22/10/20 T 262.21-22.
[521] 12/08/21 T88.45-49.
[522] 10/08/21 T71.33-34. See also 11/08/21 T8.39-40.
[523] Tab 50 (ADF Medical records) at 101-102.
[524] Tab 50 (ADF Medical Records) at 102.
[525] Exhibit 57 (WhatsApp and SMS messages) at 2443.
[526] Exhibit 57 (WhatsApp and SMS messages) at 2444.
[527] Tab 50 (ADF Medical Records) at 45.

316. CPL Turner tested positive for cocaine in his system after this overdose.[528] WO1 EL stated that he was made aware that toxicology had been taken of CPL Turner's bloods and it indicated there was a prohibited substance there and that a decision was to hold any future administrative action until CPL Turner was mentally stable because he was not "going to dump that on him as well".[529]

317. On 7 March 2017, CPL Turner was discharged from St Vincent's Hospital to Holsworthy Health Centre.

318. On 8 March 2017, CAPT KV prepared a "Comprehensive Assessment and Management Plan", recording that CPL Turner had thoughts of suicide. In a section entitled "estimation of risk", CAPT KV assessed CPL Turner as "low risk".

319. On 8 March 2017, CPL Turner was transferred to the inpatient mental health unit at SSPH. Dr Sringeri's notes in relation to the admission record that CPL Turner's PTSD was "rekindled about 18 months ago" and that he had been drinking excessively to manage PTSD and depressive symptoms. His "current issues" were listed as "PTSD - reliving experiences, mood swings, irritability and anger, panic attacks".

320. On 15 March 2017, CPL Turner absconded from SSPH. He messaged CPL TJ and informed her he was drunk. She told him to go back to the hospital. It appears she and the Padre subsequently located CPL Turner and took him back to SSPH.[530]

321. In late March 2017, CPL Turner made a claim to DVA for compensation. He listed his injuries which included "major depression" and "suicidal behaviour" and identified that his symptoms were first suffered in 2009.[531]

322. On 29 March 2017, CPL Turner was discharged from SSPH. A copy of the discharge summary prepared by Dr Sringeri was sent to Dr Hale. The discharge summary notes (inter alia):[532]

> "[CPL Turner] was transferred from St Vincent's Hospital Sydney, where he was admitted with the history of taking an overdose of multiple prescription medications under the influence of alcohol.
>
> [He] reported witnessing a significant trauma during his deployment to Iraq in relation to finding human remains of an US Marine. The above said trauma has rekindled the memories of the traumas he has experienced during his previous deployments. He also reported experiencing a setback in his study of that (sic) he was demoted interrelation (sic) to a minor mistake and he with (sic) extremely disappointed for the

[528] Tab 50 (ADF Medical records) at 94.
[529] Tab 23 (IGADF ROI with WO1 EL on 15 August 2018) at 32.
[530] Exhibit 57 (WhatsApp and SMS messages) at 2512-2514; Tab 50 (ADF Medical Records) at 96.
[531] Tab 60 (DVA Medical Records) at 45ff.
[532] Tab 54 (Sydney SW Hospital - March 2017 admission) at 3-5.

> same. He reported experiencing significant distress in relation to divorce proceedings and child custody issues.
>
> He reported experiencing intrusive memories, flashbacks and nightmares of trauma. He reported experiencing intrusive and recurrent flashbacks and memories of decomposed human remains and the smell of decomposed human body. He reported experiencing mood swings, irritability and anger. He described episodes of panic attacks related to reliving experiences of PTSD. He reported experiencing persistent anxiety, agitation and tremulousness. His sleep was disturbed due to nightmares. He also reported having frequent arguments with his girlfriend.
> ….
> On 19 March 2017 he was found to be extremely angry, irritable and physically aggressive in relation to constant phone calls and message from his ex-wife (sic) legal team."

323. Under the heading "state on discharge" it was stated that CPL Turner had achieved considerable improvement in his depressive symptoms and moderate improvement in his PTSD symptoms. The discharge summary noted that Dr Sringeri would review him on 13 April 2017.[533] On the day of discharge, CPL Turner was reviewed by Dr Hale.

324. In early April 2017, CPL Turner returned to work and was placed under the daily supervision of the 2CDO Human Performance Wing (**HPW**) and Mr Cardinaels, who was the leader of that wing.[534]

325. CAPT MH stated in his ROI that at this stage, C Company was deployed and, in his view, "[CPL Turner] was just running his own show, from what I could see".[535]

(g) Second suicide attempt and April 2017 admission

326. On 1 April 2017, CPL Turner failed to attend a medical appointment which had been scheduled for that day. When contacted, he advised that he was well and there was a problem with his base access pass.

327. CPL Turner continued to engage in what can be described as controlling behaviour of CPL TJ through this time. On 11 April 2017, he engaged in a long series of messages accusing CPL TJ of having been unfaithful and lying to him. CPL TJ asked CPL Turner to bring her house key downstairs to her. He responded with a claim that she had been dishonest and then ceased messaging her.[536] He subsequently attempted suicide by overdosing on prescription medication. He was admitted to St Vincent's Hospital.

[533] Tab 54 (Sydney SW Hospital - March 2017 admission) at 5.
[534] Tab 15 (IGADF ROI with SGT MC on 5 June 2018) at 3-4.
[535] Tab 18 (IGADF ROI with CAPT MH on 5 June 2018) at 20-21.
[536] Exhibit 57 (WhatsApp and SMS messages) at 2698.

328. On 21 April 2017, CPL Turner was transferred to SSPH. Later that day, he absconded from the hospital.[537]

329. Hannah Steele's evidence was to the effect that CPL Turner was at his apartment with police. Hannah Steele stated that she, Steven Turner, LCPL DL, and CPL Turner's family had decided on a plan involving staying with CPL Turner all weekend, with CPL Turner to return to work on Monday. Hannah Steele's evidence was that she heard a phone call in which CAPT KV called CPL Turner and was abusive to him.[538] Hannah Steele gave evidence that she witnessed CAPT KV calling CPL Turner on the phone, in front of Steven Turner, after and berated him over the phone with "lots of F's" and "really inappropriate language", and that CPL Turner "hated" CAPT KV after this.[539] She acknowledged that she could not hear the full conversation, but could hear that there was an "aggressive person on the other end", and all she could remember were "lots of F's and that was it", and that Ian was becoming "upset" as a result of the conversation.[540]

330. CAPT KV stated that this conversation did not happen. He stated he would never have berated or had that kind of conversation with a member.[541]

331. Steven Turner gave a further statement with detail about the conversation with CAPT KV, including that CAPT KV was swearing and shouting at CPL Turner.[542] CAPT KV put on a responsive statement denying that this had occurred.[543]

Submissions regarding the phone call between CAPT KV and Steven Turner

Submissions of Counsel Assisting

332. During the final tranche of hearing days, then-Senior Counsel Assisting made an oral submission that neither Steven Turner nor CAPT KV needed to be recalled to deal with the evidence as to what happened, noting they both gave evidence about it and made their position clear in that evidence. It remains the position of Counsel Assisting that it was not necessary to recall either CAPT KV or Steven Turner. It is submitted, however, that having regard to all the evidence, a finding about what happened can be made. The evidence is relevant as it relates to the therapeutic relationship that CPL Turner had with CAPT KV, who was his clinical case coordinator. That being said, it should

[537] Tab 50 (ADF Medical Records) at 29.
[538] Tab 8 (Statement of Hannah Steele) at 3 [14].
[539] 19/10/20 T35.11-17.
[540] 19/10/20 T46.32-36.
[541] 10/08/21 T7-.27-33.
[542] Exhibit 49 (Statement of Steven Turner dated 11 August 2022) at 5-6.
[543] Exhibit 60 (Supplementary Statement of CAPT KV dated 16 December 2022).

be clear that the submission of Counsel Assisting is not that this interaction had any causative effect on CPL Turner's declining mental health. It is simply relevant as evidence of the relationship between him and one of his treating clinicians.

333. It is submitted by Counsel Assisting that there are cogent reasons to prefer the evidence of Steven Turner over that of CAPT KV. *First*, it was corroborated by the evidence of Hannah Steele. *Second*, it appeared from CPL Turner's messages that he did not have a particularly positive relationship with CAPT KV, noting that in June 2017 CPL Turner described CAPT KV as "annoying the fuck out of me" and "just annoying" during a phone psychological consultation.[544] *Third*, there was no apparent motive on the part of Steven Turner or Hannah Steele to confect this incident. CAPT KV's evidence, by contrast, was generally given in a manner which tended to minimise any personal responsibility for matters around his care of CPL Turner (for example, in relation to why he did not give information to UWBs about CPL Turner's mental health, and why he did not report CPL Turner's suicidality reported to him in the RtAPS). Denial of this incident is consistent with the manner in which he otherwise responded to questions which he perceived as criticising his conduct in the care of CPL Turner.

Submissions of Mr and Mrs Turner

334. Mr and Mrs Turner submit that the delay between the service of the brief and the provision of Steven Turner's statement can be explained by Mr Turner's service-related PTSD issues which "resurged" following CPL Turner's death and that it was not until later when he was well enough to engage with the coronial proceedings that he realised that CAPT KV had denied that the abusive phone call had ever occurred.[545] On this point, Counsel Assisting cautions that the submission is passed on instructions rather than evidence before the Inquest and should, therefore, not form the basis of a finding.[546]

335. In relation to the text message between CAPT KV and Steven Turner and the Commonwealth's position that "one text message does not define a relationship", Mr and Mrs Turner refer to other contemporaneous records that support a finding that CPL Turner did not view CAPT KV positively.[547]

336. Furthermore, they strongly support Counsel Assisting's submission that the phone call with CPL Turner in fact occurred given that CAPT KV was unable to respond to over

[544] Exhibit 57 (WhatsApp and SMS messages) at 3119.
[545] Submissions in reply of Mr and Mrs Turner dated 22 July 2024 at [58(a)].
[546] Submissions in reply of Counsel Assisting dated 22 August 2024 at [107].
[547] Tab 50 at 81; Tab 56 at 59; Tab 18 at 28-29.

50 questions during the Inquest because of an inability to recall events and the fact that he only vaguely remembered CPL Turner's escape (the same night as the alleged phone call). They also agree that neither Hannah Steele nor Steven Turner had a motive to be untruthful about the existence of the call.[548]

Submissions of the Commonwealth

337. The Commonwealth submits that Counsel Assisting's invitation to prefer the evidence of Steven Turner to that of CAPT KV "effectively" seeks a finding that CAPT KV lied to the Court. Accordingly, it is submitted that the rules of procedural fairness required CAPT KV to be recalled to give oral evidence for it to be put to him that he "lied" in his statement. Aside from procedural fairness, it is submitted that such a finding is unnecessary and insufficiently supported by the evidence in any event; the Commonwealth sets out in detail the evidence that it submits weighs against such a finding.[549]

Submissions in reply of Counsel Assisting

338. Counsel Assisting considers that the Commonwealth's objection on procedural fairness grounds ought to be rejected.[550] The question as to whether this conversation occurred was put to CAPT KV multiple times[551] and he denied it multiple times, including in a further statement given in circumstances where he was on notice that Steven Turner had made a statement alleging that the conversation did occur. The suggestion of the Commonwealth appears to be that the dictates of procedural fairness required CAPT KV to be recalled in order for Counsel Assisting to say "I put to you that you are lying", and so, presumably, he could repeat what he said in oral evidence "I am telling the truth"[552] and what he said in his statement "This statement is true".[553] Counsel Assisting highlights that the rules of procedural fairness are concerned to avoid practical injustice.[554]

339. On that basis, Counsel Assisting notes that practical and substantive fairness *was* afforded to CAPT KV: the allegation was put to him, and when a further statement was prepared by Steven Turner making the same allegation, CAPT KV had the opportunity (of which he availed himself) to put on a written statement addressing that allegation.

[548] Submissions in reply of Mr and Mrs Turner dated 22 July 2024 at [59]-[62].
[549] Submissions of the Commonwealth dated 7 June 2024 at [531]-[545], [548].
[550] Submissions in reply of Counsel Assisting dated 22 August 2024 at [229]-[231].
[551] 10/08/21 T70-71.
[552] 10/08/21 T70.35-37.
[553] Exhibit 60 at [1].
[554] *Re: Minister for Immigration and Multicultural and Indigenous Affairs; Ex parte Lam* (2003) 214 CLR 1; [2003] HCA 6 at [37]-[38].

That is sufficient to reject the suggestion by the Commonwealth that CAPT KV was not on notice that an adverse finding might be made in this regard.

340. Lastly, Counsel Assisting notes that it is *not* implicit in a rejection of CAPT KV's evidence that he was deliberately lying, and Counsel Assisting does not suggest that such a finding necessarily needs to be made. That one person's version of events is preferred over another's does not *necessarily* draw with it an inference that the other is deliberately lying. It may, depending on the circumstances, be an equally available inference in a particular case that with the passage of time, the person does not remember what has happened and is honestly but wrongly convinced it did not happen because they do not remember it.

Consideration

341. I do not accept that there is procedural unfairness in deciding this issue. I am aware of the differing accounts given by CAPT KV, Steven Turner, and Hannah Steele on this issue. CAPT KV was well aware of the allegation that he berated CPL Turner on the telephone at a time when CPL Turner was particularly vulnerable. CAPT KV strenuously denied the conversation, although he had significant memory deficits about other events which occurred around that time.

342. I have considered the matter carefully and prefer the evidence of Steven Turner and Hannah Steele on this issue. I accept the reasons for the delay in Steven Turner providing his account. His version is largely corroborated by the evidence of Hannah Steele. I also accept that Steven Turner's account does not seem to be out of keeping with other contemporaneous evidence about the relationship between CAPT KV and CPL Turner.

343. Returning to the evidence, CAPT MH stated that he went to the house with LCPL DL and met Mr Cardinaels outside the apartment. He said that he and LCPL DL "managed to talk Ian into admitting himself into the facility" and that Mr Cardinaels took CPL Turner and Steven Turner to the hospital where he checked himself in.[555]

344. CAPT MH stated in his ROI that on 23 April 2017, he went to visit CPL Turner and CAPT KV was there, and CPL Turner was "highly agitated" and didn't want to talk to CAPT KV, and it got to the point where CAPT MH stated "get the fuck out of the room"

[555] Tab 18 (IGADF ROI with CAPT MH on 5 June 2018) at 28.

because "you're not helping".[556] CPL Turner stated to CPL TJ that he had an altercation with the CO on 23 April 2017.[557]

345. On 27 April 2017, CPL Turner was admitted to St John of God Hospital (SJoGH) under the care of Dr Malik. At the time CPL Turner was admitted to SJoGH, Dr Malik was provided with a referral letter from the ADF and medical records from Liverpool Hospital. He did not otherwise receive information from the ADF about CPL Turner's history of psychiatric or psychological care within the ADF.[558] The request from Dr Hale reads:

> "Thank you for admitting Ian Turner, a 35 year old soldier. He has a long history of mental illness and suicidal ideation, but only recently diagnosed with PTSD and depression. He has recently made a suicide attempt involving polypharmacy and spent a week in intensive care. He is still a high risk patient with high changeability and requires inpatient treatment.
>
> He Is currently admitted to the Liverpool PECC unit, and will require transfer to your facility."
>
> The provisional diagnosis was stated to be: "Suicidal attempt by polypharmacy"

346. Hannah Steele's evidence was to the effect that CPL Turner disliked being at SJoGH and that his program was being updated "without his input".[559]

347. COL MF stated in his ROI that he went out to discuss his care with the health team, but that CPL Turner had stated that "he did not want to see the chain of command".[560] Dr Malik stated that CPL Turner did not want the content of his consults to be released to the ADF and that he was very distrustful of the ADF.[561]

348. On 25 May 2017, CPL Turner was discharged from SJoGH. The discharge summary recorded that CPL Turner did not want an extension of his stay and agreed to follow up as an outpatient. It recorded that he was "unfit for duties, considering medical discharge".[562] It appears that Dr Malik was under the impression, from CPL Turner, that Patricia Turner would be staying with him after he was discharged.[563] That impression was incorrect and Dr Malik confirmed in his oral evidence that he was relying on what CPL Turner said to him but that, in any event, his mother being there would not have "cure[d] anything" and he could still have avoided her and isolated himself.[564]

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[556] Tab 18 (IGADF ROI with CAPT MH on 5 June 2018) at 29.
[557] Exhibit 57 (WhatsApp and SMS messages) at 2729.
[558] 20/10/20 at T118.28-50.
[559] Tab 8 (Statement of Hannah Steele) at 3 [16].
[560] Tab 17 (IGADF ROI with COL MF on 22 August 2018) at 22.
[561] Tab 112 (Statement of Dr Malik) at 4 [26].
[562] Tab 56 (St John of God Records) at 43.
[563] Tab 112 (Statement of Dr Malik) at 17 [110].
[564] 20/10/20 T129.15-21.

(h) The rehabilitation plan

349. There was some evidence in the Inquest about CPL Turner's "rehabilitation plan" during the course of 2017. Hannah Steele stated in her statement that during this time all she knew CPL Turner was doing was "going to the gym and drinking at the Moore Park View Hotel".[565] In her oral evidence, she said that CPL Turner had voiced to her that he did not have an engaging rehab plan: "It was, like guitar, gym, coffee with friends" and he felt he "could have actually been doing something a little more valuable with the skills and knowledge he had".[566]

350. The Rehabilitation Plan produced to the Inquest by APM, the external rehabilitation provider used by the ADF, identified little more by way of activities than the gym and medical appointments.[567] Mr Cardinaels was asked about this, noting the evidence was that at least up until 10 July 2017, CPL Turner's apparent "goal" was to return to work. He could not recall any return-to-work program which was put in place for CPL Turner.[568]

351. Ultimately, the evidence before the Inquest left the distinct impression that there was no real plan put in place, when CPL Turner was released from hospital on each occasion, as to what he would be doing each day or how he would be working towards a situation where he either returned to work as a Commando, returned to work in the ADF in a different capacity, engaged in some further study, or discharged and transitioned to civilian life. As Professor McFarlane emphasised in his oral evidence, this was "critical": CPL Turner had a lot of capacity and if he was no longer deployable, that should not have been considered to be the end of his military career. He emphasised: "it's about then (sic) how you transition that person into roles and for the ADF to identify roles to which people can be transferred, where they can maintain their respect, they retain their membership of their units".[569]

(i) June to July 2017

352. On 19 June 2017, CPL Turner undertook a trip to the Gold Coast for around 5 days to attend a memorial for CPL Baird.[570]

353. On 28 June 2017, CPL Turner obtained his assistance dog, Lucky.[571]

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[565] Tab 8 (Statement of Hannah Steele) at 4 [20].
[566] 19/10/20 at T34.19-23.
[567] Exhibit 34 at 146 (Rehabilitation Schedule for 3 to 7 July 2017).
[568] 09/09/22 T37.1-22.
[569] 08/02/23 T44.
[570] Tab 50 (ADF Medical Records) at 67.
[571] Tab 50 (ADF Medical Records) at 66.

354. On 28 June 2017, Mr Cardinaels emailed Carmel Poulter, the APM Rehabilitation consultant, copying CAPT KV, with the subject line "Ian daily program update" setting out a weekly schedule for CPL Turner, in the following terms:[572]

> After Ians Office call today with PS, we have the following below for update to his weekly battle rythym.
>
> Mondays – 2 Cdo Gym (train), 2 Cdo - Tie in with Dog cell for Companion dog assistance, Drs Appt with Brendan, Boxing in the afternoons when no back problems Monday 3 July Jess Swain appt and Tuesdays there after.
>
> Tuesdays – Randwick – Gym (train) Randwick – Dispensary (weekly now), (Companion dog - Self training), Jess Swain. Canoe training when available
>
> Wednesdays – 2 Cdo Gym (train), 2 Cdo - Tie in with Dog cell for Companion dog assistance, Psych Appt with PS_CAPT, Boxing in the afternoons when no back problems
>
> Thursdays – Randwick – Gym (train), (Companion dog - Self training), Canoe training when available.
>
> Fridays – Randwick - Gym, (SJOG fortnightly) (Companion dog - Self training), Boxing.
>
> Ian, let us know if anything different?
>
> Carmel, I have left out Guitar lessons, as still issues Ian said?

355. It appears that around 2 July 2017, CPL TJ and CPL Turner commenced a break in their relationship.[573] CPL TJ stated in her ROI that she said to CPL Turner "I just need a break", she had told him that they needed to "take some space but it was just like with that it was kind of more to motivate him to be like get healthy", and that they were still catching up regularly.[574]

356. On 4 July 2017, CPL Turner attended an appointment with Dr Jessica Swain, psychiatrist.[575]

357. On 6 July 2017, CPL Turner reported to Dr Hale that he was struggling and overwhelmed and reported an incident where he had punched a patron of a pub for allegedly assaulting his companion dog.[576]

358. On 7 July 2017, a welfare board was conducted. The minutes suggest it was attended by (inter alia) COL MF, WO1 EL, WO2 MM, CAPT SW and CAPT KV.[577] However, notes taken indicate that at least Dr Hale and Mr Cardinaels were also present.

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[572] Exhibit 31, Tranche 5 at 21.
[573] See Exhibit 57 (WhatsApp and SMS messages) at 1861.
[574] Tab 27 (IGADF ROI with CPL TJ on 14 August 2018) at 26-27.
[575] Tab 50 (ADF Medical records) at 16.
[576] Tab 50 (ADF Medical records) at 15.
[577] Tab 38 (Welfare Board Minutes) at 16.

359. Dr Hale submits that he was not, in fact, present at the UWB, noting that the minutes indicate that the medical officer present was "CAPT SW"[578] and that the references to what it is noted he said in the "other stakeholder comments" are attributable to either CAPT SW, Dr Reppas, or CAPT KV.[579] In support of this submission, Dr Hale refers to the evidence that this welfare board was an Individual Welfare Board (**IWB**) (where two officers and a NCO were listed as present) and not a UWB (where those two officers and NCO were not listed in attendance).[580]

360. Counsel Assisting submits that the references to Dr Hale's opinion under the "other stakeholder comments" and the reference to Dr Hale responding to a question from the CO who "rang in" further supports a finding that Dr Hale was present at the UWB.[581]

361. On the face of the minutes document, I accept it is more likely than not that Dr Hale was present.

362. The notes indicate that COL MF was unhappy that the overdose or the dissociative episode which CPL Turner had was not reported to him earlier. The notes report that the CO "wants a way forward", he "wants the mbr to parade at work every day and his plan/program needs to be gripped up", he wanted a "rolling roster for the next 72 h for contact with the mbr when he is not parading at HPW", CPL Turner was to be on a "directed rehab plan and not an agreed plan", and the CO "needs to know immediately if he misses an apt". It also appears that a proposal for CPL Turner to go on leave to his family was discussed but that it was considered that he would "not benefit going on leave to his family given that there is a tendency to drink with his brothers".[582] COL MF apparently "acknowledge[d] issues with family" and said that "before any leave given an assessment will need to be made before leave is approved".[583] CAPT KV later sent an email to COL MF setting out the names of individuals who were going to spend the weekend with CPL Turner and advising that he had spoken to the Padre and the Padre was going to tell CPL TJ not to contact CPL Turner.[584]

363. CPL TJ's evidence was that she recalled being told not to speak to CPL Turner because the Padre said it was "the best for Ian" and that she agreed but did not

[578] Tab 38 (Welfare Board Minutes) at 16.
[579] Submissions of Dr Hale dated 31 May 2024 at [21].
[580] Submissions of Dr Hale dated 31 May 2024 at [22].
[581] Submissions in reply of Counsel Assisting dated 22 August 2024 at [133]-[134].
[582] Tab 38 (Welfare Board Minutes) at 18.
[583] Tab 38 (Welfare Board Minutes) at 20.
[584] Tab 50 (ADF medical records) at 62.

ultimately comply with what the Padre had said, and still contacted CPL Turner when he contacted her.[585]

364. On 7 July 2017, CAPT KV sent an email to Dr Swain reporting that "there has been a turn of events with Ian and new information that came to us only last night and this morning. Ian admitted to OD on prescribed medication and drinking heavily over the weekend, which explains the loss of memory". It recorded that "we have a safety plan in place for the next 72 hours and a more controlling rehab plan for the next month" and that CPL Turner would have a "battle buddy with him at all times over the next 72 hours".

365. On 10 July 2017, Dr Malik wrote to Dr Hale stating that "Ian was reviewed today and he reports he has curtailed use by self…his flashbacks and nightmares remain and he feels helpless…he is unfit for work of any kind and I will recommend a medical discharge". The report further recommended that CPL Turner "not to drive in the morning if he feels sedated from the previous night medications" and that "[w]ork itself has become a trigger and he relives traumas when he is exposed to it. I will recommend that until he is discharged from army for him to attend doctor's appointments on base after 10am".[586]

366. Dr Malik's evidence was to the effect that CPL Turner disclosed to Dr Malik that he had been drinking. Dr Malik indicated that he stated that he would prefer that CPL Turner be admitted to hospital, but CPL Turner declined.[587] CPL Turner had also stated to Dr Malik that attending work had caused him to be triggered by seeing uniformed people. Dr Malik stated that he wrote the letter because he wanted the ADF to "engage him a bit different … give him, you know, time to attend".[588] He was asked why he did not contact Dr Hale to put into place a protective structure around this trigger and Dr Malik indicated that he "wrote a letter" and "that's up to them".[589]

367. Dr Malik's last interaction with CPL Turner was on 10 July 2017. His evidence was that CPL Turner gave him (Dr Malik) no reason to think he was suicidal – he had engaged with him on the Friday (7 July) and Monday (10 July) and he said he was not suicidal.[590]

368. On 10 July 2017, medical notes made by Dr Hale record that "given current risk level, member is to be directed for inpatient care to ensure safety", that "refusal to enter

[585] 12/08/21 39.27-42.
[586] Tab 112 (Statement of Dr Malik) at 20.
[587] 20/10/20 T134.39-50.
[588] 20/10/20 T136.13-15.
[589] 20/10/20 T136.20-23.
[590] 20/10/20 T138.

inpatient service to be grounds for DFDA action", and that "failure to remain within an inpatient facility to be grounds for DFDA action". It also stated that a "contract" was to be written up "detailing all aspects of the members agreed upon plan" with the "consequences of failing to meet required taskings" being "DFDA action".

369. COL MF stated in his ROI that everybody [i.e., in 2CDO] "100 per cent was committed to" providing care for CPL Turner through welfare boards, arrangements for picquets, and trying to track him down when he left in-patient care. COL MF stated "it became apparent quite quickly that he was not fulfilling his side of the bargain". As a result, a decision was made by COL MF that "he is to report at the unit…he is to do everything through the unit because what he agreed to as part of his, in effect, his rehab and welfare plan, he was not living up to".[591] COL MF stated that he "really got the sense that the manipulation of the system was starting to kick in again".[592] WO1 EL stated that during the start of July, leadership was getting "feedback from the staff that Ian was missing appointments" and "wordage of Ian being belligerent to medical staff and chains of command", so "we had to realign the rehab plan again" and "this time we made it that Ian had to parade daily at Holsworthy Barracks to HPW".[593]

370. COL MF stated that there were allegations made by Joanna Turner "that Ian was involved with criminal elements, outlaw motorcycle groups, drugs and potentially, in effect, you know, hitman type roles".[594] COL MF also said he was concerned about the involvement of Hannah Steele, who he alleged was "on the scene providing…advice" contrary to CPL Turner's rehabilitation plan, and so, "pretty much, the reins were sort of pulled right in…and then he subsequently was successful in a suicide attempt shortly thereafter".[595]

371. COL MF accepted he did not consider discussing with Dr Malik, who was providing care to CPL Turner, whether his direction to "grip up" CPL Turner's plan would be positive or negative for CPL Turner at that time.[596] It is also notable that Dr Hale's evidence was that treating CPL Turner's medical issues as a disciplinary issue would have been "counterproductive" in terms of his therapeutic treatment. That evidence was given in relation to directing CPL Turner to enter inpatient treatment.[597] Dr Hale accepted that it was possible that a mandatory direction that CPL Turner comply with

[591] Tab 17 (IGADF ROI with COL MF on 22 August 2018) at 27.
[592] Tab 17 (IGADF ROI with COL MF on 22 August 2018) at 27.
[593] Tab 23 (IGADF ROI with WO1 EL on 15 August 2018) at 25-27.
[594] Tab 17 (IGADF ROI with COL MF on 22 August 2018) at 27-28.
[595] Tab 17 (IGADF ROI with COL MF on 22 August 2018) at 29.
[596] 22/10/20 T273-274.
[597] 23/10/20 T392.20-23.

his rehabilitation was potentially counterproductive.[598] CAPT KV indicated that he was not in favour of using discipline to make sure that CPL Turner stayed safe and that using discipline was not his idea, but rather the CO's.[599]

372. On 11 July 2017, Dr Hale and CAPT KV exchanged emails about plans for CPL Turner's future, having regard to the letter from Dr Malik that he was no longer fit for duty and should proceed to a discharge. It was noted that Dr Hale considered an extended transition of two years would be suitable which would give CPL Turner the time to develop his research/academic skills and remain supported medically and psychologically.[600]

12 to 15 July 2017

373. On 12 July 2017, CPL Turner was reviewed by the unit medical officer along with CAPT KV.[601] The entry in the medical records log records that "Dr Reppas' recommendations" were discussed and that CPL Turner stated that he did not want to go back into an inpatient facility and would self-discharge if directed to go there. An "Alcohol Relapse Prevention Plan" that CPL Turner "would be happy to comply with" was discussed involving "random PST each week", "random alcohol breath tests each week", and that if "exposed to a stressor … he is to engage in a stress coping strategy". The notes record that CPL Turner agreed to a "Safety plan" in the following terms:

> "- call his ex-girlfriend or a work mate if he has thoughts of suicide or self-harm
> - avoid alcohol
> - continue with prescribed medication
> - attend medical appointments (new schedule starting Monday 17 Jul: psychiatrist Mondays (at SJOG), psychologist Tuesdays and Thursdays (Sydney), MHP Psych Wednesdays and MO Fridays at Tobruk HC)
> - engage in regular enjoyable activities - PT twice a day and walking his dog with friends or his ex-girlfriend twice a day
> - regular contact with his supervisor (by phone or in person at Tobruk Lines)"

374. CAPT KV's evidence was that this was the safety plan for the weekend of 15-16 July.[602] His evidence was that there was no plan for CPL Turner to have a "battle buddy" over the weekend of 15-16 July because he wanted to treat CPL Turner like an adult.[603]

375. On 14 July 2017, CPL Turner suffered a back injury at the gym. He consulted with Dr Hale, who noted that he was in such pain that he was unable to sit and was visibly

[598] 23/10/20 T411.42-45.
[599] 11/08/21 T11.29-48, T47.1-4.
[600] Exhibit 4 at 302-303.
[601] Tab 50 (ADF medical records) at 59-60.
[602] 10/08/21 T771-9.
[603] 11/08/21 T22.12-18.

distressed. He was prescribed pain medication and other muscular treatments.[604] Dr Hale also gave evidence that treating CPL Turner's severe pain was essential for his mental wellbeing as his pain was another stressor and his ability to go to the gym was a "key component of his health care plan and his welfare plan".[605]

376. Over the period from 2 July to 14 July 2017, CPL Turner continued to engage in significant bombardment of CPL TJ via messages, imploring her to get back together with him and accusing her of various misdeeds including cheating on him or generally not caring about him. She continued to reiterate that CPL Turner needed to focus on getting better for himself before they could recommence a relationship but offered a significant amount of support for him via messages through this time. He subsequently got upset about a photo of CPL TJ which she had posted on social media. She deleted that photo. CPL Turner accused CPL TJ again of cheating on him and then ceased messaging her.[606]

377. On Saturday 15 July 2017, Mr Cardinaels attended CPL Turner's unit but could not obtain access to the unit. Using a ladder, he obtained access to the apartment and located CPL Turner deceased, cold and stiff sitting on the couch.[607] Ambulance officers and police arrived and CPL Turner was pronounced deceased by ambulance officers.[608]

378. Toxicology reports indicated that CPL Turner had toxic quantities of Amitriptyline and Paracetamol and potentially lethal quantities of codeine and Nortriptyline in his system, as well as a number of other drugs.[609]

379. Next to empty boxes of medication was a notebook containing six suicide notes addressed to various people.[610]

380. I am satisfied to the requisite standard that in all the circumstances including recent suicidal ideation, a prior recent suicide attempt and the notes which were found at the scene that CPL Turner intended to end his life. No party submitted that I should consider an accidental overdose.

[604] Tab 50 (ADF medical records) at 59. See also 23/10/20 T403-404.
[605] 23/10/20 T303.1-44.
[606] Exhibit 57 (WhatsApp and SMS messages) at 1953-1954.
[607] Tab 15 (IGADF ROI with SGT MC on 5 June 2018) at 15-17.
[608] Tab 1 (Report of Death to the Coroner) at 3. See also Statement of Tim Giblett (Tab 5) at 2 [7].
[609] Tab 3 (Limited Autopsy Report for the Coroner) at 4. See also Tab 4 (Toxicology Report).
[610] Tab 5 (Statement of Tim Giblett) at 3 [8].

Other factual issues

(a) The relationship between Andrea Cantwell and Matthew Cardinaels

Submissions of Counsel Assisting

381. Ms Andrea Cantwell is a clinical psychologist. Her clinical interactions with CPL Turner were in March 2017 around the time of his first suicide attempt.[611] She took on the role of clinical case coordinator around 2 March 2017, having been handed over his case from Ms Amy Sullivan.[612] On or around 30 March 2017, having treated CPL Turner for just under one month, she was advised that CPL Turner had requested a change to his mental health treatment and that Ms Cantwell would no longer be part of the treating team. Ms Cantwell's evidence was that she was not aware of any issues that CPL Turner had with her while she was the clinical case coordinator and thought they had developed a good rapport.[613]

382. Ms Cantwell was not called to give oral evidence at the Inquest.

383. There was evidence in the brief in relation to a dispute between Andrea Cantwell and Mr Cardinaels. That evidence revealed some difficulty between Ms Cantwell and Mr Cardinaels about which it appears Ms Cantwell subsequently made a complaint.[614] As was made clear by then-Senior Counsel Assisting, this disagreement was not the subject of statements by Ms Cantwell or Mr Cardinaels, and was not dealt with in their oral evidence.[615] The submission of Counsel Assisting remains that I would be unable to reach any firm finding in relation to what happened as between Ms Cantwell and Mr Cardinaels, nor could it be particularly relevant to the issues in the Inquest.

Consideration

384. I accept Counsel Assisting's submission on this issue.

(b) After action review, IGADF Report, and other institutional self-reflections

Submissions of Counsel Assisting

385. On 21 August 2017, a SOCOMD-JHC Joint After Action Review (**AAR**) was conducted in relation to the death of CPL Turner, at 2CDO. Minutes of that AAR were signed by

[611] Exhibit 40 (Statement of Andrea Cantwell dated 31 August 2022) at 1.
[612] Exhibit 40 (Statement of Andrea Cantwell dated 31 August 2022) at 1.
[613] Exhibit 40 (Statement of Andrea Cantwell dated 31 August 2022) at 6.
[614] Exhibit 31, Tranche 3 at 181-184.
[615] 01/02/23 T8.31-41.

BRIG GD on 22 October 2017 and a number of recommendations were made.[616] Those recommendations were as follows:

RECOMMENDATIONS FROM SOCOMD-JHC JOINT AAR – MANAGEMENT OF CPL TURNER

1. Strengthen Holsworthy Health Centre and Tobruk Clinic in order to better manage military members of all risk profiles. Investigate alternate in-patient holding capabilities that could be developed

Agreed in principle- *The White Paper includes funding for five uniformed Army psychiatrists. It has been agreed to establish one of those position in Holsworthy. It also includes seven uniformed Army Senior Medical Officers. It has been agreed to establish one of those in Holsworthy.*
A review of Garrison Health psychiatric referral patterns has been completed and Holsworthy has been identified for the addition of an On-base psychiatry service. This would attempt to fill the gap whilst a uniformed psychiatrist is Recruited.
The provision of an On-base psychiatry service will enhance the in-patient holding capabilities. High risk psychiatric patients require specialist psychiatric in-patient treatment which is limited to select public hospitals and well beyond the remit of Joint health Command to develop.

2. Review health policy to have members discharging from civilian hospitals transferred back to an ADF health centre to maintain positive control of complex cases.

Agreed- *For ADF Health Policy Steering Group to progress.*

3. Amend Defence health policy to ensure that ADF members being managed with restricted access to prescription medication have this clearly articulated to all health providers, including the requirement that no external prescriptions are to be provided to the member.

Agreed- *DGGH has initiated discussion with the Department of Health to establish the ability of Defence to access and integrate into the Commonwealth Prescription Shopping Programme. This will inform the Defence health policy changes recommended.*

4. Include Director Garrison Operations (JHC) in the quarterly Commander Special Forces Welfare Board to elevate awareness/ understanding of SOCOMD's most complex cases up the chain in JHC.

Agreed

5. JHC to lodge a complaint in relation to CPL Turners advocate ad provide feedback to the advocate's ex –service organisation on boundaries for future advocate support.

Agreed in part- *Feedback letter written to ESO by CJHLTH. Insufficient evidence to support a complaint to AHPRA as advocate wasn't being employed as a nurse.*[1]

386. On 9 February 2018, a memorandum titled "Joint Capabilities Group Joint Health Command: Health File Review CPL IJ Turner" was signed by SE Sharkey, which attached the minutes of the AAR Review and the AAR Recommendations Status.[617]

387. On 2 October 2020, the AGS wrote to the Crown Solicitor's Office identifying the steps which had been taken by the ADF in response to recommendations arising from the joint AAR. In relation to recommendation (a), a full-time ADF psychiatrist is now employed at HQ Joint Health Unit Central, which manages ADF health centres and clinics in the Sydney metro area including Holsworthy Health Centre and Tobruk Clinic.

[616] Tab 36 (Outcome of Health File Review resulting from the death of CPL TI) at 5-9.
[617] Tab 36 (Outcome of Health File Review resulting from the death of CPL TI).

A full time ADF senior medical officer is also now based at Holsworthy Health Centre. It was decided that the development and operation of inpatient specialist psychiatric treatment facilities was beyond the capacity and remit of Joint Health Command and the ADF.[618] The AGS also pointed to various policies which addressed the recommendations and stated that Commander Special Forces welfare boards have been held on two occasions since CPL Turner's death, once in 2018 and once in 2019.[619]

388. On 28 November 2022, the AGS wrote again in relation to the recommendations which had been further assessed since the AGS' previous letter of 2 October 2020. The AGS provided a number of further policy documents. Of note was an update to the Military Personnel Manual to provide that commanders should consider conducting IWBs for members who are the accused, complainant, or key witness in any disciplinary matter.[620] It was also noted that in late October 2020, a Joint Transition Authority was established within the ADF to support ADF members and their families during the transition from military to civilian life.[621]

389. On 7 April 2019, the IGADF published a report of the Inquiry into CPL Turner's death.

390. On 29 April 2019, the IGADF published a report into Military Justice Issues concerning CPL Turner.

391. Neither the AAR nor the IGADF report identified a number of the issues which have been canvassed in the Inquest, including the appropriateness or otherwise of the medical clearance granted to CPL Turner to deploy to Iraq in 2016. The AAR did not investigate the issue of the clearance granted to CPL Turner in 2016 at all. The IGADF report dealt with the medical clearance in relatively short order, concluding, based apparently on the evidence of MAJ AF, that "it was more detrimental to CPL Turner's mental health to leave him behind than allow him to deploy".[622] This conclusion was seemingly reached without asking any mental health professional about the reliability of CPL Turner's performance in the workplace as an indicator of PTSD or the risk of recurrence of PTSD if CPL Turner deployed. Similarly, the IGADF report noted the effect of the disciplinary proceedings on CPL Turner's mental health, as well as his move from B Company to C Company, but did not investigate whether support was provided to CPL Turner in respect of his mental health through this period. It does not

[618] Tab 119 (Letter from AGS to CSO dated 2 October 2020) at 2.
[619] Tab 119 (Letter from AGS to CSO dated 2 October 2020) at 4.
[620] Exhibit 62 (Letter from AGS to CSO dated 28 November 2022) at 5.
[621] Exhibit 62 (Letter from AGS to CSO dated 28 November 2022) at 6.
[622] Tab 13 (IGADF Report) at 6.

appear that the IGADF Inquiry involved the gathering of relevant contemporaneous documents to verify the matters which were stated by witnesses in their ROIs. Ultimately, it is not clear that either of these investigations were designed to engage in any particularly critical process of self-reflection by the ADF on how CPL Turner's declining mental health was managed by the ADF throughout 2013 to 2017.

392. The consequence of this was that there was no contemporaneous assessment by those in positions of responsibility within the ADF to the adequacy of their response, how it could have improved, or how additional steps may have assisted in the circumstances. Such questions were, thus, necessarily being considered for the first time in the context of the Inquest after the passage of considerable time, with knowledge that criticisms may well be made (given that letters of sufficient interest were served on the ADF and ultimately on individual members) and in the context of public scrutiny from outside the organisation itself.

393. MAJ AF was asked in his record of interview with the IGADF, as were other interviewees, what he considered to be the cause of CPL Turner's decision to take his own life. He listed the charge and demotion, the transfer to C Company which took him "out of his intimate support network" and the embarrassment associated with that, and his lack of relationships outside the workplace.[623] MAJ AF concluded that "he had every opportunity to turn it around. He had every opportunity thrown at him, given to him. There's a point where, I think, the organisation didn't fail him but, for lack of a better term, and this is harsh, he failed the organisation".[624] MAJ AF was given the opportunity to recant this in his oral evidence but chose not to do so.[625]

394. The evidence of MAJ AF, as well as the outcome of the two reviews conducted by the ADF into CPL Turner's death, is relevant to the culture within CPL Turner's Chain of Command, and the effect this had on the ADF's ability to properly manage his mental health. I accept Counsel Assisting's submission that it demonstrates a serious lack of awareness of the severity and impact of his PTSD, the failure to recognise its severity throughout 2015 and 2016, and an unwillingness to recognise the system failures which led CPL Turner to experience such a serious decline in his mental health by the start of 2017.

[623] Tab 16 (IGADF ROI with MAJ AF on 24 July 2018) at 36-37.
[624] Tab 16 (IGADF ROI with MAJ AF on 24 July 2018) at 37.
[625] 05/08/21 T9.

Submissions of the Commonwealth

395. The Commonwealth submits that a review and critique of the IGADF report would be beyond the statutory jurisdiction of this Inquest and any adverse findings about that report or its processes would be a denial of procedural fairness.[626] Further, it is submitted that to the extent the IGADF report is criticised for not covering certain matters, regard should be had to its particular statutory mandate and its limited reach by contrast to this Inquest.[627] The Commonwealth raises similar objections with respect to the AAR process.[628] To the extent that both reviews were said to be relevant to the culture within CPL Turner's Chain of Command, the Commonwealth submits that this proposition should be rejected and is a procedurally unfair proposed finding.[629]

Consideration

396. I accept that it is not my place to conduct a detailed critique of the IGADF report or the AAR process. Nevertheless, the report and evidence pertaining to the AAR process are extremely useful in understanding the culture within CPL Turner's Chain of Command and indeed the broader Army at the time of his mental health decline. In my view, the evidence establishes a serious lack of awareness of the severity and impact of CPL Turner's PTSD. There is a failure to understand and grapple with the way in which ADF decisions were impacting on his mental health over a long period. I accept Counsel Assisting's submissions on this issue.

397. There is no procedural unfairness to recognise, using evidence obtained from the IGADF report or the AAR process, amongst other evidence, that there was an inability to understand what was required for a truly therapeutic approach to CPL Turner's mental health management. While Dr Hale accepted that treating CPL Turner's medical issues as disciplinary issues would be "counterproductive", in my view a disciplinary approach infected CPL Turner's management right up to and even after his death.

398. COL MF wanted to "pull the reins in" and believed that CPL Turner was not "fulfilling his side of the bargain." He feared that CPL Turner was "manipulating the system". Even more telling was MAJ AF's shocking pronouncement in his record of interview that CPL Turner "failed the organisation" with his decision to take his own life. It was revealing that he took this firm view of what had occurred. MAJ AF's understanding of

[626] Submissions of the Commonwealth dated 7 June 2024 at [803]-[806].
[627] Submissions of the Commonwealth dated 7 June 2024 at [807]-[808].
[628] Submissions of the Commonwealth dated 7 June 2024 at [812]-[814]
[629] Submissions of the Commonwealth dated 7 June 2024 at [818].

CPL Turner's suicide appeared to remain within a strictly disciplinary framework, where the fault lay squarely with CPL Turner. When asked to identify why CPL Turner failed the ADF, he answered "suicide is unacceptable. Killing yourself is an unacceptable course of action and Ian should not have done it."[630] While MAJ AF's lack of insight and compassion was particularly striking, his inability to properly consider the possibility of systems failures within the ADF was in line with some others who also gave evidence. Indeed, the IGDAF report and the AAR process demonstrate aspects of a culture that supports an officer such as MAJ AF to hold the harmful views he did. The inquest revealed the ongoing need to destigmatise PTSD and mental health issues in the ADF. This evidence from a senior officer indicates the size of the task ahead. It was clear to me that there was intransigent thinking at all levels of the organisation.

(c) Relationship with Hannah Steele

Submissions of Counsel Assisting

399. CPL Turner's relationship with Hannah Steele became the subject of focus in reviews after his death which ultimately proved to be entirely misplaced. Ms Steele worked for the Vietnam Veterans, Peacekeepers and Peacemakers Association (**VVPPA**). She first met CPL Turner sometime in 2013. She became close friends with him in late 2016 when he moved into the building across from hers. In 2017, Ms Steele would meet up with CPL Turner for coffee after the gym and talk about life. She had a sexual relationship with CPL Turner on two occasions in 2017, one in January which was how they became close, and once during a period when he had not been in hospital for a few weeks (noting she was not clear on the timing).[631] Ms Steele's evidence to the Inquest demonstrated that she was a friend to CPL Turner throughout 2017 and attempted to assist him as such, including by visiting him in hospital and obtaining a service dog to keep him company.[632]

400. In February 2018, the ADF wrote a letter to Ms Steele's employer informing them that she had acted outside her bounds as an advocate for CPL Turner.[633] Ms Steele's employer replied to the ADF making clear that she was not CPL Turner's advocate[634] and ultimately the ADF apologised for the false claims which had been made about

[630] 5/8/21 T45.44 to T46.17.
[631] 19/10/20 at T50.5-15.
[632] Tab 8 (Statement of Hannah Steele).
[633] Tab 9 (Letter from TL Smart AM, Air Vice-Marshal to Mr Frank Cole, NSW State President of the VVPPA (NSW Branch) dated 17 January 2018).
[634] Tab 9 (Letter from Mr Frank Cole, NSW State President of the VVPPA (NSW Branch) to TL Smart AM, Air Vice-Marshal, dated 6 February 2018) at 5-6. See also Tab 8 (Statement of Hannah Steele) at 5 [28].

Ms Steele to her employer.[635] Counsel Assisting submits that it is plainly regrettable that Ms Steele was subjected to this treatment from the ADF in circumstances where, as she stated, "I was just his friend".[636] Counsel Assisting considers that the evidence does not provide any basis for finding that Ms Steele interfered with CPL Turner's treatment during 2017.

Submissions of the Commonwealth

401. The Commonwealth submits that a finding should not be made that Hannah Steele was "just his [CPL Turner's] friend" and that, in fact, their relationship was such that it "added to the entangled complexity of [CPL Turner's] life".[637]

Submissions in reply of Counsel Assisting

402. Counsel Assisting notes that the Commonwealth's characterisation omits the express references to the pair being "close friends" and having "had a sexual relationship" in the same paragraph. Beyond that, Counsel Assisting considers it is not apparent what the Commonwealth seeks to add in its submission other than eschewing the attribution of any blame to Ms Steele. Counsel Assisting considers there to be no basis for any finding that Ms Steele interfered with CPL Turner's treatment during 2017 as had previously been asserted by the ADF in 2018.[638]

Consideration

403. I reject the Commonwealth's submission that CPL Turner's relationship with Hannah Steele "added to the entangled complexity" of CPL Turner's life. I have seen no evidence that their friendship interfered with his treatment during 2017. Without that I reject the apparent implication that her contact with CPL Turner was somehow problematic.

(d) CPL Turner's identity as a commando and part of B Company, 2CDO

Submissions of Counsel Assisting

404. It was apparent from the evidence adduced during the Inquest that CPL Turner's sense of identity was intrinsically connected to his service in the ADF, particularly, as a Commando, and even more particularly, as part of B Company. MAJ AF described it thus: "Ian was a passionate bloke, whose self-worth and identity was intimately

[635] Tab 9 (Letter from TL Smart AM, Air Vice Marshal to Mr Frank Cole, NSW State President of the VVPPA (NSW Branch) dated 9 October 2018) at 12.
[636] Tab 8 (Statement of Hannah Steele) at 5 [28].
[637] Submissions of the Commonwealth dated 7 June 2024 at [819].
[638] Submissions in reply of Counsel Assisting dated 22 August 2024 at [243].

connected to the army and his position in the regiment. He considered himself to be vital to the company…almost his identity was B Company…And that was good and bad".[639]

405. Padre MP spoke more generally, giving an example of another individual who he had found attempting to commit suicide, and said "it came down to the fact that he couldn't, you know, he couldn't be what he wanted to be and it meant so much to him, it was so much engrained in his identity that he didn't want to live if he couldn't be a commando".[640] He stated that "they've got a motto commando for life and that's real, it's like, you know, they live by this stuff".[641]

406. LCPCL DL stated that he remembered seeing CPL Turner when he was in a coma and he had a "whole sleeve of his arm tattooed in a dedication to our company…I remember just looking at it and thinking that's how much this meant to you and it was taken away from you".[642] LTCOL SW stated in his ROI that when he spoke to CPL Turner in hospital after his second suicide attempt, "what came out in the discussion was that the only thing that had kept him tethered was his work, and you know being operationally employed was the thing that – you know he's high functioning in that environment".[643]

407. Christine Turner recounted a message during her IGADF ROI where CPL Turner stated that "I'm in a position where every single piece of my identity of how I view myself in this world has been taken from me. I was a husband and a father. I was the most senior team commander in all of [SOCOMD]. Now I'm dad one out of four weekends. I'm a 2IC in a different company and there is no more war to be fought".[644]

408. Mr Cardinaels, for example, who had spent some 18 years in the unit, indicated that it was "not the case at all" that inevitably for all commandos there would come a time where they were not sufficiently fit to continue to undertake that role.[645] This was at odds with the expert evidence (discussed below) which suggested that there was a limited number of deployments it was expected a soldier could undergo. Mr Cardinaels indicated that work had "started" in educating Commandos who were in training as to the need to be a "multi-dimensional human being", to have "interests outside work",

[639] Tab 16 (IGADF ROI with MAJ AF on 24 July 2018) at 6.
[640] Tab 19 (IGADF ROI with Padre MP on 18 September 2018) at 29.
[641] Tab 19 (IGADF ROI with Padre MP on 18 September 2018) at 30.
[642] Tab 21 (IGADF ROI with LCPL DL on 14 August 2018) at 10.
[643] Tab 22 (IGADF ROI with LTCOL SW on 11 December 2018) at 14.
[644] Tab 34 (IGADF ROI with Christine Turner on 21 August 2018) at 14.
[645] 02/08/21 T16.6-8.

and to have an "understanding of how you thrive and readjust to life in the community after your time".[646]

Consideration

409. It is clear that CPL Turner's identity as a commando and more specifically as a member of B Company was integral to his understanding of himself. While his peers could recognise this to some degree, I was not convinced that the issue was properly understood or catered for in plans for CPL Turner's transition from active duty. It is an issue to which I will return.

EXPERT EVIDENCE

410. A significant volume of written expert evidence was received by the Inquest. The experts gave oral evidence in conclave over the course of two days in February 2023.

(a) Dr Olav Nielssen

411. Dr Nielssen was engaged by Counsel Assisting and he provided two reports to the Inquest. Dr Nielssen is a psychiatrist working in private practice. He has clinical professorial appointments at the University of Sydney and Macquarie University, works in the homeless sector at Matthew Talbot Hospital and consults for an online treatment service for anxiety and depression, which includes a PTSD course.[647]

412. In his first report, Dr Nielssen stated that, in his opinion, CPL Turner's service and events arising from his service were a significant factor contributing to his death. He stated that PTSD is associated with an increased propensity to drink alcohol because of the temporary reduction in arousal and anxiety provided by alcohol. He further stated that CPL Turner's prosecution, demotion, and transfer over the cock-carding incident was "likely to have had a detrimental effect for a person who had reached his level of service and was very attached to his immediate unit and is also likely to have contributed to the development of a depressive illness."[648]

413. Dr Nielssen's main criticism of CPL Turner's care from 2014 to 2017 was allowing his return to active service after the identification of PTSD, as "further exposure to trauma would be expected to re-trigger the condition". He disagreed with the view reached in the Clinical Perspective Document that a further tour of duty might help CPL Turner's recovery, considering it was not consistent with medical advice.[649] He stated that CPL

[646] 02/08/21 T6.14-23.
[647] 07/02/23 T12.15-19.
[648] Report of Dr Nielssen dated 12 August 2020 (Tab 108) at 10.
[649] Report of Dr Nielssen dated 12 August 2020 (Tab 108) at 10.

Turner's redeployment to the Middle East after having been diagnosed with PTSD was "probably not in Mr Turner's best interest, as any further trauma could trigger the recurrence of the disorder".[650]

414. Dr Nielssen considered that CPL Turner received intensive intervention during his time managed under the HPW with regular reviews by various health professionals.[651]

415. Dr Nielssen noted that ADF policies included the requirement for regular mental health reviews and the removal of access to weapons and ammunition to members deemed to be at risk of committing suicide. Dr Nielssen noted that CPL Turner had the "obvious disincentive of losing the possibility of further rotations by raising serious mental health concerns".[652]

416. Dr Nielssen considered it was difficult to assess the extent of the impact of the disciplinary proceedings on CPL Turner but stated "criminal proceedings of any kind are distressing".[653] He considered that his redeployment to C Company was likely to have had a "significant detrimental effect for a person of Mr Turner's personality and background".[654]

417. Dr Nielssen considered whether other factors arising during CPL Turner's service contributed to his death and referred to the possibility of the use of anabolic steroids and cocaine which carried the risk of more severe depression.

418. In his supplementary report, Dr Nielssen stated he did not consider that the specific details of traumatic events needed to be known to a psychiatrist in order to diagnose and treat combat-related PTSD. His view was that revisiting the details of trauma can "exacerbate rather than relieve symptoms".[655]

419. In relation to possible recommendations, Dr Nielssen stated:[656]

    i. it seems inadvisable to return people diagnosed with service-related PTSD to active service because of the risk of further experiences adding to existing trauma;

[650] Report of Dr Nielssen dated 12 August 2020 (Tab 108) at 15.
[651] Report of Dr Nielssen dated 12 August 2020 (Tab 108) at 11.
[652] Report of Dr Nielssen dated 12 August 2020 (Tab 108) at 11.
[653] Report of Dr Nielssen dated 12 August 2020 (Tab 108) at 11.
[654] Report of Dr Nielssen dated 12 August 2020 (Tab 108) at 12.
[655] Supplementary Report of Dr Nielssen dated 3 July 2021 (Exhibit 9) at 4.
[656] Report of Dr Nielssen dated 12 August 2020 (Tab 108) at 13-14.

ii. the military should consider a cap on the number of tours in which members are exposed to real danger, both as a matter of fairness and to reduce the liability for PTSD in elite troops subjected to constant rotation;

iii. improved pastoral care of very exposed members of the ADF when they leave the military;

iv. the supervision of substance use, given the ready availability of "on the spot and hair testing".

(b) Dr Matthew Large

420. Dr Large was engaged by Dr Sringeri and provided three reports to the Inquest. Dr Large is a psychiatrist. He is the senior psychiatrist at the Prince of Wales Hospital, where he was engaged in work primarily in an Emergency Department and Emergency Psychiatrist Care Centre. He is also the Clinical Director of the Eastern Suburbs Mental Health Service and the conjoint professor in psychiatry and the University of New South Wales.[657]

421. In his first report, Dr Large stated that at the time of CPL Turner's death he had a number of psychiatric conditions, "the most prominent of which was a substance use disorder, best characterised as a severe alcohol use disorder".[658] He stated that CPL Turner had also suffered from PTSD after being exposed to combat trauma, a depressive condition (which he considered was "secondary to his alcohol use", and some symptoms of adult or residual ADHD (but which were equally likely to be due to alcohol use disorder or trauma related symptoms).[659] Dr Large considered that it was likely there was "something of a vicious cycle of causality between PTSD and alcohol use" and that a "direct connection between his ADF service and alcohol use is probable".[660]

422. Dr Large considered that the relative importance of these conditions was hard to assess but accepted there was a temporal relationship between his combat stress, PTSD symptoms, and increased drinking but that his alcohol use contributed to the severity of his PTSD.[661]

423. Dr Large stated that "in the most general terms suicide is quite unpredictable", that suicide events are "not well explained by suicide risk factors even among people with

[657] 07/02/23 T9.21-26.
[658] Report of Dr Large dated 28 September 2020 (Tab 109) at 47.
[659] Report of Dr Large dated 28 September 2020 (Tab 109) at 47-48.
[660] Report of Dr Large dated 28 September 2020 (Tab 109) at 49.
[661] Report of Dr Large dated 28 September 2020 (Tab 109) at 48.

a significant history of suicidal behaviour", and that CPL Turner's suicide was "not unexpected given his presentation but could not have been reasonably anticipated over any clinically relevant time frame".[662]

424. Dr Large was asked whether it was clinically appropriate in 2014 and 2015 for Dr Sringeri to determine CPL Turner was "fit for duty". Dr Large explained that the "main role of an external treating psychiatrist" other than providing treatment "was to inform the ADF of [CPL Turner's] clinical state". He stated that "decisions about suitability for military duty are complex and go beyond a treating psychiatrist's views".[663] Notwithstanding that view, he stated that Dr Sringeri was "within peer acceptable practice" in his view that CPL Turner was "fit for duty" and that a "slightly separate question was whether his return to work and possibly active duty was likely to be good or bad for [CPL Turner's] mental health" but that he had "no strong grounds to question this conclusion by people that knew him".[664]

425. Dr Large was also asked about Dr Sringeri having cleared CPL Turner as fit for duty on 13 July 2016 (in relation to the deployment on OP OKRA). It should be noted that Dr Large reviewed the notes of Dr Sringeri in which it is reported that CPL Turner stated "next deployment only involves training Iraqi soldiers and didn't involve any combat" and "his duties, limited to training Iraqi soldiers only".[665] He stated that although it "is not really the role of a psychiatrist to be decision maker in matters related to fitness for military service, Dr Sringeri clearly considered the impact of [CPL Turner's] condition on his ability to perform non-combat duties and concluded that [CPL Turner] was capable of this non-combat role", and that "most psychiatrists would conclude that there were grounds to consider [CPL Turner] fit for this form of deployment".[666]

426. Dr Large was asked about the role of a psychiatrist as a decision-maker in relation to whether an ADF member is fit for duty. His opinion was that the role of the psychiatrist is to provide information about the psychiatric state of the ADF member in order to assist the ADF to make decisions about fitness to return to duties. He stated that "it was quite reasonable for Dr Sringeri to express the view that [CPL Turner] was fit for deployment and that he would be capable of performing his duties" but that "the final question of whether he was cleared for deployment was not ultimately one that lay with Dr Sringeri".[667]

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[662] Report of Dr Large dated 28 September 2020 (Tab 109) at 48.
[663] Report of Dr Large dated 28 September 2020 (Tab 109) at 50.
[664] Report of Dr Large dated 28 September 2020 (Tab 109) at 50.
[665] Tab 111 (Statement of Dr Sringeri dated 25 September 2020) at 90.
[666] Report of Dr Large dated 28 September 2020 (Tab 109) at 50.
[667] Report of Dr Large dated 28 September 2020 (Tab 109) at 51.

427. In his supplementary report, Dr Large referred to the reports of other experts. He stated he suspected he had a minor difference with Dr Hopwood and Dr Dinnen in that he placed a greater emphasis on the role of the alcohol/substance use disorder that CPL Turner was experiencing as an explanatory factor for his decline in mental health and ultimate suicide. He stated he held this view because "alcoholism is the most common mental disorder experienced by Australian men".[668]

(c) Dr Malcolm Hopwood

428. Dr Hopwood was engaged by the ADF and provided three reports to the Inquest. Dr Hopwood is a psychiatrist and a professor of psychiatry at the University of Melbourne.[669]

429. In his first report, Dr Hopwood considered that it appeared from Joanna Turner's evidence that CPL Turner had begun to develop symptoms of PTSD before his clinical presentation (those could have been for a year "and possibly longer") and that it was not uncommon for earlier stages of illness to be first evidence to those close to the affected individual.[670] Dr Hopwood considered that the treatment CPL Turner received for his mental health difficulties in 2014 and again in 2017 were of the standard he expected and that he could not identify any specific interventions that would have been guaranteed to prevent his suicide.[671]

430. Dr Hopwood considered that it was "clear that the trauma that led to [CPL Turner's] development of PTSD was related to his service in the ADF" and that the disability associated with his mental health difficulties also clearly complicated the latter stages of his career and may have contributed to his disciplinary issues and subsequent company transfer. Dr Hopwood considered that these events were significant stressors because of the pride which CPL Turner placed in his military career.[672]

431. Dr Hopwood considered an "important question" relates to whether CPL Turner's mental health had improved as much as perceived between 2014 and 2016, or whether some degree of ongoing impairment was disguised by inadequate review or by any attempt on the part of CPL Turner to minimise symptoms and that this was a "difficult question to answer based on document review".[673]

[668] Supplementary Report of Dr Large dated 16 July 2021 (Exhibit 8) at 4.
[669] 07/02/23 T5.17-18.
[670] Report of Dr Hopwood dated 12 October 2020 (Tab 110) at 4-5.
[671] Report of Dr Hopwood dated 12 October 2020 (Tab 110) at 7.
[672] Report of Dr Hopwood dated 12 October 2020 (Tab 110) at 7-8.
[673] Report of Dr Hopwood dated 12 October 2020 (Tab 110) at 8.

432. Dr Hopwood considered that it was clear there was a potential tension between the desire of a soldier to pursue a valued military career and the discussion of any career related mental health issues. He considered it was impossible to completely eradicate this tension but that "hopefully all involved in the care of someone such as [CPL Turner] are aware of the tension".[674]

433. He stated that it was likely that CPL Turner's disciplinary proceedings and redeployment to C Company were "significant additional blows" and that they may have added to his sense of demoralisation and depression. He also commented that the loss of rank seemed a particularly strong punishment.[675]

434. Dr Hopwood stated that it was important to acknowledge that the very nature of military service "particularly deployment in a conflict zone is inherently potentially traumatic".[676] He also stated that there is an "indisputable body of evidence that suggest that prior trauma and/or PTSD increase the risk of the development of PTSD with subsequent trauma exposure". He further noted that whilst the "intent of deployment may not appear inherently traumatic" (referring to the 2016 OP OKRA deployment), it must be difficult to guarantee this given the unpredictability of such a zone and the individual nature of what is or isn't traumatic".[677]

435. In his supplementary report, Dr Hopwood explained the term "combat related PTSD", noting it is usually used to refer to PTSD resulting from an individual's experience in a military conflict zone.[678] He stated the symptoms of combat-related PTSD are essentially identical to those of civilian trauma-related PTSD. He explained that there is a common conception amongst mental health professionals that combat-related PTSD may be different in three main respects to civilian-related PTSD:[679]

    i. First, it arises from circumstances that involve events challenging the normal human moral boundaries, which creates a higher risk of PTSD and can create challenges in its management. He noted that if the events that led to PTSD are associated with moral ambiguity or shame/guilt, it is likely that performing exposure-based psychotherapy may be more challenging.

    ii. Second, the occurrence of combat-related PTSD is within a specifically military culture with its associated issues of pride in service, and complex issues

[674] Report of Dr Hopwood dated 12 October 2020 (Tab 110) at 8.
[675] Report of Dr Hopwood dated 12 October 2020 (Tab 110) at 9.
[676] Report of Dr Hopwood dated 12 October 2020 (Tab 110) at 10.
[677] Report of Dr Hopwood dated 12 October 2020 (Tab 110) at 11.
[678] Supplementary Report of Dr Hopwood dated 8 July 2021 (Exhibit 5) at 3.
[679] Supplementary Report of Dr Hopwood dated 8 July 2021 (Exhibit 5) at 3-4.

around the cessation of a military career and that the presence of such systemic issues can complicate presentation and delay treatment.

iii. Third, there is a limited body of evidence suggesting specifically that combat related PTSD may respond less well to treatment than civilian PTSD.

436. Dr Hopwood further stated that the functional impacts of PTSD are diverse and can result in social withdrawal and the disruption of normal interpersonal relationships. He stated that it was also associated with irritability and may be associated with aggressive behaviour and impulsivity. He also stated that PTSD can contribute to the risk of violent behaviour. He noted that substance abuse can increase the risk of criminal or anti-social behaviour.[680]

437. In relation to exposure-based therapy, Dr Hopwood's evidence was that most treatment guidelines would recommend that co-morbid problems such as depression or active substance abuse need to be brought under control before exposure-based therapy is commenced. He explained that for some individuals, exposure-based therapies remained an overwhelming prospect.[681]

438. Dr Hopwood stated that individuals with even severe PTSD can hide or minimise their symptoms, but that the ability to do so is influenced by the severity of PTSD.[682]

439. In relation to the disclosure of traumatic events as part of treatment, Dr Hopwood stated that in his experience treating current and former members of the ADF, it was "quite clear that effective treatment will generally require a discussion of all relevant traumatic events". He stated that on treating combat-related PTSD, there are traumatic issues that have great sensitivity including in the sense of being security-classified. He stated it "is indeed clinically unhelpful" when this occurs as it interferes with effective care and, although it can sometimes be informally handled, "on other occasions it is insurmountable and unhelpful".[683]

440. Dr Hopwood further stated that current clinical guidelines indicate that "evidence-based psychotherapy" is the most common treatment of choice for PTSD and that the guidelines recommend three forms of psychotherapy, being Cognitive Behavioural Therapy (**CBT**), Cognitive Processing Therapy (**CPT**), and Eye Movement Desensitisation Reprocessing (**EMDR**). A key component of each of those therapies

[680] Supplementary Report of Dr Hopwood dated 8 July 2021 (Exhibit 5) at 4-5.
[681] Supplementary Report of Dr Hopwood dated 8 July 2021 (Exhibit 5) at 6.
[682] Supplementary Report of Dr Hopwood dated 8 July 2021 (Exhibit 5) at 6.
[683] Supplementary Report of Dr Hopwood dated 8 July 2021 (Exhibit 5) at 8.

was an "exposure to and reworking of the traumatic memories, which are seen as central to the symptomatology of PTSD".[684]

441. In his further supplementary report, Dr Hopwood stated that he agreed with Dr Nielssen that the most salient issue in CPL Turner's treatment was the decision to allow him to return to active service after he was identified as suffering from PTSD.[685] Dr Hopwood noted Dr Large's comments in relation to the significance of CPL Turner's alcohol use disorder. He stated that there was a considerable body of evidence supporting the close relationship between alcohol misuse and symptoms of PTSD and that in CPL Turner's case there was evidence from Joanna Turner that his alcohol use escalated significantly at the same time as the development of his PTSD symptoms. He also concurred with Dr Large's opinion on the role of a psychiatrist in decisions about deployment.[686]

442. Dr Hopwood considered that decisions in relation to deployment required clinical input and also adequate expertise in military mental health and independence from specific unit-based concerns.[687]

443. Dr Hopwood further agreed with Dr Dinnen's views (discussed further below) about the issues involved in private psychiatrists effectively communicating to health services within the ADF, and the difficulties involved in the lack of psychiatrists involved in the ADF.[688]

444. Dr Hopwood stated that he disagreed with Dr Malik's evidence that the role of a psychiatrist in PTSD was as a "prescriber", stating that in general it was the role of a psychiatrist to fully understand the presentation and to provide ongoing support as a minimum in addition to pharmacotherapy.[689]

(d) Dr Anthony Dinnen

445. Dr Dinnen was engaged by Mr and Mrs Turner and provided two reports to the Inquest. Dr Dinnen is a psychiatrist in private practice. He had consulted in the past with St Vincent's Hospital and DVA.[690]

446. In his first report, Dr Dinnen stated that in his view there was "no disincentive within the military for its members to raise mental health issues but it is well known that to do

[684] Supplementary Report of Dr Hopwood dated 8 July 2021 (Exhibit 5) at 7.
[685] Further Supplementary Report of Dr Hopwood dated 26 July 2021 (Exhibit 6) at 2.
[686] Further Supplementary Report of Dr Hopwood dated 26 July 2021 (Exhibit 6) at 2.
[687] Further Supplementary Report of Dr Hopwood dated 26 July 2021 (Exhibit 6) at 2.
[688] Further Supplementary Report of Dr Hopwood dated 26 July 2021 (Exhibit 6) at 3.
[689] Further Supplementary Report of Dr Hopwood dated 26 July 2021 (Exhibit 6) at 3.
[690] 07/02/23 T14.1-3.

so has an adverse effect on status, deployment and promotion" and that the more determined an ADF member is to pursue their career, the less likely they are to raise issues of mental health.[691] Dr Dinnen stated that the "only change" he would like to see in military health is for psychiatrists to be full time employees of the military and to be given total and full responsibility for managing patient assessment and care, with psychologists as ancillary. He considered that as an "outside consultant" he was aware his recommendations carried less weight than psychologists who are "on base".[692]

447. In his supplementary report, Dr Dinnen stated that he disagreed with Dr Nielssen's view that CPL Turner's deployment in 2106 was not consistent with medical advice, stating that he was "aware of many of my patients through the years who have continued to serve both in the Police and in the Military…after diagnosis of PTSD".[693] He further stated he did not consider that a serving Defence member would be hindered in their treatment by reason of the security classification of information.[694] Dr Dinnen stated he did not agree with the "fashion in recent years" to delve into traumatic experiences as part of treatment for PTSD.[695]

(e) Professor Alexander McFarlane

448. Professor McFarlane was engaged by Counsel Assisting and provided one report to the Inquest dated 15 July 2021. Professor McFarlane is an Emeritus Professor of Psychiatry at the University of Adelaide, and a Professorial fellow at Phoenix Australia, having previously been the Director of the Centre for Traumatic Stress Studies and head of the Department of Psychiatry at the University of Adelaide.[696] He had a lengthy history of service in the ADF as a member of the RAAF specialist reserves, as a specialist adviser to the DVA and as a senior investigator in the Deployment Health Surveillance Program.[697]

449. In his report, Professor McFarlane was asked about the impact of CPL Turner's service within the ADF on his mental health. His evidence was that it was unlikely that any single traumatic exposure in the course of CPL Turner's deployments was the cause of his chronic PTSD, but that it was the "cumulative exposure throughout his deployment".[698] He referred to a number of studies in which he had been involved of ADF personnel since 2000. Professor McFarlane then stated that there were various

[691] Report of Dr Dinnen dated 17 September 2020 (Tab 110A).
[692] Report of Dr Dinnen dated 17 September 2020 (Tab 110A) at 11.
[693] Supplementary Report of Dr Dinnen dated 26 July 2021 (Exhibit 7) at 2.
[694] Supplementary Report of Dr Dinnen dated 26 July 2021 (Exhibit 7) at 7.
[695] Supplementary Report of Dr Dinnen dated 26 July 2021 (Exhibit 7) at 7.
[696] Report of Professor McFarlane dated 15 July 2021 (Exhibit 12) at 80.
[697] Report of Professor McFarlane dated 15 July 2021 (Exhibit 12) at 77; 07/02/23 T6.
[698] Report of Professor McFarlane dated 15 July 2021 (Exhibit 12) at 55.

reports detailing CPL Turner's increasing development of symptomatology on his RtAPS and POPS screens and that no accumulative tracking of the trajectory existed in the material. He noted that it is recognised there is a delayed onset of symptoms in ADF members and that maximal distress related to combat exposure does not occur in the immediate post-deployment period. He noted an absence of material about how to map and manage the emerging risk to CPL Turner throughout his career.[699] In particular, he noted that there was little by way of follow up in the context of him returning early from deployment in 2015. In his view, one of the reasons for the POPS screen is the recognition that there is frequently an escalation of symptoms in the period following the individual's return from deployment and that CPL Turner was an individual who should have received and been directed to undergo more regular follow up.[700]

450. Professor McFarlane also noted that there was no consideration of CPL Turner's progressive decline over a long period in the assessment of risks to CPL Turner from future deployments. He stated that CPL Turner's symptoms around 2013 as reported by Joanna Turner were indicative that he was suffering from PTSD.[701] He noted, for example, that the AAR report had set out CPL Turner's major sources of distress as "being estranged from his wife", "disciplinary proceedings and its consequence", "his current relationship", and "PTSD symptoms that were labile". In Professor McFarlane's view, this tended to confuse cause and effect because the probability was that CPL Turner's marital issues and disciplinary proceedings were "secondary manifestations of his underlying post-traumatic stress disorder".[702]

451. In relation to the cock-carding incident and disciplinary proceedings, Professor McFarlane noted that reckless and risk-taking behaviour was a symptom of PTSD. He considered that an important question was whether the known history of CPL Turner's PTSD, depression, and alcohol abuse was taken into account when moving him from B Company to C Company. He stated that the loss of supports to an individual who is considered to be unwell has predictable consequences. He also considered that an important question arose as to whether there was adequate consideration around whether his mental health was reflected in his behaviour in the cock-carding incident.[703]

[699] Report of Professor McFarlane dated 15 July 2021 (Exhibit 12) at 63.
[700] Report of Professor McFarlane dated 15 July 2021 (Exhibit 12) at 33.
[701] Report of Professor McFarlane dated 15 July 2021 (Exhibit 12) at 11.
[702] Report of Professor McFarlane dated 15 July 2021 (Exhibit 12) at 34.
[703] Report of Professor McFarlane dated 15 July 2021 (Exhibit 12) at 13.

452. In relation to CPL Turner's deployment on OP OKRA in 2016, Professor McFarlane did not consider MAJ AF had the necessary expertise to determine the risks to CPL Turner of a further deployment.[704] In his view, COL MF's evidence demonstrated that he did not take into account the significance of the foreseeable risk to CPL Turner as a consequence of being redeployed, which Professor McFarlane did not consider to be an appropriate step to have been taken at that time. He noted that further trauma exposure posed a significant risk of leading to an exacerbation of CPL Turner's PTSD. In his view, further exposure had the potential to reinforce earlier traumatic memories, and dealing with incidents such as the human remains of the US pilot were likely to have played a significant role in the exacerbation of his condition.[705]

453. In relation to whether CPL Turner was "fit for duty" at the time of the 2016 deployment, Professor McFarlane emphasised that the question is not "simply whether an individual can perform their duties", noting many people can perform their duties while suffering with a psychiatric illness". Rather, the "critical question to be considered is the consequences for an individual of an exacerbation of their condition" and that it was also critical to assess the risks they would behave in a less than optimal way while deployed (including acting outside the rules of engagement, or other risk-taking behaviour).[706]

454. In relation to the issue of domestic violence perpetrated by CPL Turner on Joanna Turner, Professor McFarlane stated that these are "core aspects" of PTSD and that these matters were the consequence and markers of his declining mental health which should have alerted Command and clinicians to his predicament, noting that his marital difficulties and the domestic violence were issues that were known to the ADF.[707]

455. In relation to CPL Turner's alcohol abuse, Professor McFarlane considered that given this was an issue which was identified by the ADF, it should have been dealt with aggressively in terms of his underlying symptoms, rather than just have been considered a "drinking behaviour". He stated that CPL Turner was clearly an individual at substantial risk of a future exacerbation of his condition. Professor McFarlane noted that alcohol abuse frequently initially manifests as a form of self-medication in individuals with PTSD.[708]

[704] Report of Professor McFarlane dated 15 July 2021 (Exhibit 12) at 18.
[705] Report of Professor McFarlane dated 15 July 2021 (Exhibit 12) at 20.
[706] Report of Professor McFarlane dated 15 July 2021 (Exhibit 12) at 43.
[707] Report of Professor McFarlane dated 15 July 2021 (Exhibit 12) at 64.
[708] Report of Professor McFarlane dated 15 July 2021 (Exhibit 12) at 18-19.

456. Professor McFarlane also considered the ADF had failed to create "a system and culture of transition from high combat exposed units [such] as 2 CDO and an understanding of the limited period during which most people can tolerate repeated combat exposures".[709] His evidence was that from the day CPL Turner joined the commandos he should have been assisted in understanding that there were limits to the period of service in high combat environments and with preparing him for transition. He likened this to players in the AFL pursuing an education while playing football, to ensure they have a career to move onto at the end of their professional sporting life.[710] Professor McFarlane's opinion was that the policies and procedures of the ADF do not take into account a long-term strategy for preparing individuals for transition. Rather, when an individual is "broken", they tend to be discharged. This did not allow, in his opinion, a soldier such as CPL Turner to consider alternative career paths within the ADF so as to sustain their service and capacity to remain within the workforce.[711]

457. His opinion was that individuals within the ADF who were responsible for CPL Turner's career management did not assist him properly to appraise the risks to his mental health or assign him to realistic roles that would have allowed him to continue serving other than as a commando. Professor McFarlane noted that CPL Turner had a great deal of combat experience that would have been of assistance in many domains.[712]

458. In relation to the adequacy of mental health treatment provided to CPL Turner, Professor McFarlane considered that this needed to be considered in the context of the "system of care" available to CPL Turner. He considered there were a number of issues with rehabilitation and the mental health programs at 2CDO (from his own research into that unit conducted in 2017) namely:[713]

    i. a lack of experience in the clinicians involved in the care, including the risk of junior clinicians being overawed by the culture and identity of special forces members;

    ii. the adequacy of clinical governance and quality assurance;

    iii. the workforce having little awareness of research programs and critical information emerging from the research and risks of ongoing combat exposures, a lack of trust between special forces soldiers and the health

[709] Report of Professor McFarlane dated 15 July 2021 (Exhibit 12) at 65.
[710] Report of Professor McFarlane dated 15 July 2021 (Exhibit 12) at 68.
[711] Report of Professor McFarlane dated 15 July 2021 (Exhibit 12) at 70.
[712] Report of Professor McFarlane dated 15 July 2021 (Exhibit 12) at 69.
[713] Report of Professor McFarlane dated 15 July 2021 (Exhibit 12) at 66-67.

practitioners, and a lack of understanding of the issues within Command of the accumulating risks to deploying personnel;

iv. the lack of security clearances for practitioners, and the need to go outside the ADF for psychiatric help with clinicians with whom soldiers could not adequately communicate;

v. health practitioners outside the military not having sufficient knowledge of the ADF and issues of veterans' mental health because there are unique assessment skills required by clinicians in those settings; and

vi. the concern within special forces by 2017 of the potential investigation and prosecution of war crimes.

459. Professor McFarlane also considered that a central tenet of understanding the mental health of a combat force is to understand the issue of cumulative stress exposure and the progressive recruitment of symptoms. In particular, he considered this was not simply a matter of whether an individual does or does not have a psychiatric disorder. The issue is whether the subsyndromal symptoms and the prior cumulative trauma exposure "do or do not pose a significant foreseeable risk to the individual's mental health".[714] He stated that there was no evidence that this perspective was undertaken or considered in CPL Turner's management. He considered this to be of particular importance following CPL Turner's admission in 2014 and the assessments made about the risk to him of future deployments. Professor McFarlane stated "in my opinion this was ill advised on many accounts".[715] Professor McFarlane stated he was perplexed by Dr Sringeri's assessment reports about CPL Turner's recovery in 2014, particularly because there was no discussion about the risk of CPL Turner having ceased his medication.[716]

460. In relation to the issue of security clearances, Professor McFarlane stated that it is very difficult to use trauma focused CBT with an individual where they have concerns about divulging matters that have significant security clearance issues around them. Professor McFarlane considered that a core element of PTSD is the re-experiencing of traumatic events that have led to the disorder. The disclosure of these events and the details are important aspects of treatment, in particular in exposure-based treatments. He considered that not being able to disclose information for reasons of security classification was an important impediment to receiving effective treatment.

[714] Report of Professor McFarlane dated 15 July 2021 (Exhibit 12) at 65-67.
[715] Report of Professor McFarlane dated 15 July 2021 (Exhibit 12) at 67.
[716] Report of Professor McFarlane dated 15 July 2021 (Exhibit 12) at 67-68.

His opinion was that a critical aspect of exposure based treatments is an exploration of all aspects of the traumatic memory. If an individual is specifically quarantining or withholding information, this disclosure may well be a critical issue to the necessary reprocessing of traumatic memories. He considered this was likely to decrease the effectiveness of psychological interventions.[717] Professor McFarlane referred specifically to Dr Malik's evidence to the effective of "there are some secretive missions, so I mean, I don't know how much…He was involved in some secretive mission from the army which I wasn't aware of".[718] He stated that this highlighted a barrier that existed because Dr Malik did not have security clearances.[719] In his opinion, it is not possible to effectively treat a veteran unless their traumatic exposure can be fully explored.[720]

461. Professor McFarlane noted that he had been sufficiently concerned about this issue for some time and had raised it in various forums, including by writing to the Attorney General during his time on a committee of the Australian Medical Association. He stated that if there is a perceived issue by the patient in a clinical setting in relation to the security risk, they are unlikely to fully disclose matters to the clinician. He considered that in the setting of CPL Turner's case, this would have impacted upon his willingness to engage with treating clinicians if there were reasons for him to have concerns about disclosure. In his view, this was an impediment to effective exposure-based psychological interventions.[721]

462. Professor McFarlane also stated that the interfaces between the various health systems which were involved in CPL Turner's treatment meant that there were inevitably discontinuities.[722]

463. In his opinion, once an individual has demonstrated suicidal thinking, there is a considerable risk to that individual if they are further exposed to a combat environment on deployment. This was particularly the case, in his opinion, when they had been diagnosed with PTSD.[723]

464. In relation to Joanna Turner, including the domestic violence that she suffered, his evidence was that it was critical an individual with PTSD be treated in the context of their family relationships. He noted that spouses and family members will often have

[717] Report of Professor McFarlane dated 15 July 2021 (Exhibit 12) at 73.
[718] 20/10/20 T123.43-44.
[719] Report of Professor McFarlane dated 15 July 2021 (Exhibit 12) at 46.
[720] Report of Professor McFarlane dated 15 July 2021 (Exhibit 12) at 48.
[721] Report of Professor McFarlane dated 15 July 2021 (Exhibit 12) at 73.
[722] Report of Professor McFarlane dated 15 July 2021 (Exhibit 12) at 68.
[723] Report of Professor McFarlane dated 15 July 2021 (Exhibit 12) at 69.

particular insights into the individual's difficulties and the impact on their family. He considered that these were matters that the ADF should take into account when considering future deployment.[724] He described domestic violence as a "major indicator of the probability of psychiatric disorder in a soldier".[725]

465. He considered it to be critical that the ADF have a way of supporting such transitions in a manner that assists and maintains an individual status and self-esteem. He considered that such considerations were not taken into account in the context of his deployment in 2016, when dealing with the charges against him, and when he was redeployed to C Company (noting CPL Turner considered this to be further punishment for the disciplinary proceedings). He stated that, in summary, the medical services available to CPL Turner were not fit for purpose.[726]

466. Professor McFarlane considered that there was a critical disincentive for CPL Turner to disclose his mental health difficulties by reason of the medical employment category that downgrades our soldiers' ability to be accepted on deployments. He noted that commandos are extremely committed to being part of the fighting group and minimise their psychological distress so as to ensure they remain identified as part of their company. He also noted the financial incentives to remain in the deployment cycle.[727] Professor McFarlane noted he is concerned about the capacity of Special Forces soldiers to manipulate the opinion and behaviour of health professionals undertaking their care.[728]

467. Professor McFarlane noted the heavy burden which has been placed on Special Forces soldiers in the context of the duration of a conflict in the Middle East area of operations. He considered that Command had failed to implement a strategy or plan to assist individuals when the cost of deployment had become excessive. He also noted that soldiers, and particularly commandos, have an unusual capacity to minimise or deny their own suffering and physical welfare.[729]

468. In relation to the approach of the clinicians (and other experts) Professor McFarlane noted that in his view, it was important to state that the management of CPL Turner's mental health from 2016 onwards presented a very difficult clinical challenge. He stated that his social alienation and increasing nihilism were the consequences of his lengthy career in the ADF and its impact on his mental health. He considered this

[724] Report of Professor McFarlane dated 15 July 2021 (Exhibit 12) at 69.
[725] Report of Professor McFarlane dated 15 July 2021 (Exhibit 12) at 24.
[726] Report of Professor McFarlane dated 15 July 2021 (Exhibit 12) at 70.
[727] Report of Professor McFarlane dated 15 July 2021 (Exhibit 12) at 70.
[728] Report of Professor McFarlane dated 15 July 2021 (Exhibit 12) at 30.
[729] Report of Professor McFarlane dated 15 July 2021 (Exhibit 12) at 70.

situation would have been extremely challenging and difficult for any clinician to treat and effectively manage. He was at pains to point out that the differences of opinion he expressed were with the aim of identifying systemic and overarching issues that needed to be addressed.[730] His main areas of concern with CPL Turner's treatment by external consultants were identified as follows:

i. In relation to Dr Sringeri, Dr Sringeri's involvement in CPL Turner's cessation of medication in 2015 so that he would be fit to undertake active duties in the ADF. Professor McFarlane noted it would have been possible to apply for a medical waiver that would have allowed continued prescription of medication. He also noted the importance of antidepressant medication in relapse prevention.[731] Dr Sringeri's assessment of CPL Turner in 2014 and 2015 of having "PTSD in remission" in circumstances where there was a risk of subsyndromal symptoms and relapse on further trauma exposure.[732] He also noted the difficult situation Dr Sringeri faced by being the person identified by the Court in 2015 as having legal responsibility to notify breaches of his treatment plan. In Professor McFarlane's view, this would have impacted CPL Turner's openness in his consultations.[733]

ii. In relation to Dr Large, Professor McFarlane noted that if decisions about suitability for military duty were outside Dr Sringeri's role then that should have been stated in his report to the ADF. He did not consider that Dr Sringeri had adequately set out the limits of his opinions as to suitability for duty in his reports to the ADF.[734]

iii. In relation to each of Dr Sringeri and Dr Malik, regarding the focus of each of those psychiatrists in prescribing medication as against psychotherapy, he stated he did not accept that a psychiatrist is not doing psychotherapy even if it is "at a minimum, supportive psychotherapy".[735]

469. Professor McFarlane had a number of recommendations arising out of his review of the material in relation to CPL Turner's death. The recommendations were as follows (emphasis in original):

> "[R]ecommendations addressing matters arising specifically from CPL Turners death could include:

[730] Report of Professor McFarlane dated 15 July 2021 (Exhibit 12) at 76.
[731] Report of Professor McFarlane dated 15 July 2021 (Exhibit 12) at 50.
[732] Report of Professor McFarlane dated 15 July 2021 (Exhibit 12) at 50.
[733] Report of Professor McFarlane dated 15 July 2021 (Exhibit 12) at 53.
[734] Report of Professor McFarlane dated 15 July 2021 (Exhibit 12) at 42.
[735] Report of Professor McFarlane dated 15 July 2021 (Exhibit 12) at 52.

1) An independent review be conducted into the Inquiry conducted by the IGADF and Joint Health Command into CPL Turner's death. This inquiry should ascertain what documents were or were not reviewed and what opinions were sought in regards to the quality of care provided to him.
2) Arising from these findings a set of recommendations should be made about how to improve the quality of the reviews and audits conducted within the IGADF and Joint Health Command and their overarching clinical governance.
3) Systematic steps be put in place to map the longitudinal history of an ADF soldier's deployments, including their RtAPS and POP screens data in conjunction with their reported psychiatric diagnoses and treatment provided.
4) An actuarial risk analysis be conducted within Joint Health Command of the optimal rotation cycle and number of deployments that can be undertaken by combat personnel without posing an undue risk to their mental health and to identify steps that can be undertaken to prolong their life and service in a combat environment.
5) In the event of a Commando or soldier being deployed following treatment for post traumatic stress disorder, an independent clinical assessment be made by a psychiatrist who is not directly involved in the individual's treatment, This is to protect the relationship between the clinician and the patient as being the gatekeeper to operational duties, which in turn can disrupt the disclosure of information.
6) Security clearances should be put in place for all clinicians treating Special Forces operators because of the potential security concerns within the patient's mind when disclosing information.
7) An integrated system of care to be put in place where the psychiatrist and other clinicians used by the ADF are not simply chosen by location but by specialist expertise demonstrated in the domains of military and veterans' psychiatry. This necessitates adequate training and experience be provided in these domains.
8) That families be actively engaged in the treatment program to provide them with support so as to ensure that all of the domains of the veteran's presentation are being addressed.
9) In the context of an ADF member having threatened or having attempted suicide there should be an independent needs-based assessment followed by interventions to meet the patient's needs and reduce exposure to the known risk factors. These include:
    i) Evidence-based treatment
    ii) Relationship counselling
    iii) Psychosocial support
10) An overview of the risk of suicide in ADF personnel should be made on the basis of the presence of a history of past attempts and/or ideation, a history of major depressive disorder and/or posttraumatic stress disorder, physical health difficulties and a history of traumatic stress exposures. The design of such an assessment should be done as is recommended by the Productivity Commission, which requires the more extensive use of data and a greater focus on outcomes.
11) The care of veterans should be oversighted with clinical measures. If there is a failure of improvement, a second opinion should be obtained, and a step-to-care model implemented. This should include novel and emerging treatments such as intravenous ketamine, which has been shown to have a significant impact on mood disturbance and suicidality.
12) There should be an increase in the number of uniform psychiatrists in the ADF with specialist training with trauma-related psychiatry in military and veterans' psychiatry. The barriers to employing such psychiatrists should be identified and overcome.
13) Assuming that CPL Turner's death is indicative of wider problems within the ADF, there should be ongoing monitoring of suicidality and suicidal risk and ADF personnel should (sic) be conducted as part of a continued health surveillance program.
14) A system of step care for PTSD to be established by the ADF to address treatment resistance, i.e. limited or non-response to first line evidence-based interventions. This should use a staged model of care for PTSD and other disorders. A method of ensuring early review by senior consultants be established to assist in the

management of high-risk patients (*Mcfarlane, A.C, Bryant R, PTSD: the need to use emerging knowledge to improve systems of care and clinical practice in Australia, Australas Psychiatry, 2017;25:329-331).*

15) The ADF should assess and manage the risk of the impact of the war crimes prosecutions of the mental health and suicide risk of those ADF personnel who may be impacted by these proceedings.

Finally, there have been various inquiries conducted into the issues of suicide and self-harm by current and former ADF personnel, which include:

- National Mental Health Commission report of 28th March 2017;
- Foreign Affairs, Defence, Trade and Reference Committee Report "*the constant battle: suicide by veterans"* August 2017;
- Productivity Commission Inquiry Report "*A better way to support veterans"* No. 93, 27th June 2019;
- The Inquiry into Transition by the Australian Defence Force (ADF Joint Standing Committee on Foreign Affairs, Defence and Trade) of April 2019 (to be reviewed).

Against the background of these inquiries, further recommendations could include the following:

1. To review and critique what information and research has been conducted into the suicide and suicidality of ADF personnel and veterans and its relationship to their mental health and the adequacy of treatment service to provide high standard care.

2. To enquire whether information about mental health and suicidality of ADF personnel and veterans has been optimally utilised. In the light of these findings to make recommendations about what research and quality assurance data could assist in identifying how the risk of suicide could be minimised and what changes in the system of health care are required.
3. To identify the barriers of the implementations of future, current and previous recommendations about implementing suicide prevention programs and improvements to mental health services. To make recommendations about how to address these barriers to implementation.
4. To make recommendations for how to optimally oversight the provision of mental health care by the ADF and DVA moving forward so as to ensure findings and recommendations that emerge about the causes of suicide and poor mental health can be appropriately implemented and operationalised.

These recommendations are broad matters that should have informed the care that was provided to CPL Turner and the risk of his death by suicide."[736]

(f) The expert conclave

470. The experts gave concurrent oral evidence over the course of two days.

The nature of PTSD

471. Dr Hopwood's evidence was that PTSD can undergo both "spontaneous resolution and resolution through treatment". He stated that the chances of spontaneous resolution diminishes the longer the disorder is present and thus the impact of treatment can be dependent on its timing in relation to the onset (that is, the earlier treatment is initiated, the better the outcome). His view was that once treatment is commenced, remission remains possible but that the highest rates of remission were

[736] Report of Professor McFarlane dated 15 July 2021 (Exhibit 12) at 74-76.

seen in individuals with single traumatic episodes and PTSD which is uncomplicated by other disorders.[737]

472. Dr Hopwood's evidence was that the prognosis for a person with a diagnosis of PTSD is highly variable but decreases with length of time having the disorder and the development of co-morbidities. He stated that a return to what is ostensibly a normal level of functioning is possible for individuals who achieve remission, but that those persons can still have a relapse of the condition most likely in association with other stressful life events or specific reminders of their trauma. Dr Hopwood stated that in relation to CPL Turner it is reasonable to state that if his PTSD had gone into remission prior to his 2016 deployment, it would have been appropriate to take into consideration the risk of relapse with this deployment.[738]

473. Dr Hopwood explained in relation to the concept "subsyndromal symptoms" that these are symptoms that do not meet the threshold criteria for a diagnosis of PTSD.[739]

474. It should be noted that Dr Sringeri was also asked about the nature of PTSD and its treatment. Dr Sringeri's evidence was that PTSD is "treatable" but rather than being curable *per se*, people can "function at normal level" with "minimum symptoms", but they will always be more vulnerable as a population. He considered that combat-induced PTSD made a person more vulnerable to future PTSD from combat-related circumstances.[740] His view was that psychological treatment was the mainstay for treatment of PTSD and that exposure therapy, CPT, and EMDR have good evidence in the management of PTSD.[741]

The interaction of PTSD, alcohol, and major depressive disorder

475. Professor McFarlane's evidence was that alcohol abuse is a recognised co-morbidity of PTSD. He stated that there is a well-established literature base demonstrating that alcohol misuse is a "consequence and a complication of PTSD".[742] He explained that alcohol abuse might be something that alerts family or social networks to the fact that a person may in fact be suffering from a psychiatric disorder.[743] In terms of alcohol abuse and the experience of PTSD, he considered that the evidence pointed to alcohol in fact mitigating the symptoms of PTSD because of anxiolytic effects of alcohol. However, when alcohol is consumed excessively, that creates a secondary set of

[737] Supplementary Report of Dr Hopwood dated 8 July 2021 (Exhibit 5) at 5-6.
[738] Supplementary Report of Dr Hopwood dated 8 July 2021 (Exhibit 5) at 6.
[739] 07/02/23 T35.
[740] 22/10/20 T326.27-42.
[741] 22/10/20 T240.15-19.
[742] 07/02/23 T16.
[743] 07/02/23 T16.

behavioural problems and difficulties (albeit not necessary worsening the condition of PTSD).[744] Dr Dinnen agreed with Professor McFarlane.[745]

476. Dr Large's opinion was that alcohol is only anxiolytic when it is being drunk, and that in alcohol withdrawal, anxiety is a prominent feature. He was also of the view that alcohol use can predispose a person to PTSD.[746] Dr Nielssen agreed with Dr Large.[747] Dr Dinnen did not agree that alcohol use can lead to PTSD, but considered it was a prodromal sign, that is, an indication that the person is coping with their psychiatric symptoms in an unhealthy way.[748] Dr Hopwood did not consider there was an established base in the literature demonstrating that alcohol abuse alone would predispose an individual to developing PTSD, other than by increasing the risk of being involved in a traumatic incident.[749] Professor McFarlane did not agree that alcohol abuse was something that would predispose an individual to developing PTSD (aside from the risk that people who abuse alcohol are more likely to be involved in accidents and therefore trauma exposure).[750]

477. Dr Large explained his opinion on this might differ from that of Professor McFarlane because he worked almost solely with in-patients, so none of the patients he sees are currently drinking alcohol (rather, they are admitted and the hospitalisation would withdraw those individuals from substances). He stated that his view that alcohol use is associated with an increased severity in PTSD symptoms was "probably heavily informed by seeing people with post-traumatic stress disorder withdraw from alcohol", not by seeing people who have PTSD and are continuing to drink alcohol.[751]

478. Dr Large, Dr Nielssen, and Dr Hopwood agreed that CPL Turner's alcohol abuse was likely responsive to his symptoms of PTSD in the period 2013 to 2017, and itself contributed to the severity of his PTSD.[752] Dr Dinnen disagreed and considered that the ongoing use of alcohol had an ongoing anxiolytic effect, so would not worsen PTSD. He stated that in his view, CPL Turner's alcohol use in 2013 to 2017 was not "anything other than a reflection of his disturbance", but rather was a form of "self-medication".[753] Dr Hopwood clarified that alcohol abuse was likely to lessen the prospects of engaging with treatment and have an impact on other areas of a person's

[744] 07/02/23 T17.
[745] 07/02/23 T20.
[746] 07/02/23 T17.
[747] 07/02/23 T19.
[748] 07/02/23 T20-21.
[749] 07/02/23 T21.
[750] 07/02/23 T18-19.
[751] 07/02/23 T335.
[752] 07/02/23 T21-22.
[753] 07/02/23 T22.

life and those things were unlikely to help with PTSD: he stated "the presence of a significant alcohol use disorder is likely to make the overall situation with PTSD worse, even if indirectly".[754]

479. In respect of CPL Turner specifically, Professor McFarlane considered that it was "very important to separate the symptoms of his post-traumatic stress disorder from the alcohol use disorder, because alcohol use disorder creates its own difficulties independent of PTSD".[755] In his view, CPL Turner's alcohol use disorder was not what made his PTSD worse, but rather it was his continued trauma exposure and continued deployment. He acknowledged that "his alcohol use certainly didn't help".[756]

The interaction of PTSD with domestic violence

480. Dr Hopwood considered there was an association of PTSD in veterans with domestic violence, but that this was an issue that "was long hidden and not discussed and researched well".[757] He also indicated that he had seen patterns where a person with PTSD, in response to their fear, will attempt to control the behaviours of their family, and can be expressed forcefully and might amount to "coercive control".[758] He also accepted that domestic violence might raise a red flag that PTSD is more active than is otherwise apparent.[759]

481. Professor McFarlane considered that domestic violence is a red flag for PTSD and other psychiatric disorders.[760] He noted a study which he had done of the fire service in South Australia revealed that a person's dysfunction associated with their PTSD symptoms was most apparent in their domestic environment: so they would be difficult to deal with and manage in their home environments, but be capable of functioning in their work environments. He considered that domestic violence is of particular significance because it may well "be the place where somebody's difficulties first become manifest".[761] In his view, the mere fact of the AVO having been sought in 2015 was a red flag which ought to have been taken into account in July 2016 when the decision to deploy CPL Turner was made.[762]

482. Dr Large accepted that domestic violence was a red flag for many things, including PTSD. However, he emphasised that the "XY chromosome and alcohol on a

[754] 07/02/23 T22.
[755] 07/02/23 T23.
[756] 07/02/23 T23.
[757] 07/02/23 T40.
[758] 07/02/23 T40.
[759] 07/02/23 T40.
[760] 07/02/23 T40-41.
[761] 07/02/23 T41.
[762] 07/02/23 T56.

population basis" were the causes of controlling and violent behaviour, that domestic violence is a huge societal problem, and that PTSD is not "the prominent cause of it".[763]

483. Dr Dinnen considered that PTSD was a potent cause of domestic friction but that the cases where there is actual domestic violence were "not frequent" and usually there were other factors involved.[764]

The risks of further deployments in the context of PTSD

484. Professor McFarlane explained research which had been done by way of tests of neural function on Special Forces soldiers and other members of the ADF and explained that one of the effects of prolonged deployments which had been shown was a diminished ability of target detection, as instead what happens is "they react to everything" and lose the ability to discriminate.[765]

485. Professor McFarlane emphasised in his oral evidence that CPL Turner had a heavy load of deployments and exposure to trauma. Professor McFarlane emphasised that it has been recognised in the psychiatric literature that there are limits of the period over which you can deploy people and that after a point further combat exposure places an unacceptable hazard to military personnel.[766]

CPL Turner's symptoms in 2015 and 2016

486. The experts were taken to a number of documents in relation to CPL Turner's mental state spanning the period from February 2015 to November 2015.[767] Dr Hopwood's evidence was that CPL Turner had symptoms of PTSD late in 2015.[768] Professor McFarlane agreed with this and indicated that the matters written in the VVCS records from CPL Turner's attendance in November 2015 indicated he was suffering from significant symptoms.[769] Dr Large accepted that it could not be said CPL Turner had no symptoms of PTSD over the period of 2015 leading into 2016 and that it could not be assumed that the reason CPL Turner declined further treatment was because he was managing.[770] In his view, the starting point was that, accepting CPL Turner had PTSD in 2014, it was fairly unlikely that his symptoms would remain resolved over long

[763] 07/02/23 T41.
[764] 07/02/23 T39.
[765] 07/02/23 T36.
[766] 08/02/23 T46-47.
[767] 07/02/23 T43-45.
[768] 07/02/23 T48.
[769] 07/02/23 T52.
[770] 07/02/23 T57-58.

periods of time.[771] Dr Nielssen considered CPL Turner had symptoms throughout 2015 and had understated them.[772]

487. In relation to self-reporting symptoms, Dr Hopwood accepted that there were limits to self-reporting and that one of them is if the reporting occurs in the context of employment in a career which is valued. In relation to how an interviewer could ascertain if a person had or did not have symptoms, Dr Hopwood accepted that there was no perfection in the skill of seeking out symptoms and it was possible for someone to conceal their symptoms.[773]

488. In relation to whether a doctor could attempt to obtain a corroborative history from other people, Dr Hopwood indicated this was not always straightforward and could be destructive to any future therapeutic relationship.[774] He accepted that information such as that which Joanna Turner had — that CPL Turner was suffering from nightmares and flashbacks in 2015 — would have indicated that CPL Turner had symptoms of PTSD.[775] Professor McFarlane considered that corroborative evidence was extremely valuable but recognised that the issues of consent are complex.[776]

489. Professor McFarlane indicated that underreporting is an endemic issue in the Special Forces community and that there was a major probability of CPL Turner underreporting his symptoms in 2015 and 2016.[777] He considered it significant that he did not find in the health records a record of the information which Joanna Turner had provided to BRIG Langford or information which she had been providing to Selena Clancy or the Chaplain (Padre). He further considered that the records around CPL Turner's return from deployment in 2015 were "remarkably naïve", in that there ought to have been evidence of inquiries into the welfare of Joanna Turner and her children, as this may have led to exploration of CPL Turner's own difficulties.[778] Professor McFarlane considered that there was a substantial body of evidence in the health records which demonstrated residual or recurrent PTSD symptoms throughout 2016, and that "it's not to be critical of the individual health practitioners and I think, they have to, you know, deal with this in a clinical context" but rather "it's the failure of anybody to actually

[771] 07/02/23 T58.
[772] 07/02/23 T59.
[773] 07/02/23 T49.
[774] 07/02/23 T50.
[775] 07/02/23 T1-52.
[776] 07/02/23 T56.
[777] 07/02/23 T54-55.
[778] 07/02/23 T53-55.

take an oversight of these records and I think that's a particularly important issue when it came to the decision to re-deploy him".[779]

The 2016 clearance to deploy on OP OKRA

490. Professor McFarlane's opinion was that based on CPL Turner's presentation in 2014, the probability of him being fit to deploy in 2016 was low, but it was necessary to give him the benefit of the doubt and assess him.[780] In doing that assessment, it would have been important to consider all of the information available in the health record.[781]

491. In his view, it was very naïve to think that being deployed would be good for CPL Turner's mental health. He recognised that it might have been a further trauma for CPL Turner if he could not deploy with his teammates. However, he considered this was a matter that had to be managed with soldiers and that managing a transition out of a deployment cycle is something that did not happen for CPL Turner.[782] In his view, it was incorrect to consider that it was better for CPL Turner's mental health to deploy than to not deploy.[783] He referred specifically to the assumption that being in Iraq might be good for CPL Turner because he would get away from alcohol and stated that, in his view, CPL Turner "needed a lot more going into an environment with an abstinence of alcohol and a detox facility probably would have been a better idea than thinking that…Iraq was going to be a detox deployment".[784]

492. In relation to Dr Sringeri's 13 July 2016 letter, Professor McFarlane considered that Dr Sringeri was in an "invidious position" because he did not have access to all of the information in the ADF health records. He considered that Dr Sringeri's opinion was at risk of underestimating his difficulties. In his view, this was one of the problems with the ADF outsourcing aspects of clinical care because Dr Sringeri would not have understood the complexity of the issues involved, in particular in taking account of CPL Turner's prior exposures and the nature of the activities on those deployments, as well as the secretive nature of the activities he might be involved in on the Iraq deployment in 2016.[785]

493. Professor McFarlane considered that it was not the role of an individual psychiatrist to make a recommendation about whether or not an ADF member was fit to deploy.[786] In

[779] 07/02/23 T53.
[780] 07/02/23 T63.
[781] 07/02/23 T63.
[782] 07/02/23 T63-64.
[783] 07/02/23 T64-65.
[784] 07/02/23 T65.
[785] 07/02/23 T54.
[786] 08/02/23 T7.

his view, a civilian psychiatrist can provide valuable information about what they know about the patient's condition, but that it was the role of the military to undertake the specific risk analysis based on whether the person should or should not deploy.[787]

494. Professor McFarlane's view was that, assuming the entry in the brief of evidence which records the referral request from the ADF to Dr Sringeri on 11 July 2016 was the full referral letter, he considered it was manifestly inadequate.[788] He explained that it ought to have had a specific set of facts, including things that Dr Sringeri might not know (even as CPL Turner's treating clinician), which were contained in the ADF medical records.[789] He was asked whether a civilian psychiatrist can reach a view about fitness to deploy. His answer was firmly to the effect that a civilian psychiatrist can provide information, but that information should be fed into the military system for determining waivers. In his view, "if we are to make the system better…getting these sorts of things right is absolutely critical" and it was important to have psychiatrists actually employed in the military.[790] In his view, the decision on whether to deploy CPL Turner was not "about his fitness to deploy" but rather the medical employment classifications in the ADF and also about the "risk of reinjury and the recognition of the long-term costs and consequences to personnel" and that these issues were not addressed in the referral letter to Dr Sringeri.[791]

495. Dr Large's opinion was that fitness to deploy is not solely the province of psychiatry. In his view, a psychiatrist asked to give a view about whether or not CPL Turner was fit to deploy in 2016 should have known about what was going to be required of the solider on the deployment: but that "probabilistic decisions about that sort of thing are, you know, they're up to the armed forces and up to the individual as much as the psychiatrist".[792] In his view, the use of the term "very low" in the context of risk of relapse as at July 2016 was problematic because CPL Turner was always at risk of relapse and probabilistic statements are difficult to interpret, and that CPL Turner was not likely to ever be at a "low risk" of relapse, even in civilian life.[793] In his view, it would have been possible for a psychiatrist to form a view that the psychiatric harm would be greater to CPL Turner by not deploying than deploying.[794] Dr Large explained under cross-examination by Senior Counsel for the ADF that "fitness" seems to contain at least two elements, one being capacity and the other being risk. In his view, it was very

[787] 08/02/23 T9.
[788] 08/02/23 T12.
[789] 08/02/23 T18.
[790] 08/02/23 T12-13.
[791] 08/02/23 T13.
[792] 07/02/23 T67.
[793] 07/02/23 T67-69.
[794] 07/02/23 T70.

clear that CPL Turner had the capacity to deploy but as to risk, "we really allow patients to carry their own risk".[795]

496. Dr Nielssen's opinion was that CPL Turner was "perfectly fit" but that "even without hindsight bias I would say that it wouldn't do him any good, that accumulative effects of multiple deployments and the cumulative traumas greatly increase the probability of enduring psychological harm".[796] In his view, the risk of further trauma would simply increase the probability of a disabling PTSD in the longer term.[797] In his view, there was a reasonable view that another deployment may have been better for his mental health than not deploying.[798] He later clarified that "it wouldn't have done him any good, but whether he was fit from a military point of view and whether there was a possibility that going on the deployment might have made him feel better, both those views were available".[799] He considered that CPL Turner was at a real risk of relapse if deployed in 2016.[800] He stated that it was not accurate to say that CPL Turner's chances of recurrence of PTSD were very low.[801]

497. Dr Nielssen appeared to draw a distinction between the concept of being fit to perform duties and whether performing those duties carried a risk of harm to the individual. He considered it important to consider the perspective of who was doing the assessment: "if you're doing the assessment on behalf of the army to try and fill the roster of people deployed, well, obviously, you say well, you'll do a good job and he's a really good soldier. If you're worrying about him and the effect on him and its likely effect, then that's a different story" and you would say "this could be bad for you…you should think about going to do something a bit quieter and don't expose yourself anymore to this sort of danger".[802] He explained that in his view, CPL Turner was fit to deploy but "the customer is always right…and it was his wishes that were respected, his clear wishes that he wanted to be deployed".[803]

498. Dr Dinnen indicated that CPL Turner's symptoms as contained in the ADF medical records for the period of 2015 should have been taken into account in the decision of whether or not CPL Turner should have been deployed in 2016.[804] Dr Dinnen's view was that he was "fit for deployment" and that, as a psychiatrist, his first responsibility

[795] 08/02/23 T23.
[796] 07/02/23 T71.
[797] 07/02/23 T71.
[798] 07/02/23 T71.
[799] 07/02/23 T72.
[800] 07/02/23 T71.
[801] 07/02/23 T73.
[802] 07/02/23 T73.
[803] 08/02/23 T24.
[804] 07/02/23 T60.

was “to the interests of the person we’re looking after” and that CPL Turner would have been “convincing to me that he was capable of doing it”. However, he would have said to him “this is not good for you. You’ve been damaged enough. Do you really want to do this”.[805] Again, Dr Dinnen (like Dr Nielssen) appeared to draw a distinction between CPL Turner being fit to deploy (that is, capable of doing his job) and the risk to him of that deployment.[806] He stated that he would have told him about the risks of deployment and said in his report “I’m concerned about the consequences of this deployment, but he considers himself fit” and that “he’ll need careful monitoring when he returns”.[807] In his view, the chances of recurrence of PTSD on deployment were not very low and he would have advised him that deployment was likely to make things worse if he had seen him.[808]

499. Dr Hopwood agreed that it was appropriate to take a person’s adherence to treatment into account in assessing the wavier to deploy in 2016.[809] In his view, it was an available view that CPL Turner was fit to deploy, but it was not an available view that the deployment had a very low risk of worsening of his mental health. In his view, he considered it was optimistic to consider that the environment of deployment on OP OKRA was any less likely to be a traumatic environment than being “closer to the frontline”. In his view, the likelihood of recurrence was “very high”.[810] He indicated that he would feel a responsibility to let the ADF know that the risk of recurrence of PTSD, depression, and alcohol abuse was very high,[811] although he later clarified he would more accurately say “moderate to high risk of relapse, certainly not very low”.[812] Dr Hopwood was asked if a psychiatrist indicated to the ADF that a person was “fit for all duties from a psychiatric point of view”, whether the ADF was entitled to take that opinion at face value for someone who has had PTSD, or whether a psychiatrist should identify specific risks of relapse. Dr Hopwood stated he saw his role as a psychiatrist to inform the ADF about the risks, but believed that they would bring experience and knowledge to the table and have “operating principles that they apply”.[813] He stated that the “decision to deploy or not is, of course, that of the ADF”.[814] Ultimately, he accepted his evidence was that there may come a point where a person’s mental health is so bad they should not deploy, but above that point the role of a consultant

[805] 07/02/23 T77.
[806] 07/02/23 T77.
[807] 07/02/23 T77.
[808] 07/02/23 T80.
[809] 07/02/23 T48.
[810] 07/02/23 T82-83.
[811] 07/02/23 T83.
[812] 07/02/23 T84.
[813] 08/02/23 T4.
[814] 08/02/23 T4.

psychiatrist is to advise of the risks and consequences from a psychiatric perspective and then to indicate the question of deployment is one for the ADF.[815]

500. Dr Hopwood did not consider there was a reasonably available view that it would be better for CPL Turner's mental health to deploy in July 2016 than to not deploy.[816]

The disciplinary proceedings

501. Dr Nielssen did not consider there was a direct relationship between PTSD and susceptibility to risk-taking behaviour and impulsivity.[817] Dr Dinnen stated he was aware of literature demonstrating an increased risk of violence in traumatised veterans in America.[818] However, he agreed with Dr Nielssen that for most people who have been traumatised, they are more vigilant, more cautious, and less impulsive.[819] In his view, the relationship between PTSD and violence or unlawful behaviour is complicated and that one reaction to trauma is anger and a desire to seek vengeance, which is not really a "factor of PTSD so much as a response to traumatic events which they've witnessed".[820]

502. Dr Hopwood considered there was an association of impulsivity and risk-taking behaviour in individuals with PTSD. He distinguished this from a person avoiding specific reminders of their trauma, but considered that impulsive behaviour, including irritability, was a "very real and prominent feature for some people in their PTSD".[821] In his view, a person who had no symptoms of PTSD but a past history of PTSD would still be at risk of a recrudescence of symptoms and a recrudescence of the impulsivity associated with that.[822] Further, if a person still had symptoms (even subsyndromal symptoms), it would be more likely the person was at risk of acting impulsively.[823]

503. Dr Dinnen's view was that having had PTSD, CPL Turner was at an increased risk of anger and irritability in 2016 and it would have increased his emotional response.[824]

504. Professor McFarlane's evidence was that there is a clear link between PTSD and the propensity for people to do things that are completely out of character.[825] He explained that part of PTSD is "numbing, where people feel dead", and so they will "do things

[815] 08/02/23 T5.
[816] 08/02/23 T6.
[817] 07/02/23 T32.
[818] 07/02/23 T32.
[819] 07/02/23 T33.
[820] 07/02/23 T33.
[821] 07/02/23 T3.4
[822] 07/02/23 T34.
[823] 07/02/23 T34.
[824] 07/02/23 T33.
[825] 07/02/23 T35-36.

that make them feel alive again".[826] Dr Large accepted there was a relationship between impulsivity and exposure to trauma.[827]

Use of steroids

505. Professor McFarlane's evidence was that the use of steroids can have "significant psychotropic effects", "increase people's aggressiveness", and "increase their disinhibition".[828] He considered the effects of steroid use on symptoms of PTSD is "really unclear", but that the drugs had "other adverse effects on his mental state".[829] He noted that there was an important question about CPL Turner's motivation for steroid abuse, noting that it commenced after he had experienced significant trauma and may have been motivated by a sense of seeking revenge, by increasing his physical strength and endurance in the battlefield.[830]

506. Dr Hopwood was not sure about whether PTSD could have caused CPL Turner to engage in steroid use and noted that, in his experience of treating ADF special forces, he had met other members who used anabolic steroids, so he found it difficult to be certain about the relationship between PTSD and steroid use.[831]

Use of other drugs

507. Dr Hopwood considered that there was a potential link between CPL Turner's use of cocaine and his PTSD, referring to the euphoriant effects of cocaine.[832] He also noted that use of illicit drugs which are difficult to discuss made treatment difficult because a person may not disclose that use and it can make developing a trusting and effective therapeutic relationship difficult.[833]

(g) Professor Naren Gunja

508. Professor Gunja was engaged by the ADF and provided one report to the Inquest dated 16 December 2022.[834] He was asked a number of questions in relation to the effects or likely effects on a person of steroids and fitness supplements, and the interaction of various medications. Dr Gunja was not required to give oral evidence to the Inquest.

[826] 07/02/23 T35.
[827] 07/02/23 T38.
[828] 07/02/23 T25.
[829] 07/02/23 T25.
[830] 07/02/23 T25.
[831] 07/02/23 T31.
[832] 07/02/23 T30-31.
[833] 07/02/23 T32.
[834] Exhibit 64.

PRELIMINARY MATTERS

509. There are a number of preliminary matters to be addresses prior to a consideration of the issues explored at the Inquest. Those matters concern:

i. the Commonwealth's submissions regarding procedural fairness; and

ii. the parties' submissions that Counsel Assisting's submissions are tainted by an unacceptable degree of hindsight bias.

Procedural fairness

510. The Commonwealth's submissions complain that evidence was not led during the course of the Inquest from individuals "who would have been able to shed light on relevant events"[835] and that, as such, there are now "consequences for the findings, comments and recommendations that [I am] now in a position to make."[836] Particular findings and comments were thereafter identified as not being open to me on this basis.[837]

Submissions

511. Counsel Assisting has provided submissions on this issue.[838] Counsel Assisting notes that objections of this nature call for attention to two specific considerations:

i. identification of the precise subject to whom procedural fairness is said to be owed; and

ii. identification of the content of the obligation owed to that subject.

512. In the coronial context, the subject to whom the obligation is owed is one against whom an adverse finding or comment may be made. Such a person is entitled to be heard against the making of such a finding.[839] It follows that a "coroner is not bound to observe the rules of natural justice in relation to each and every person who may be referred to during the course of the inquiry. Such an obligation arises *only* when an adverse finding against the person in question is contemplated."[840] The ability of a witness or evidence to "shed light" on a subject matter is, in and of itself, insufficient to give rise to an obligation of procedural fairness to that witness.

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[835] Submissions of the Commonwealth dated 7 June 2024 at [30].
[836] Submissions of the Commonwealth dated 7 June 2024 at [31].
[837] See, e.g., Submissions of the Commonwealth dated 7 June 2024 [111], [125(a)], [153], [158], [171], [176(d)], [185], [191], [215], [221], [236], [245], [474], [484]-[485], [546], [639], [665], [722], [732], [795], [804], [818].
[838] Submissions in reply of Counsel Assisting dated 22 August 2024 at [3]-[14].
[839] *Annetts v McCann* [1990] HCA 57; 170 CLR 596 at [7]-[9] (Mason CJ, Deane and McHugh JJ).
[840] *R v Somes; ex parte Woods* [1998] ACTSC 160 at [27] (Crispin J) (emphasis added).

513. The content of the obligation extends only to the ability of the subject of a proposed adverse finding or comment to be heard on *that* topic – it is not a plenary "right to make submissions on the general subject matter of the inquest."[841]

514. Counsel Assisting contends that the obligation does not arise in a vacuum. Rather, it is to be balanced against the obligation on a coroner to appropriately confine the scope of the inquiry to meet its "primary duty"[842] in s 81 of the *Coroners Act 2009* (NSW) (***Coroners Act***), lest a coroner "be constantly torn between the need to contain the scope of the inquiry and the need to ensure that all interested parties were treated fairly."[843]

515. Counsel Assisting points out that, as the Commonwealth accepts,[844] the purpose of the inquiry is not "to conduct a wide-ranging inquiry akin to that of a Royal Commission"[845] and it is "important that extraneous factors do not get in the way of that primary duty".[846] To that end, a coroner, through the exercise of "proper discretion and commonsense",[847] is entitled to limit the ambit of the inquiry and have regard to "the importance of keeping the inquiry within reasonable bounds and expense".[848] If potential evidence that Counsel Assisting might have called has "no reasonable likelihood of influencing the outcome" of the inquiry, there is no obligation to procure that evidence even if it is potentially relevant to the subject matter of the inquiry.[849] Counsel Assisting considers that such considerations are to be borne in mind when determining the degree to which I am required to hear further evidence on a particular issue in order to satisfy obligations of procedural fairness.

516. Viewing the Commonwealth's submissions in the context of the above principles, Counsel Assisting makes the following observations.

517. *First,* to the extent an adverse comment or finding is sought in Counsel Assisting's submissions, the subject of that comment or finding has been relevantly identified in those submissions. In this respect, a distinction needs to be drawn between the conduct of an individual within an organisation and the conduct of an organisation as a whole. While it is accepted that an organisation acts through individuals, an adverse finding as to a deficiency in the conduct of an individual in the performance of their role

[841] *Annetts v McCann* [1990] HCA 57; 170 CLR 596 at [9] (Mason CJ, Deane and McHugh JJ).
[842] Submissions of the Commonwealth dated 7 June 2024 at [21].
[843] See *R v Doogan; ex parte Lucas-Smith* [2005] ACTSC 74; 158 ACTR 1 at [28] (Higgins CJ, Crispin and Bennett JJ).
[844] Submissions of the Commonwealth dated 7 June 2024 at [18], [22].
[845] *R v Doogan; ex parte Lucas-Smith* [2005] ACTSC 74; 158 ACTR 1 at [28] (Higgins CJ, Crispin and Bennett JJ).
[846] *Commissioner of Police v Attorney General for New South Wales* [2022] NSWSC 595 at [99] (Wright J)).
[847] *Conway v Jerram, Magistrate and NSW State Coroner* [2011] NSWCA 319 at [48] (Young JA).
[848] *Gallagher v The Coroners Court of the Australian Capital Territory* [2022] ACTSC 160; 370 FLR 115 at [30] (McCallum CJ).
[849] *Doomadgee v Clements* [2006] QSC 357; 2 Qd R 351 at [52] (Muir J); *Inquest into the death of Kumanjayi Walker (Ruling No 7)* [2023] NTLC 11 at [4]-[5] (Judge Armitage).

within the organisation is different in terms to an adverse finding that an organisation as a whole acted in a deficient manner. Accordingly, to submit that an adverse finding cannot be made against an individual and therefore "through them the ADF"[850] risks eliding the intended subject of the proposed comment or finding.

518. An example of the importance of focussing on the correct subject of the finding or comment is illustrative. The Commonwealth submits that because evidence was not led from "medical personnel involved in the RtAPS/POPS screenings conducted between 2008-2013", adverse findings or comments cannot be made against the "the relevant personnel (and, through them the ADF)".[851] This is apparently responsive[852] to Counsel Assisting's submission that there "were early warning signs" in these screenings that CPL Turner "was experiencing significant trauma and was slowly developing the symptoms of PTSD".[853] Counsel Assisting notes that, when that submission is read in context,[854] the relevant finding is that during this period it appeared the ADF did not have "in place any longitudinal method of identifying individuals who were at particular risk of deterioration in their mental health". Clearly, these paragraphs do not identify a particular deficiency in the care provided by the medical personnel involved in any particular RtAPS/POPS screening *per se*. Rather, they focus on an identified systemic issue in the ADF. It is not necessary that such a deficiency is identified "through" the conduct of any particular individual as the Commonwealth submits.

519. *Second,* it is submitted that to the extent that I would make a comment or finding as to the *institutional* response of the ADF, the discharge of the obligation of procedural fairness to the ADF does not require that Counsel Assisting call all available witnesses who might "shed light" or give evidence relevant to a particular topic. It is submitted that unless a coroner formed the view that there was a reasonable likelihood, based on the evidence that has been adduced, that the evidence of an uncalled witness could influence the outcome of a proposed finding, a coroner is entitled to limit the ambit of the inquiry and proceed in the absence of that evidence. Counsel Assisting submits that a coroner is not obliged to hear from each and every individual involved in an organisational process in order to form a view about the adequacy of that organisational process. Such an obligation would render the coronial process unworkable and would bespeak the "wide-ranging inquiry" or "discursive

[850] See e.g. Submissions of the Commonwealth dated 7 June 2024 at [102], [171], [191], [484].
[851] Submissions of the Commonwealth dated 7 June 2024 at [111].
[852] Submissions of the Commonwealth dated 7 June 2024 at [102].
[853] Submissions of Counsel Assisting dated 2 November 2023 at [443].
[854] Submissions of Counsel Assisting dated 2 November 2023 at [444].

investigation"[855] that is eschewed in the coronial context. It also pays insufficient regard to the extensive documentary evidence in this case.

520. *Third,* while the Commonwealth makes a general complaint as to the timing and specificity of issues being identified in respect of which there may be adverse findings,[856] the focus of the obligation of procedural fairness is on the ability to which the relevant party has to adequately respond to such anticipated findings. In the coronial context, the matters in issue are not predetermined in advance of a hearing by a pleading or indictment,[857] they develop throughout the hearing process. In that context, "procedural fairness [does] not require the […] Coroner to disclose during the hearing what [their] mental processes were concerning the resolution of the issues in the matter before [them]".[858] Nor where a party is aware of the relevant issues is a coroner required to put forward findings on a preliminary basis for comment.[859] It is "only when the coroner has reached the stage of contemplating the making of an unfavourable finding" or where it is being "seriously considered"[860] that the obligation of procedural fairness arises. As such, it is submitted that where the issue has been identified at a point in time of the coronial process which allows the relevant party sufficient opportunity to respond,[861] the obligation will ordinarily have been satisfied. Counsel Assisting notes that each of the interested parties have been given the opportunity to provide lengthy and detailed submissions in reply to issues raised during the Inquest, and at the very latest in submissions of Counsel Assisting provided to the parties some seven months before responsive submissions being filed.

521. *Fourth,* to the extent that an adverse finding or comment possibly arises with respect to an individual, such individuals have been given the opportunity to be heard on the substance of such a matter in this Inquest. It is to be noted that the rule in *Browne v Dunn* (1893) 6 R 67 has no direct application in the non-adversarial coronial context, although there remains the subsisting obligation to afford witnesses procedural fairness.[862] Accordingly, contrary to the objection raised at times by the Commonwealth,[863] Counsel Assisting submits that where a witness has been given the opportunity to give their account of a version of events and the topic on which any

[855] *R v Doogan; ex parte Lucas-Smith* [2005] ACTSC 74; 158 ACTR 1 at [28] (Higgins CJ, Crispin and Bennett JJ).
[856] Submissions of the Commonwealth dated 7 June 2024 at [24]-[27], [33].
[857] *Commissioner of Police v Attorney General for New South Wales* [2022] NSWSC 595 at [83] (Wright J).
[858] *Onuma v The Coroner's Court of South Australia* [2011] SASC 218; 111 SASR 382 at [98] (Kelly J).
[859] *Commissioner of Police v Coroners Court of South Australia* [2020] SASCFC 64; 138 SASR 535 at [78] (Kourakis CJ; Parker and Hughes JJ) (citing *Musumeci v Attorney General of NSW* [2003] NSWCA 77; 57 NSWLR 193).
[860] *Musumeci v Attorney General of NSW* [2003] NSWCA 77; 57 NSWLR 193 at [113] (Ipp JA, Beazley JA agreeing).
[861] See e.g. *Onuma v The Coroner's Court of South Australia* [2011] SASC 218; 111 SASR 382 at [97] (Kelly J).
[862] *Commissioner of Police v Coroners Court of South Australia* [2020] SASCFC 64; 138 SASR 535 at [83]-[84] (Kourakis CJ; Parker and Hughes JJ); *Mead v Mulligan* [2013] WASC 460 at [80(f)] (Kenneth Martin J).
[863] See e.g. CS [93], [532].

adverse finding may be made has been raised in the course of doing so, Counsel Assisting is not obliged to recall such a witness to put each possible conclusion that the coroner might draw from their evidence to them.

Consideration

522. I have carefully considered the Commonwealth and Counsel Assisting's comprehensive submissions on this matter. I accept that while the rules of evidence do not strictly apply in coronial proceedings,[864] there is well established authority that persons having a "sufficient interest" must be afforded procedural fairness in coronial proceedings and that an inquest must be conducted in a manner which allows such persons to be heard should an adverse finding be contemplated. However, I reject the Commonwealth's suggestion that I am restricted from making findings and recommendations in relation to the ADF where not every witness who may have been able to give evidence on a certain issue has been called. I accept Counsel Assisting's submission that I am not obliged to hear from each and every individual involved in an organisational process in order to form a view about the adequacy of that process. This would place an onerous burden on the Court and make coronial proceedings unworkable. I pause to say that I am unaware of any request from the Commonwealth to call a witness which was refused.

523. In any event, I have taken into account specific Commonwealth submissions on this issue as they arise and I am content that any adverse finding I make is properly grounded in the evidence and is made only when issues of fairness have been carefully considered.

Hindsight bias

524. The Commonwealth and some of the interested parties have referred to the concept of "hindsight bias" and criticise the approach of Counsel Assisting in both the conduct of the Inquest and written submissions.[865]

Submissions

525. Counsel Assisting has provided submissions addressing these criticisms.[866]

[864] *Coroners Act* NSW (2009) s 58.
[865] See, e.g., Submissions of the Commonwealth dated 7 June at [56]-[57]; Submissions in reply of GPCAPT Ross dated 22 July 2024 at [17]; Submissions in reply of Dr Hale dated 19 July 2024 at [6]; Submissions of CAPT MH dated 7 June 2024 at [3].
[866] Submissions in reply of Counsel Assisting dated 22 August 2024 at [15]-[20].

526. The Commonwealth refers to certain case law[867] that is concerned with actions in negligence, the purpose and outcome of which are to attribute responsibility in the form of tortious liability to a particular person. Counsel Assisting submits that avoiding hindsight bias in that context ensures that reasonably acting defendants are not unfairly subjected to adverse liability judgments, the role of a coroner is not to attribute liability or blame for a death to any person or organisation.[868]

527. In submissions in reply, Counsel Assisting submits that "the Coroner should be astute to avoid hindsight bias in judging the actions of any particular person or organisation in the process of making a finding which results in adverse criticism of their conduct, at the time their conduct was engaged in."[869] It is submitted that a finding of that kind would be unfair for essentially the same reasons as hindsight bias is to be eschewed in the context of actions in negligence. It is not the case that a coroner is required to approach the findings to be made as if the coronial process is not one that is obviously being conduct with the benefit of hindsight. Rather, a coroner looks back at what happened in respect of a particular death with the benefit of all the facts available to them and determine what findings should be made about manner and cause and what recommendations (if any) should be made arising out of the death of a person.[870]

528. Counsel Assisting submits that it would be artificial, and pointless, to attempt to approach the Inquest and the findings as if they were not what they plainly are: a retrospective analysis of the manner and cause of a death, with a view to making recommendations as to the future to address the matters arising from those findings as to manner and cause of death. They note it would deprive the coronial process of much of its utility if an inquest were confined to assessing all the facts from the perspective of those individuals involved at the relevant time, because it would deprive the coroner of the ability to formulate sensible recommendations or generate learnings from the tragic circumstances with which this jurisdiction is concerned.

529. In this respect, Counsel Assisting refers to the comments of State Coroner Barnes in the *Inquest into the deaths arising from the Lindt Café Siege* (2017), in which his Honour stated at [25]:

> "relying on the benefits of hindsight is understandable but unnecessary. The inquest compiled a more complete picture of the events of 15 – 16 December than was available to any individual at the time. The insight this knowledge afforded can be applied to the benefit of police and the public. Such use of hindsight is fair and proper.

[867] *Rosenberg v Percival* (2001) 205 CLR 434 at [16] and *Tapp v Australian Bushmen's Campdraft & Rodeo Association Limited* (2022) 273 CLR 454 at [60].
[868] Submissions in reply of Counsel Assisting dated 22 August 2024 at [15].
[869] Submissions in reply of Counsel Assisting dated 22 August 2024 at [16].
[870] See Abernethy et al, *Waller's Coronial Law and Practice in New South Wales* (4th ed, 2010) at [I.124]-[I.125],

> Using hindsight to criticise individuals by reference to things that they did not know and could not reasonably have been expected to know would be unfair. That has not been done in this report."

530. Counsel Assisting also refers to the findings of State Coroner O'Sullivan in *Inquest into the death of CS* (2022), in which her Honour stated at [10]-[11]:

> "A coronial inquest takes places, necessarily, after the event. It follows that, unavoidably, a coronial inquest is conducted with the benefit of hindsight.
>
> However, in performing the role set out in ss. 81 and 82 of the Act, it is accepted that a Coroner must judge the appropriateness of steps taken or not taken by an involved person or organisation against the information that was available to that individual or organisation at the time, and not, as has been pointed out in submissions, through the prism of the tragic outcome of the case. Indeed, coronial inquests routinely examine whether, armed with the knowledge available to the relevant individual or organisation at the time, a party could have or should have acted differently in the particular circumstances that presented themselves. This is, in my view, entirely appropriate, and indeed a fundamental aspect of the coronial jurisdiction."

531. Counsel Assisting submits that any finding involving the criticism of a person or organisation's conduct of a particular matter is not to be infected with hindsight bias in order to ensure it is not an unfair criticism. Counsel Assisting further submits that, with the benefit of all of the hindsight that the coronial inquest brings, findings as to the appropriateness or otherwise of the conduct of persons or organisations and recommendations in respect of future conduct of persons or organisations involved in the Inquest should be made. It is submitted that such a finding is not unfair and can acknowledge the contemporaneous limitations upon those involved in those decisions having regard to what they knew at the time they engaged in relevant conduct.[871]

Consideration

532. In my view, criticisms of the approach taken by Counsel Assisting on this issue are misplaced and demonstrate a conceptual misunderstanding of the work of a coronial court. There is no doubt that the Inquest was able to compile a more complete picture of the events leading up to CPL Turner's death than would have been available to any single individual at the time. This is the strength of the kind of review which can occur in this Court. It allows a coroner to have a broad overall understanding of events which can be particularly useful in identifying the true circumstances of a death, any systemic issues that may arise, and the possible need for recommendations. It does not mean that particular individuals are thereby judged as though they too had the benefit of this overview at the time they were making relevant decisions.

[871] Submissions in reply of Counsel Assisting dated 22 August 2024 at [20].

533. I am perfectly confident that a retrospective analysis of the cause and manner of death can take place with a view to making recommendations, at the same time as evidence is collected which demonstrates what individuals knew at any particular time. I accept Counsel Assisting's submissions on this matter.

Conclusions of other inquiries and foreseeability

Submissions

Submissions of Mr and Mrs Turner

534. Mr and Mrs Turner submit that I should consider the publicly available material regarding veterans' suicide, in particular the information that was available to the ADF before CPL Turner's death concerning those matters.[872] For example, they draw attention to parts of the *Review of Mental Health Care in the ADF and Transition through Discharge* of Professor David Dunt (**Dunt Report**) (which formed part of the ADF Mental Health and Wellbeing Strategy implemented in 2011) that is drawn upon in the statement of Professor McFarlane.

Submissions of Counsel Assisting

535. Counsel Assisting submits that insofar as the submission suggests that publicly available material would be used as a basis of an adverse finding, I am limited to the evidence that was adduced during the Inquest.[873] They consider that any aspects of the Dunt Report not contained in or adopted by Professor McFarlane ought not be relied upon in my findings.[874] I accept that submission.

536. Mr and Mrs Turner also refer to other reports and inquiries referred to by Professor McFarlane in his report, including the report *"Suicidality in the Australian Defence Force: results from the 2010 ADF Mental Health Prevalence and Wellbeing Dataset*" of May 2012 (which made a number of observations pertinent to the risk factors identified in CPL Turner's suicide), the report *McFarlane and Bryant. Predicted trajectories of morbidity for the Australian Defence Force 23rd May 2013*, and an extensive research program conducted as the part of the Deployment Health Surveillance Program examining members of 2CDO prior to 2010 to 2011. Mr and Mrs Turner contend that, as a result of these other investigations, the ADF was "forewarned of risk factors" and that "the ADF were left wanting in handling the known risks".[875]

[872] Submissions in reply of Mr and Mrs Turner dated 22 July 2024 at [4]-[13].
[873] Submissions in reply of Counsel Assisting dated 22 August 2024 at [95].
[874] Submissions in reply of Counsel Assisting dated 22 August 2024 at [96].
[875] Submissions in reply of Mr and Mrs Turner dated 22 July 2024 at [19].

537. Counsel Assisting notes that a recognition that deployment to a conflict zone was "inherently potentially traumatic" was a feature of the evidence in the Inquest from both ADF members[876] and the experts.[877] In this sense, they agree that there was a degree of foreseeability in relation to the risk of deterioration in the mental health of a member with a known diagnosis of PTSD who was to be deployed to a combat zone. However, Counsel Assisting more particularly relies on the *specific* knowledge the ADF had in relation to CPL Turner's condition in support of a conclusion that his deployment was "inherently risky".[878]

Consideration

538. In my view, there was ample evidence before the Court from the experts to ground a finding that there was a degree of foreseeability in relation to the risk of deterioration in the mental health of a member with a known diagnosis of PTSD who was to be deployed to a combat zone. The question that needs to be answered is why did the ADF not understand the level of risk involved. It is a question to which I will return.

ISSUES FOR CONSIDERATION

539. A list of issues to be considered at the Inquest was initially prepared and circulated to the parties on 23 July 2020 before the commencement of the first tranche of hearing days on proceedings on 19 October 2020. As a result of evidence arising during the first two tranches of hearing days, an updated list of issues was circulated on 10 August 2022. The issues identified in that list were as follows:

Issue 1: The cause of CPL Turner's death;

Issue 2: The impact of CPL Turner's service in the ADF upon his mental health and his death in the context of his personality type and interpersonal relationships;

Issue 3: The adequacy of the ADF's response to CPL Turner's mental health issues in particular from 2014 to July 2017 and whether CPL Turner's declining mental health was appropriately managed by the ADF in general and in particular by the Human Performance Wing at Holsworthy;

Issue 4: Whether there was any disincentive to CPL Turner raising mental health issues or seeking mental health treatment by reason of ADF policies or procedures;

[876] Submissions of Counsel Assisting dated 2 November 2023 at [104]-[105].
[877] Submissions of Counsel Assisting dated 2 November 2023 at [362].
[878] Submissions in reply of Counsel Assisting dated 22 August 2024 at [97].

Issue 5: The extent to which the investigation and laying of charges arising from an incident involving a pornographic playing card affected CPL Turner's mental health, the extent to which CPL Turner's mental health history was taken into account in this process and whether adequate support was provided in these circumstances;

Issue 6: The extent to which, if any, that CPL Turner's redeployment in early 2017 to Charlie Company affected his mental health and whether adequate support was provided in these circumstances;

Issue 7: Whether lack of communication and/or cooperation between prescribing doctors played a part in CPL Turner's death by enabling him to obtain more prescription medication than intended and/or by undermining his mental health care and treatment and the adequacy of the healthcare provided to CPL Turner during 2017;

Issue 8: The circumstances by which CPL Turner came to have significant supplies of medication available to him at the time of his death;

Issue 9: Whether any electronic or other material was removed (other than by the NSW Police Force) from CPL Turner's premises after his death, and if so, the present location of that material and the reasons for its removal;

Issue 10: Whether CPL Turner was made aware of allegations made against him in late June 2017 and reported to ADFIS and the NSWPF, and if so, the circumstances in which he was made aware, his response, and the impact (if any) on his mental health issues;

Issue 11: Whether any other factors arising during CPL Turner's service contributed to his death; and

Issue 12: Whether any recommendations should be made arising from the circumstances of CPL Turner's death.

540. The above issues are considered in detail below.

Issue 1 – The cause of CPL Turner's death

Evidence

541. The evidence relevant to this issue is set out in the chronology above. In addition to that evidence, it is noted that the Amended Death Certificate issued on 28 March 2018 records CPL Turner's cause of death as "(1) Multi-Drug Toxicity".[879]

Submissions

Submissions of Counsel Assisting

542. Counsel Assisting submits that on the whole of the evidence before the Inquest, it is plain enough that CPL Turner's mental state in the lead up to his death was affected by his relationship difficulties with CPL TJ, including the matters the subject of CPL TJ's confidential statement, the breakdown of his marriage with Joanna Turner, the concerns he had about access to his children, and the concerns he had about his treatment by the ADF during and after the 2016 Iraq deployment. It is submitted that it is plain enough that there was a multifactorial set of circumstances that led to CPL Turner's death by suicide.[880]

Submissions of Mr and Mrs Turner

543. Mr and Mrs Turner have requested that the death certificate registered on the NSW Register of Births, Deaths and Marriages be amended to state that the cause of death and duration of last illness include "multi-drug toxicity, hours" and "post-traumatic stress disorder, years".[881]

Submissions of the Commonwealth

544. The Commonwealth accepts that CPL Turner was suffering from PTSD, alcohol use disorder, and major depression at the time of his death and that these issues *and* CPL Turner's death "were causally related to his service in the ADF".[882]

545. The Commonwealth notes that both DVA and the IGADF had made findings linking CPL Turner's death with his service within the ADF.[883]

[879] Tab 56 (St John of God Hospital medical records) at 16.
[880] 29/08/22 at T8-9.
[881] Submissions of Mr and Mrs Turner dated 28 January 2024 at [13]-[14].
[882] Submissions of the Commonwealth dated 7 June 2024 at [28].
[883] Submissions of the Commonwealth dated 7 June 2024 at [3].

Submissions in reply

546. Counsel Assisting supports a finding that PTSD was causative of CPL Turner's death and that the NSW Register of Births, Deaths and Marriages be updated accordingly (by way of notification under s 34(1) of the *Coroners Act*). However, they do not consider it necessary to include the proposed "durations" of each cause of death proposed by Mr and Mrs Turner given that such findings do not fall within the ambit of ss 34(4) and 81(1) of the *Coroners Act* and that the toxicology report does not provide a basis for the time at which the relevant substances were consumed.

Consideration

547. In my view, it is appropriate to record multi-drug toxicity as CPL Turner's cause of death, with post-traumatic stress disorder listed as the antecedent cause. It is not the usual practice to record time periods when a cause of death is recorded by a coroner, although medical practitioners often add this information. I will refrain.

Issue 2 - The impact of CPL Turner's service in the ADF upon his mental health and his death in the context of his personality type and interpersonal relationships

Evidence

548. The evidence relevant to this issue is set out in the chronology above.

Submissions

Submissions of Counsel Assisting

549. Counsel Assisting submits[884] that CPL Turner's mental decline in the months preceding his suicide was plainly attributable to the PTSD he suffered, which was caused by his service in the ADF. They note that there is a significant volume of evidence before the Court to that effect. For example, Dr Malik considered CPL Turner was one of the worst cases of PTSD that he had seen.[885] Dr Malik's evidence was that his advice to CPL Turner was that he should not be going back to the military after his second suicide attempt[886] and his view was that even without remaining in the ADF, CPL Turner would have struggled, but at least the obvious trigger in which he can put himself and others in harm would have been taken away if he had left the ADF.[887]

[884] Submissions of Counsel Assisting dated 2 November 2023 at [441]-[444].
[885] 20/10/20 T132.14-17.
[886] 20/10/20 T121. 46-48.
[887] 20/10/20 T122.35-42.

550. Counsel Assisting refers to the fact that CPL Turner completed a heavy load of deployments to Afghanistan and to my comment during the course of the expert conclave that "[a]s a country, we had asked him to do a very great deal".[888]

551. Those repeated deployments had a cumulative negative effect on his mental health and the worsening of his PTSD. There were early warning signs, by way of CPL Turner's RtAPS and POPS screenings, which revealed that he was experiencing significant trauma and was slowly developing the symptoms of PTSD. This was particularly the case in relation to the POPS screenings following the 2011-2012 Afghanistan Deployment, after which CPL Turner reported significant alcohol use and a number of other symptoms of PTSD including restlessness, hyper-alertness, flashbacks, and nightmares.

552. Counsel Assisting further submits that it does not appear that the ADF had in place any longitudinal method of identifying individuals who were at particular risk of deterioration in their mental health.

Submissions of Mr and Mrs Turner

553. Mr and Mrs Turner submit that the traumatic events that punctuated CPL Turner's service in the ADF, including the loss of friends on the battlefield, took their toll on him.[889] They refer to the body recovery as being a "significant trauma" that CPL Turner experienced on his last deployment and they agree with Professor McFarlane's evidence that this was a "very significant" trigger to his distress and onset of his PTSD.[890]

554. Mr and Mrs Turner also submit that the burden placed on the 2CDO impacted CPL Turner's ability to take annual leave, attend therapy, and re-integrate into family life.[891] The number and frequency of deployments, along with the requirement to be away from home for other ADF courses and exercises, meant that CPL Turner was not given the time or opportunity to recover from the stress of repeated high tempo deployments and re-establish his internal equilibrium.[892] They contend that the impact of being away from home so often meant that he was unable to commit to long-term psychological therapy or intervention.[893]

[888] 08/02/23 T46.
[889] Submissions of Mr and Mrs Turner dated 28 January 2024 at [21].
[890] Submissions of Mr and Mrs Turner dated 28 January 2024 at [22].
[891] Submissions of Mr and Mrs Turner dated 28 January 2024 at [33].
[892] Submissions of Mr and Mrs Turner dated 28 January 2024 at [36].
[893] Submissions of Mr and Mrs Turner dated 28 January 2024 at [36].

555. Mr and Mrs Turner further submit that the evidence indicates that PTSD was a root cause of the breakdown of CPL Turner's interpersonal relationships, notably those with Joanna Turner and CPL TJ.[894] Mr and Mrs Turner would like to see a clear finding that there was a strong correlation between incidents of domestic violence and CPL Turner's PTSD.[895]

Submissions of the Commonwealth

556. The ADF accepts that CPL Turner's PTSD emerged in the period after his enlistment in the ADF in 2000, most notably in the period 2007-2013, during which CPL Turner was deployed to Afghanistan on four occasions. CPL Turner experienced a number of distressing incidents during these deployments, including the loss of several friends/colleagues which were "doubtlessly sufficient to cause the development of PTSD". As Counsel Assisting observes, the signs/symptoms of PTSD developed slowly across a number of years. The turning point came in 2013; including him "being withdrawn, quick to anger [and] drinking a significant amount". Joanna Turner also dated the commencement of CPL Turner's steroid use to this time.[896]

557. The ADF accepts Counsel Assisting's submission that "[t]here were *early warning signs*, by way of CPL Turner's RtAPS and POPS screenings [in the pre-2014] period, which revealed that he was experiencing significant trauma and was slowly developing the symptoms of PTSD".[897]

Submissions in reply

558. Counsel Assisting supports a finding that there was a causative relationship between CPL Turner's PTSD and the domestic violence to which Joanna Turner was subjected.[898] In support of this, Counsel Assisting points to Joanna Turner's evidence of it not being in CPL Turner's nature to be violent towards her and the children, the first time of violence towards her was in 2005 after he had returned from Iraq, and that acts of violence towards her son were not consistent with CPL Turner's behaviour pre-2012.[899] However, Counsel Assisting does not support a finding that attributes PTSD as the *sole* and/or ongoing exclusive cause of domestic violence throughout the relevant period (referring to the evidence regarding CPL Turner's alcohol consumption

[894] Submissions of Mr and Mrs Turner dated 28 January 2024 at [46].
[895] Submissions of Mr and Mrs Turner dated 28 January 2024 at [48].
[896] Submissions of the Commonwealth dated 7 June 2024 at [99].
[897] Submissions of the Commonwealth dated 7 June 2024 at [102].
[898] Submissions in reply of Counsel Assisting dated 22 August 2024 at [46].
[899] Tab 6 (Statement of Joanna Turner dated 6 January 2018) at 1; Tab 32 (IGADF evidence of Joanna Turner) at 34; 19/10/2020 T52.24 and T71.42.

associated with his bouts of violence[900] and the lack of consensus amongst the experts as to whether PTSD was a frequently recognised cause of domestic violence (despite raising a "red flag" for PTSD) (as summarised at [480] to [483] above)).

Consideration

559. I accept Counsel Assisting's submission that CPL Turner's mental decline in the months preceding his death was directly attributable to the PTSD he suffered as a result of his service in the ADF. In my view, it is an inescapable conclusion which arises directly from the evidence. I note Dr Malik's opinion that CPL Turner's was "one of the worst cases of PTSD" he had seen. The condition arose from repeated deployments and significant ongoing trauma. While there were warning signs recorded in CPL Turner's RtAPS and POPS screenings, the ADF had no adequate longitudinal method in place to properly identify his deterioration over a period of years.

560. I accept Mr and Mrs Turner's submissions that the burden placed on the 2CDO impacted CPL Turner's ability to take annual leave, attend therapy, and re-integrate into family life. In my view, it is likely that the pervasive culture of the regiment also affected CPL Turner's ability or willingness to reach out for help. I note that CPL TJ gave evidence that it is a "common perception amongst the differs at the regiment" that the Human Performance Wing (HPW), where CPL Turner was eventually placed, was a designation for "broken people."[901] Joanna Turner gave similar evidence as to the perception of the HPW being a place for "broken" ADF members and Mr Cardinaels also spoke of ADF members not wanting to be perceived as "weak" if they admit to having PTSD.[902]

561. There is no doubt that CPL Turner's use of alcohol was problematic. Professor McFarlane drew my attention to a well-established literature base demonstrating that alcohol use is both a "consequence and complication of PTSD." I accept that view. Professor Large had a slightly different approach suggesting that alcohol use might also pre-dispose one to PTSD, an opinion which was contested by some of the other experts. Having carefully considered the expert evidence, it remains difficult for me to precisely unpack the complex interrelation of CPL Turner's substance abuse and his PTSD. However, there is a clear correlation between the two. It is significant that there

[900] 19/10/20 T52.22; Tab 7 (Supplementary statement of Joanna Turner) at 2; Tab 32 (IGADF evidence of Joanna Turner) at 20.
[901] 12/8/21 T33.28-34.
[902] Tab 7 (Supplementary statement of Joanna Turner dated 15 August 2018) at [33]; Tab 15 (ROI with Mr Cardinaels on 5 June 2018) at 21.

is evidence suggesting that CPL Turner's use of alcohol or drugs does not appear to have been problematic prior to his ADF service.

562. In my view, the evidence establishes that there was a causative relationship between CPL Turner's PTSD and the domestic violence that Joanna Turner was subjected to. Her evidence is clear that prior to his first deployment to Iraq, CPL Turner had not subjected her or the children to acts of violence.

563. Most of the experts accepted that domestic violence was a significant red flag for PTSD, among other conditions. It troubled me greatly that the evidence disclosed a complete failure on the part of the ADF to adequately deal with this issue. Even when the ADF was aware of the AVO and police involvement, there was a failure to properly consider the issue or to identify it as a "red flag" for CPL Turner or a safety issue for an ADF family. Joanna Turner's efforts to advise BRIG Langford were ignored (a point to which I will return). She went in good faith to get some assistance, while at the same time trying to save her husband's career. In my view, she was treated appallingly by the ADF. Again and again the violence that CPL Turner was inflicting was described as "marital difficulties." Euphemisms were used to excuse and disguise what was really going on as CPL Turner's mental health deteriorated. Joanna Turner was ignored and at times vilified.

564. Dr Hopwood, who had a significant history of working with veterans, spoke of the issue of domestic violence in ADF families as one which was "long hidden and not discussed or researched well". This must stop and it is an issue to which I will return.

Issue 3 – The adequacy of the ADF's response to CPL Turner's mental health issues in particular from 2014 to July 2017 and whether CPL Turner's declining mental health was appropriately managed by the ADF in general and in particular by the Human Performance Wing at Holsworthy

Adequacy of ADF's response prior to 2014

565. The evidence relevant to this issue is set out in the chronology above at [12]-[31].

Submissions of the Commonwealth

566. In addition to the matters summarised above at [556], the Commonwealth submits that "CPL Turner's abuse of alcohol and his domestic violence behaviour predated the emergence of PTSD in the 2007-2013 period. For example, in relation to alcohol, Joanna Turner gave evidence that excessive alcohol use was a 'long-term problem for Ian', which was 'present in our relationship' prior to the first Afghanistan deployment in

2007-2008".[903] The Commonwealth also submits that "alcohol abuse is not necessarily a sign/symptom of PTSD; it may simply be a sign/symptom of alcohol use disorder."[904] This, it is submitted, may have informed how personnel may have responded to CPL Turner's presentation and whether or not they could have recognised the development of PTSD in the context of pre-existing alcohol abuse.[905] In this context, the Commonwealth submits that domestic violence may also have been perceived as being indicative of alcohol abuse rather than PTSD.[906]

567. As noted above at [557], the ADF accepts Counsel Assisting's submission that "[t]here were *early warning signs*, by way of CPL Turner's RtAPS and POPS screenings [in the pre-2014 period], which revealed that he was experienced significant trauma and was slowly developing symptoms of PTSD". However, it is submitted that no finding or comment should be made to the effect that relevant medical personnel (and, through them, the ADF) did not respond adequately to these RtAPS and POPS screenings.[907] In support of that submission, the Commonwealth notes the following:

    i. there is no suggestion that the symptoms disclosed in the screenings crossed the threshold for non-consensual mandatory reporting to the Chain of Command;

    ii. the approach taken by the psychologists who conducted the screenings to manage CPL Turner's symptoms "within" the ADF's medical system was not inappropriate;

    iii. there is every likelihood that CPL Turner was concealing or downplaying his symptoms to the psychologists;

    iv. while the psychologists perceived that CPL Turner would benefit from further psychological interventions, CPL Turner refused treatment; and

    v. statements were not obtained from the medical personnel involved in the screenings conducted between 2008-2013.

568. In relation to MAJ NB and the 2009 screenings, the Commonwealth notes[908] that MAJ NB did in fact refer CPL Turner to CAPT KH for "an RtAPS follow-up" and that CAPT

[903] Submissions of the Commonwealth dated 7 June 2024 at [100].
[904] Submissions of the Commonwealth dated 7 June 2024 at [91].
[905] Submissions of the Commonwealth dated 7 June 2024 at [90]-[93].
[906] Submissions of the Commonwealth dated 7 June 2024 at [95]-[96].
[907] Submissions of the Commonwealth dated 7 June 2024 at [102]-[112].
[908] Submissions of the Commonwealth dated 7 June 2024 at [112].

KH decided to take the opportunity to conduct a POPS because of the "timeframe for follow-up and [CPL Turner's] upcoming commitments on courses".[909]

569. The Commonwealth also submits that it is unnecessary for me to address the evidence of Joanna Turner and Padre MP concerning the wrongdoing of the ADF during the 2013 Afghanistan Deployment (summarised at [23]-[31] above) on the basis that it is "too unconnected to manner and cause of death" or, in the alternative, that no finding should be made that the events described actually occurred.[910]

Submissions of Mr and Mrs Turner

570. Mr and Mrs Turner note Dr Dinnen's and Professor Hopwood's views that CPL Turner had PTSD prior to 2014 and submit that the ADF failed to identify mental health disorders or engage in meaningful early intervention, which resulted in CPL Turner's continued deployments and made his recovery more unlikely. They identify a lack of training with respect to PTSD resulting in a failure by the ADF to provide CPL Turner with adequate mental health support, including a delay in his diagnosis. They also submit that the use of a "civilian PTSD checklist" was indicative of a lack of experience with ADF members who are exposed to prolonged combat operations and that a military-focused checklist may be more appropriate.[911]

571. In relation to CPL Turner's PTSD Checklist – Civilian (**PCL-C**) score of 51 on the 1 July 2009 RtAPS screening tool, CPL Turner's parents contend that the ADF's response to the screening was "totally inadequate" and that the ADF breached its own policy that requires that a person with such a score be "appropriately referred for assistance" given that no additional assessment, referral, or support was provided until a POPS two months later. They are also critical of MAJ NB's failure to act when the PTSD screening identified a high level of symptoms and CPL Turner was, at that point, wanting help. They contend that had there been any follow up after the RtAPS screening, CPL Turner could have been referred for psychological assistance during his six weeks leave.[912]

572. As for the POPS conducted on 12 September 2009, Mr and Mrs Turner's view is that the assessment of CPL Turner's symptoms as being attributed to ADHD was improper, noting a lack of reference in the POPS to the previous PCL-C score or high symptom levels recorded in the RtAPS. They believe that the lack of clinical assessment at this

[909] Tab 48 (ADF medical records – Psychological file) at 35, 42-3.
[910] Submissions of the Commonwealth dated 7 June 2024 at [113]-[114].
[911] Submissions of Mr and Mrs Turner dated 28 January 2024 at [50]-[55].
[912] Submissions of Mr and Mrs Turner dated 28 January 2024 at [56]-[61].

time was a missed opportunity to properly diagnose CPL Turner's symptoms. They are also critical about the conversation between CAPT DW and Mr Sakar regarding the incompatibility of severe ADHD requiring Ritalin with deployment, which resulted in no further action being taken in relation to CPL Turner. They infer that CAPT KH did not properly assess the screening results from MAJ NB and there was a lack of assessment following a conclusion of ADHD.[913]

573. Mr and Mrs Turner further submit that the RtAPS conducted on 31 January 2012 and the POPS screening on 28 August 2012 were inadequate. By the time of the latter, CPL Turner was reluctant to engage in psychological support and he continued to be deployed. At this time, the ADF was aware of other ADF members who had served alongside CPL Turner being discharged for combat-related PTSD.[914]

574. Mr and Mrs Turner also consider that the RtAPS conducted on 10 July 2013 and 16 October 2013 failed CPL Turner. In relation to the former, they contend that CPL Turner's admission of excessive alcohol consumption, the interpersonal conflict with Joanna, and his minimisation of his symptoms despite having just lost his friend in traumatic circumstances should have triggered an immediate referral for assessment and intervention. As for the latter, they note that although CAPT KH concluded that CPL Turner presented with moderate levels of PTSD symptomatology, CAPT KH recommended that no further action be taken due to CPL Turner's resistance to engage and denial of current difficulties. Mr and Mrs Turner consider that CPL Turner's unwillingness to engage with psychologists or other mental health clinicians at this time was an irrelevant consideration in deciding whether intervention was to occur. They believe that if a member is identified as having PTSD and they decline treatment, the member should not be deployable.[915]

575. In relation to the Commonwealth's submission above about CPL Turner's alcohol abuse in the 2007-2008 period, Mr and Mrs Turner note that Joanna Turner's evidence referred to by the Commonwealth is more appropriately construed as CPL Turner's consumption of alcohol being a response to his trauma memories, with his consumption of alcohol increasing over time. They note that Joanna Turner did not state that excessive alcohol use was present in the relationship prior to the first Afghanistan deployment in 2007-2008.[916] Mr and Mrs Turner also submit that the

[913] Submissions of Mr and Mrs Turner dated 28 January 2024 at [62]-[64].
[914] Submissions of Mr and Mrs Turner dated 28 January 2024 at [65]-[66].
[915] Submissions of Mr and Mrs Turner dated 28 January 2024 at [67]-[71].
[916] Submissions in reply of Mr and Mrs Turner dated 22 July 2024 at [27].

increase in drinking and emergence of CPL Turner's alcohol abuse correlates with his exposure to various traumatic experiences throughout his service with the ADF.[917]

Submissions in reply of Counsel Assisting

576. Counsel Assisting notes that Chapter 7 of Part 10 of the Defence Health Manual (DHM) states that the PCL-C is used in RtAPS and POPS questionnaires "because at this stage only a very small proportion" of the ADF "are involved in prolonged combat operations".[918] While the DHM does identify the availability of a separate checklist (PCL-Military), which inferentially would be more appropriate for those who are exposed to prolonged combat operations, the differences between the checklists are described as being "very small".[919] Counsel Assisting considers that given the adequacy of the PCL-C, PCL-Military, or some other checklist, was not a key focus of expert evidence, it would be difficult to conclude that the use of the PCL-C was deficient. Ultimately, the use of a different checklist based on self-reporting may suffer from the same vice of being subject to the member's tendency to downplay symptoms which can be guarded against with longitudinal management of conditions and the appointment of single points of coordination – being a system of the kind recommended below at [1217].[920]

577. Counsel Assisting notes that the findings sought below at [583]-[591], [639]-[645], and [664] concern institutional and systemic responses to the detection, reporting, intervention, monitoring, and support provided by the ADF where "warning signs" are disclosed in psychological screening tests. Counsel Assisting's position is that it is not necessary to make adverse findings concerning the standard of care exercised by the particular professional referred to by Mr and Mrs Turner.[921]

578. In relation to the Commonwealth's objection to a finding being made about the 2013 Afghanistan Deployment, Counsel Assisting considers that the matters raised above at [23]-[31] are sufficiently relevant to the scope of the Inquest and form part of the narrative of CPL Turner reporting having experienced a number of traumatic events during the 2013 Afghanistan Deployment and the effect those had on his mental health. Counsel Assisting considers that if those events are construed in that sense, it would be unnecessary for a specific finding to be made about the *actual occurrence* of the events or about the persons involved in any such events (given that the relevance is

[917] Submissions in reply of Mr and Mrs Turner dated 22 July 2024 at [28]-[31].
[918] Tab 84 at 12.
[919] Tab 84 at 11.
[920] Submissions in reply of Counsel Assisting dated 22 August 2024 at [53].
[921] Submissions in reply of Counsel Assisting dated 22 August 2024 at [56.2].

only in the fact that CPL Turner *reported* such events and their consequences on his mental health, including to members of the ADF).[922]

579. As for the Commonwealth's contention that no finding should be made about relevant medical personnel not responding adequately to the RtAPS and POPS screenings pre-2014, Counsel Assisting notes that no adverse finding is sought against the individuals who carried out those processes. Rather, the point proffered at [551] is made clear at [552], which relates to the absence of any longitudinal method of identifying persons at particular risk of deterioration, which is a systemic issue and not a matter of individual deficiency of any person.[923]

580. Lastly, in relation to Mr and Mrs Turner's submission on Joanna Turner's evidence on the topic of alcohol abuse prior to the 2007-2008 deployment, Counsel Assisting notes that the evidence suggests that she observed an increased consumption of alcohol at times when CPL Turner was struggling to sleep or was vocalising traumatic memories.[924] In circumstances where Joanna Turner and CPL Turner had been in a relationship since 2002, Counsel Assisting considers the submission made by the Commonwealth on this point above was open. However, the critical aspect of Joanna Turner's evidence was the *increase* of alcohol abuse over time in line with continued deployments and continued worsening of PTSD symptoms. In that respect, Counsel Assisting refers to the parts of the chronology at [15]-[80] above concerning CPL Turner's alcohol abuse.[925]

Consideration

581. Having carefully considered the evidence in relation to the ADF's response to CPL Turner's mental health prior to 2014, I find that there were missed opportunities which resulted in there being no meaningful early intervention. While I make no adverse findings against the individuals involved in the RtAPS and POPS screenings prior to 2014, it is clear the system did not identify early red flags or provide an adequate longitudinal mechanism for identifying people who were at risk of deterioration. I accept Mr and Mrs Turner's submission that a lack of institutional understanding about the nature of PTSD impacted CPL Turner's mental state prior to 2014 and resulted in his condition becoming entrenched.

[922] Submissions in reply of Counsel Assisting dated 22 August 2024 at [188].
[923] Submissions in reply of Counsel Assisting dated 22 August 2024 at [191].
[924] 19/10/2020 T53.13-18.
[925] Submissions in reply of Counsel Assisting dated 22 August 2024 at [98]-[100].

Adequacy of ADF's response in 2014

582. The evidence relevant to this issue is set out in the chronology above at [32]-[60].

Counsel Assisting's submissions

583. Counsel Assisting submits[926] that in relation to the 2014 period, CPL Turner's mental health issues reached a crescendo (by reason of the manifestation of his PTSD symptoms) in domestic violence in the home towards Joanna Turner and their children. It is noted that it appears that this violence was known to members of the ADF as early as 2013 but not recognised as a possible symptom of PTSD, nor were any interventions put in place.

584. Rather, the interventions occurred because CPL Turner's mental health affected the ADF in two negative ways: first, the ADF was notified of the AVO obtained by the NSW Police on behalf of Joanna Turner, and second, CPL Turner's colleagues considered his drinking on a course in Singleton was becoming so excessive that they discussed it with the unit psychologist. (The Commonwealth accepts that CPL Turner's mental health issues came to the attention of the ADF Chain of Command at this time.)[927]

585. Once the domestic violence became apparent, it again does not appear that there were any longitudinal systems in place which recognised the domestic violence as a possible incidence of PTSD symptoms and put in place mitigations around that risk.

586. Joanna Turner went to significant lengths to attempt to bring CPL Turner's worsening PTSD to the attention of the leadership of the ADF. She took the extraordinary step of penning a letter to the then-CO of 2CDO, BRIG Langford, raising concerns about the level of support that had been provided to her and clearly setting out her view that the domestic violence she was experiencing was attributable to CPL Turner's mental health as a result of his service. Counsel Assisting considers that the evidence as to the response of the ADF to this letter was concerning as it does not appear that any formal steps were undertaken to ensure that Joanna Turner's concerns were recorded, followed up on, and formed part of the ADF's ongoing treatment of CPL Turner's mental health.

The conditional release plan

587. During this period, CPL Turner was conditionally released by the Local Court of NSW on condition that he comply with a mental health plan for 12 months. It is not apparent

[926] Submissions of Counsel Assisting dated 2 November 2023 at [445]-[503].
[927] Submissions of the Commonwealth dated 7 June 2024 at [127].

that Dr Sringeri, who was responsible for supervising his treatment and reporting to the Local Court in respect of compliance and breaches, understood the serious nature of the undertaking which he had given to the Local Court. During the period, CPL Turner appeared to have unilaterally ceased taking medication. That was not a matter that received any particular focus in Dr Sringeri's treatment notes during that period.

588. Dr Sringeri also signed off on CPL Turner ceasing to receive psychiatric follow up for a period of 6 to 12 months after only 5 months. That is plainly inconsistent with the plan, which required CPL Turner to attend regular consultations at least for 12 months. Dr Sringeri himself acknowledged that this was a "breach in some sense". CPL Turner appeared to have breached the plan in two ways: first, by unilaterally ceasing antidepressant medication and, second, by failing to continue with psychiatric reviews for a period of 12 months.

589. It is submitted that I would find it of concern that Dr Sringeri did not appear to regard these issues as matters which required him to report back to the Local Court of NSW. It is also submitted that there was inadequate monitoring by Dr Sringeri in respect of his compliance with the plan during the period of 12 months following May 2014 when the conditional release order was made.

590. Counsel Assisting also considers it concerning that the ADF did not have any role in ensuring CPL Turner complied with the conditions of his conditional release plan. There was little by way of evidence that demonstrated the ADF had a system in place to check and ensure compliance with the conditions of that plan as it concerned CPL Turner's treatment within the ADF health system and via referral to Dr Sringeri. Although the ADF did not have formal responsibility under the conditional release plan, plainly enough the only psychotherapy with a clinical psychologist which CPL Turner was receiving was through the ADF. That meant the ADF also had a role to play in checking compliance with the conditions of the order. It is submitted that there was inadequate monitoring by the ADF of CPL Turner's compliance with the conditions of his conditional release plan. It is further submitted that the ADF had knowledge of CPL Turner's non-compliance with the orders associated with his conditional release and failed to take any action in response. Counsel Assisting notes that so much is clear from the fact that the ADF received from Dr Sringeri the reports which indicated CPL Turner was ceasing medication and then ceasing psychiatric review.

591. It ultimately appears that by reason of these two inadequate monitoring systems, CPL Turner was able to comply minimally with the conditions, engage relatively minimally in treatment, and ultimately portray a picture to his Chain of Command that his

condition was improving. According to Counsel Assisting, the evidence of Joanna Turner suggests that his condition was not improving, at all, and that CPL Turner continued to perpetrate domestic violence upon Joanna Turner and the children in the lead up to the 2015 Iraq Deployment. Counsel Assisting considers that it is all the more concerning because Joanna Turner had specifically approached the ADF (and the CO of 2CDO) in respect of her concerns about CPL Turner, and a follow up of that approach would have likely revealed to the ADF that the picture which CPL Turner was presenting about his mental health was not accurate. It is submitted that there was a failure by the ADF in this regard, which meant that CPL Turner was able to present himself throughout 2014 and into 2015 as having effectively been "cured" of his PTSD. As the expert evidence demonstrated, the likelihood of that being the case was very low. Counsel Assisting states that there should have been a significantly greater level of circumspection and probing into CPL Turner's apparently quick return to solid mental health throughout this period.

Submissions of Mr and Mrs Turner

592. Mr and Mrs Turner consider that the lack of education and experience across all levels of personnel responsible for responding to and managing CPL Turner's mental health resulted in repeated missed opportunities to provide assessment, therapeutic intervention, support, and adequate care after the diagnosis of PTSD in 2014. Their view is that the ADF breached the Army Standing Instruction (Personnel) in failing to rehabilitate CPL Turner after the PTSD diagnosis in 2014. They also refer to the chapter "Management of Post-Traumatic Stress Disorder and Acute Stress Disorder in the Australian Defence Force for Primary Care Providers" (which states that members "are to be referred" to the ADF Rehabilitation Program) in the DHM and submit that the ADF breached its policy by not referring CPL Turner to the program upon his discharge.[928]

593. Furthermore, they contend that the decision of BRIG Langford to fully employ CPL Turner two weeks before his discharge from hospital breached ADF policy and demonstrated a lack of care for CPL Turner's personal health and wellbeing.[929]

Submissions of Joanna Turner

594. In relation to her letter of 11 June 2014, Joanna Turner submits that "checking in with me on occasion by one person is not acceptable as an appropriate response" and that

[928] Submissions of Mr and Mrs Turner dated 28 January 2024 at [72]-[75].
[929] Submissions of Mr and Mrs Turner dated 28 January 2024 at [75].

CPL Turner did not face accountability. She submits that it was not sufficient for the ADF to rely on "other sources of information, including what others saw with their own eyes" in the context of claims of domestic violence, including the fact that CPL Turner may have otherwise presented as performing acceptably in the workplace.[930]

Submissions of the Commonwealth

595. Looking at the evidence as a whole, and with the benefit of hindsight, the ADF accepts that there is force in Counsel Assisting's ultimate submission about the ADF's response to CPL Turner's mental health issues in 2014, namely that: "*there should have been a significantly greater level of circumspection and probing into CPL Turner's apparently quick return to solid mental health throughout this period*". This is not to say that the ADF ignored CPL Turner's mental health issues: to the contrary, the Commonwealth submits that the ADF made a concerted, good faith effort over the course of 2014 to ensure that CPL Turner returned to full mental health, including by referring him to a very experienced external health practitioner, and by engaging the services of ADF personnel with relevant subject matter expertise. The problem, in retrospect, might best be described as a failure on the part of the ADF to "connect the dots"; that is, to draw together the constellation of issues facing CPL Turner and his family and appreciate their significance as a whole.[931]

596. The Commonwealth notes that CPL Turner had spent six weeks at SSPH in April-May 2014 where he "remained fully engaged in his health and welfare" and that Dr Sringeri observed "remarkable" improvement in PTSD symptoms upon discharge. The Commonwealth submits that with the benefit of hindsight, questions might now be asked about whether the treatment at this time "was *as effective* as it appeared at the time".[932]

597. The Commonwealth also points out that CPL Turner's unilateral decision to cease taking his antidepressant medication in mid-2014 was a matter known to Dr Sringeri and he did not raise concerns with the ADF. The Commonwealth submits that Dr Sringeri's observations of "progressive improvement" in PTSD symptoms throughout 2014, and his reports to the ADF consistent with those observations, meant "the ADF was well entitled to proceed on the basis that CPL Turner's rehabilitation was going extremely well".[933]

[930] Submissions in reply of Joanna Turner at 4.
[931] Submissions of the Commonwealth dated 7 June 2024 at [117].
[932] Submissions of the Commonwealth dated 7 June 2024 at [130]-[134] (emphasis in original).
[933] Submissions of the Commonwealth dated 7 June 2024 at [140]-[145].

598. The Commonwealth highlights that the following matters must be taken into account before any adverse findings or comments are contemplated:[934]

i. "Connecting the dots" is much easier to do in retrospect that in the moment, as recognised in Dr Large's evidence.

ii. "Connecting the dots" is much easier for a person who has access to all relevant or potentially relevant information. However, at the relevant times, no single individual or group of individuals within the ADF had anything like the access to the information before this Inquest. For this reason, Counsel Assisting's tendency to refer to "the ADF" as an entity makes little sense – the analysis must be granular.

iii. To the extent that there was a failure to "connect the dots", that points to a need for better training, including with respect to the speed and efficacy of PTSD treatment; the capacity of people with mental health issues to conceal signs/symptoms and continue performing well in the workplace; and the complex interrelationship(s) between PTSD, abuse of alcohol/drugs, and domestic violence.

iv. An important part of the ADF's response was "delivered" by CAPT SG, who was involved in CPL Turner's treatment and care on a regular basis from at least late March/early April 2014 to December 2014. CAPT SG was not asked to provide a witness statement or called to give evidence, with the result that there is a gap in the evidence. That also has procedural fairness implications in respect of any proposed adverse findings or comments in respect of CAPT SG (and, through him, the ADF). The Commonwealth also submits that CAPT SG's treatment of CPL Turner was appropriate and that he was entitled not to second guess the observations made by Dr Sringeri in this period regarding CPL Turner's progress.[935]

v. Another part of the ADF's response was "delivered" by MAJ Clancy, whose role in 2014 is not referred to in Counsel Assisting's submissions.

599. The Commonwealth also objects to any adverse findings about the role of LTCOL GG (who was acting CO of 2CDO from August 2014 to March 2015) in the context of the ADF's response to Joanna Turner's letter and meeting with BRIG Langford (noting that LTCOL GG was not called to give evidence). The Commonwealth notes that the task

[934] Submissions of the Commonwealth dated 7 June 2024 at [118]-[125].
[935] Submissions of the Commonwealth dated 7 June 2024 at [154]-[157].

of responding to Joanna Turner's letter was delegated to MAJ Clancy, the Padre, and the Adjutant.[936]

Initial interventions in response to CPL Turner's mental health issues

600. Counsel Assisting submits that the ADF initiated interventions in response to the mental health issues that came to the attention of the ADF Chain of Command in 2014 only "because" they "affected" the ADF in "negative" ways. It is submitted by the Commonwealth that the submission unfairly implies that CPL Turner's mental health issues were known to relevant operational personnel prior to April 2014, but were not active because they had no impact on the ADF given that the evidence does not support any such conclusion.[937]

601. While early warning signs of mental health issues had been observed by the medical personnel who conducted the RtAPS and POPS screenings in the pre-2014 period, there is no evidence that these matters were reported to operational personnel or that they could have been consistently with applicable ADF policy. To the extent that Joanna Turner raised mental health issues with ADF members prior to April 2014, it would seem that the persons she approached were various chaplains both inside and outside 2CDO. It is contended that the evidence does not permit the making of clear findings about how these chaplains responded and there is no evidence that they were reported to operational personnel (or at least operational personnel with rank and authority to deal with them).[938]

602. The Commonwealth submits that the evidence relating to the events of early April 2014 establishes that the ADF responded swiftly and appropriately once the issues came to its attention.[939]

The conditional release plan

603. The Commonwealth submits that findings should not be made that the ADF inadequately monitored the conditional release plan imposed by the Local Court on 3 June 2014 and that the ADF failed to respond to known non-compliance with that plan. In support of this submission, the Commonwealth notes that the evidence:

    i. does not establish that the ADF had knowledge of the orders or the terms of the treatment plan referred to in the orders;

[936] Submissions of the Commonwealth dated 7 June 2024 at [176(c)-(d)] and [184].
[937] Submissions of the Commonwealth dated 7 June 2024 at [128].
[938] Submissions of the Commonwealth dated 7 June 2024 at [128].
[939] Submissions of the Commonwealth dated 7 June 2024 at [129].

ii. indicates that the relevant ADF personnel may not have regarded CPL Turner as being in breach of the orders and/or plan (assuming they had a copy of them) and may have regarded CPL Turner as acting consistently with Dr Sringeri's advice;

iii. the orders did not impose any responsibility on the ADF to monitor compliance with the orders and/or plan; and

iv. the ADF member who was "presumably responsible" for monitoring CPL Turner's compliance with the orders and treatment plan was CAPT SG (who was not called to give evidence).[940]

604. The Commonwealth notes that if it was the case that relevant personnel were not aware of the terms of the orders, then "that was most unfortunate". It is further noted that current procedures are now designed to ensure the ADF is aware of "any civil charges" and the basis on which such charges are disposed of by the courts.[941]

The response to Joanna Turner's letter of 11 June 2014

605. The Commonwealth disagrees with Counsel Assisting's submission that there were inadequate "concrete" or "formal" steps taken from Joanna Turner's letter of 11 June 2014 in that it considers the submission does not reflect the evidence.

606. The Commonwealth notes[942] that the fact that the letter was taken seriously by the ADF is reflected in the evidence that:

i. BRIG Langford "quickly" arranged to have a meeting with her which was an "unusual" step to take for someone in his position;[943]

ii. Joanna Turner conceded that she presented things in a "positive context" to BRIG Langford which led him to believe the discussion was positive and constructive;[944]

iii. BRIG Langford delegated the ADF's response to appropriately trained subordinates;[945] and

[940] Submissions of the Commonwealth dated 7 June 2024 at [165]-[171].
[941] Submissions of the Commonwealth dated 7 June 2024 at [127].
[942] Submissions of the Commonwealth dated 7 June 2024 at [176].
[943] 21/10/2020 T203.7-9, T204.6-10.
[944] 19/10/2020 T58.19-24; 21/10/2020 T218.4-16.
[945] 21/10/2020 T184.30-34, T185.37-47.

iv. MAJ Clancy was in regular contact with Joanna Turner in 2014-2015[946] (and Joanna Turner accepted that MAJ Clancy "was doing the best she could").[947]

607. Further, the Commonwealth notes that the ADF was receiving separate and competing information about CPL Turner's condition at this time from other sources[948] and that the ADF's response was also, to an extent, "a product of [its] times" in relation to the (lack of) discourse surrounding domestic violence in the broader community.[949]

Dr Sringeri's report of 27 October 2014

608. The Commonwealth refers to the report of Dr Sringeri dated 27 October 2014, which lists "Post Traumatic Stress Disorder in remission" and "Alcohol Dependence Syndrome in remission" as diagnoses and recommendations as "Psychoeducation. In my opinion Ian is well and stable. In my opinion Ian is cleared to attend all duties from a psychiatric point. He does not require any psychiatric follow up for next 12 months and I am happy to review him if required."[950] The Commonwealth contends that in his statement dated 5 August 2021 (Exhibit 15), Dr Sringeri sought to distance himself from the plain meaning of the words "Ian is cleared to attend all duties from a psychiatric point" on the basis that he did not have (and could not be expected to have) any knowledge of the "occupation hazards" of his patients.[951]

609. The Commonwealth is also critical of the email posed by those assisting to Dr Sringeri's representatives on 11 August 2021 about his recommendation that "Ian is cleared to attend all duties from a psychiatric point" (specifically, whether he intended this to mean that CPL Turner was cleared to deploy in a combat zone) and the response from Dr Sringeri (Exhibit 19) that he did not intend to imply or suggest that he had cleared CPL Turner to deploy in a combat zone. The Commonwealth considers this to be problematic not only because the question raised was inappropriately leading, but also because the response was not made on oath or affirmation. The question of Dr Sringeri's *subjective intention* is irrelevant and the appropriate question is what the report would objectively convey to the reasonable reader.[952]

610. It is submitted that given Dr Sringeri effectively ended his treatment of CPL Turner in October 2014 with a report to the ADF that stated that CPL Turner's PTSD and alcohol dependence syndrome were "in remission", he was "well and stable", he was "cleared

[946] 13/08/2021 T14.36-38, T39.25-27.
[947] 20/10/2020 T99.11-15.
[948] Submissions of the Commonwealth dated 7 June 2024 at [175].
[949] Submissions of the Commonwealth dated 7 June 2024 at [177].
[950] Tab 47 (ADF medical records – part 2) at 16-17.
[951] Submissions of the Commonwealth dated 22 June 2024 at [146].
[952] Submissions of the Commonwealth dated 22 June 2024 at [149].

to attend all duties from a psychiatric point [of view] and he did "not require any psychiatric follow up" over the next 12 months, the ADF was well entitled to proceed on the basis that CPL Turner's rehabilitation had gone extremely well.[953]

Submissions of Dr Sringeri

The conditional release plan

611. Dr Sringeri disputes Counsel Assisting's submissions in relation to his role in the treatment of CPL Turner following the orders made by the Local Court of NSW on 3 June 2014. Dr Sringeri notes that two different orders were made, one under the *Crimes Act 1914* (Cth) and the other under the *MH(FP) Act*. While the former stipulated a period of 12 months, the latter did not specify any time period and this gave rise to a degree of ambiguity as to the length of the treatment plan. Dr Sringeri submits that there is no recommendation for a twelve-month period of medications; rather, the medication is recommended to be taken as prescribed.[954]

612. While Dr Sringeri stated there was a "breach in some sense" of the undertaking, Dr Sringeri's evidence was that CPL Turner volunteered to him that he had ceased taking medication which was in the process of being reduced in the context of a plan to cease that medication.[955]

613. Dr Sringeri further submits that the twelve-month recommendation related to 12 months of psychotherapy which was managed by the psychologist within the ADF. Had there been non-compliance with that recommendation, it was not reported to him by CPL Turner of the ADF.[956]

614. Dr Sringeri submits that there was no evidence adduced to show that Dr Sringeri was provided with a copy of the orders by CPL Turner, the ADF, or the Local Court. Rather, his evidence was that he did not receive a copy of the orders and did not know the Court would make the recommendation. Dr Sringeri contends that Counsel Assisting's submissions on this point above at [586]-[589] are procedurally unfair and that the facts do not support the making of a finding as submitted at [589] as he was unaware he had not complied with the undertaking he had volunteered.[957]

[953] Submissions of the Commonwealth dated 22 June 2024 at [150].
[954] Submissions of Dr Sringeri dated 24 April 2024 at [36]-[40].
[955] Submissions of Dr Sringeri dated 24 April 2024 at [45].
[956] Submissions of Dr Sringeri dated 24 April 2024 at [42], [44].
[957] Submissions of Dr Sringeri dated 24 April 2024 at [42]-[43], [47]-[48].

Dr Sringeri's report of 27 October 2014

615. Dr Sringeri objects to the Commonwealth's contention summarised above at [608]-[609].[958] In his statement of 5 August 2021 (Exhibit 15) he was not distancing himself from his opinion expressed in the 27 October 2014 report; rather, he was endorsing what his opinion was at the time. Dr Sringeri considers that the Commonwealth's criticism fails to appreciate the context in which the statement was given (namely, accepting some aspects and responding to other aspects of Professor McFarlane's criticisms[959] about Dr Sringeri's "admitted lack of knowledge" of the ADF, such as whether he had sufficient knowledge about the occupational hazards).[960]

616. Dr Sringeri also contends that any issues the Commonwealth (or GPCAPT Ross) wanted to raise in relation to the report ought to have been done in open court and that accepting those submissions without giving Dr Sringeri the opportunity to give evidence to rebut them would be procedurally unfair.[961]

617. Dr Sringeri suggests that the Commonwealth's submission about the statement dated 5 August 2021 is made "without acknowledgement that the only information that Dr Sringeri had was the referral letter from the ADF dated 4 April 2014, the information provided to him by CPL Turner, in addition to the observations he had made over the course of providing treatment and care to [CPL] Turner during his hospital admission in April 2014 and the follow up reviews after discharge in 2014, the two reviews in 2015, and the review on 13 July 2016". Similarly, there is no acknowledgement in the Commonwealth's submissions that the opinion expressed in the 27 October 2014 letter was within the context that related to a time when CPL Turner was not being deployed and CPL Turner informed Dr Sringeri that he was keen to join his team for the purpose of training.[962]

618. Dr Sringeri also rejects the Commonwealth's criticisms of the answers he gave in the 11 August 2021 response (Exhibit 19) and submits that such criticisms operate as "an utter denial of procedural fairness or lack of opportunity to be afforded to Dr Sringeri to respond to such criticisms through the giving of evidence" (noting he was not called to give evidence about this).[963]

[958] Submissions of the Commonwealth dated 7 June 2024 at [146].
[959] Exhibit 12 at 38-42.
[960] Submissions in reply of Dr Sringeri dated 22 July 2024 at [26]-[35], [44].
[961] Submissions in reply of Dr Sringeri dated 22 July 2024 at [43].
[962] Submissions in reply of Dr Sringeri dated 22 July 2024 at [35].
[963] Submissions in reply of Dr Sringeri dated 22 July 2024 at [24].

Submissions in reply of Counsel Assisting

619. Counsel Assisting notes that the chapter of the DHM referred to in Mr and Mrs Turner's submissions (above at [592]) is not in evidence and that without a complete picture of the referral process (including whether *acceptance* into the ADF Rehabilitation Program is mandatory), the single statement that members "are to be referred" does not provide a sufficient basis to conclude that, on the facts of this matter and on a complete picture of ADF policy, that such a policy was breached.[964]

620. Counsel Assisting does not seek a finding that Dr Sringeri sought to "distance himself" from the meaning of the words in his letter of 27 October 2014 and it is submitted that Dr Sringeri's letter was inadequate for the reasons outlined below at [673].[965]

The conditional release plan

621. In view of Dr Sringeri's submissions (as summarised above at [611]-[614]), Counsel Assisting accepts that the evidence does not enable positive findings that Dr Sringeri was provided with a copy of the form of orders made by the Local Court, that Dr Sringeri was aware CPL Turner had not acted in compliance with the terms of the conditional release order, or that Dr Sringeri did not report that fact back to the Local Court. However, it *is* submitted that it is open for a finding to be made that Dr Sringeri was aware CPL Turner was non-compliant with what Dr Sringeri had proposed and undertaken to the Court as being an appropriate treatment plan for CPL Turner.[966]

622. As for the Commonwealth's submission that the ADF did not have knowledge of the terms of the court orders or the treatment plan, Counsel Assisting submits[967] that the evidence suggests that not only were the court proceedings being monitored by the ADF, but the disposition under s 32 of the *MH(FP) Act w*as in fact anticipated. CAPT SG noted the anticipated court proceedings in his clinical notes of 30 April 2014 and 26 May 2014,[968] in the former explicitly recording that "Ian has legal representation sorted and will pursue a section 32".[969] Then, on 5 June 2014, CAPT SG recorded "Court proceedings for the AVO conducted with positive outcome".[970]

623. This monitoring by CAPT SG is consistent with expectations of other witnesses who gave evidence. MAJ AM gave evidence that he would have expected the outcome to

[964] Submissions in reply of Counsel Assisting dated 22 August 2024 at [57].
[965] Submissions in reply of Counsel Assisting dated 22 August 2024 at [172].
[966] Submissions in reply of Counsel Assisting dated 22 August 2024 at [165]-[167].
[967] Submissions in reply of Counsel Assisting dated 22 August 2024 at [195]-[200].
[968] Tab 49 (ADF unit medical records) at 535.
[969] Tab 49 (ADF unit medical records) at 543.
[970] Tab 47 (ADF central medical records – part 2) at 92.

appear on CPL Turner's medical file.[971] BRIG Langford gave evidence that, at least with respect to convictions, at the relevant time "there was a mandatory reporting obligation" and "I would be aware of it, as a general rule."[972] He also accepted the court proceedings were brought to his attention in Joanna Turner's letter.[973]

624. Even if it were to be accepted that the ADF was not aware of the outcome of the criminal charge, BRIG Langford accepted that this *should* have been brought to his attention.[974] Relevantly in this context, it is noted that Joanna Turner submitted in reply submissions that the Commonwealth, having been aware of the criminal charge, had an obligation to "document and respond effectively" to the orders made, and, either the ADF failed in responding to what they were aware of, or, failed by not ensuring they were sufficiently aware.[975]

625. As for the Commonwealth's submission that the terms of the order were ambiguous such that ADF personal may not have regarded CPL Turner as being in breach, Counsel Assisting notes that the absence of action taken does not support the positive inference that the ADF formed a view there was no breach. Rather, the clearer conclusion to be drawn is that the ADF simply did not sufficiently engage with requirements under the order at all.

The response to Joanna Turner's letter of 11 June 2014

626. In relation to the Commonwealth's reference to Joanna Turner's evidence that MAJ Clancy was "doing the best she could", Counsel Assisting highlights that this evidence is placed in the context of MAJ Clancy's role as a welfare officer for Joanna Turner and that the relevant answer given by Joanna was preceded by the qualification "I respect that people in their positions have…they can only perform their duties".[976] By contrast, Joanna Turner made a clear denial in her evidence shortly afterwards that when she was asked whether she considered she was "receiving the correct level of care and support for what [she] had told the ADF was the problem".[977] More to the point, as made clear in the submissions above at [586] and [591], the particular relevance of the ADF's response to the letter is how that information was fed into the treatment of CPL Turner's mental health for which MAJ Clancy did not have primary responsibility.[978]

[971] 6/08/2021 T11.3-7.
[972] 21/10/2020 T176.43-46.
[973] 21/10/2020 T183.42-44.
[974] 21/10/2020 T211.48-212.1.
[975] Submissions in reply of Joanna Turner at 4.
[976] 20/10/2020 T99.12.
[977] 20/10/2020 T99.28.35.
[978] Submissions in reply of Counsel Assisting dated 22 August 2024 at [201].

627. As for the Commonwealth's position that BRIG Langford was not able to personally respond to the issues raised due to his limited availability, Counsel Assisting does not submit[979] that the obligation to ensure this information was fed into CPL Turner's treatment was a *personal* one not capable of delegation. Rather, the focus was on the institutional response to this information. Counsel Assisting notes that the Commonwealth's submission should be read in light of BRIG Langford's acceptance elsewhere of the proposition that inquiries "should have been made of Mrs Turner throughout the period from 2014 onwards for the purpose of informing serious decisions about [CPL Turner's] deployment".[980]

CAPT SG

628. In relation to the Commonwealth's objection to any adverse finding about the care provided by CAPT SG, Counsel Assisting notes that none of the references to CAPT SG at [47]-[49], [53], or [55] seek an adverse finding about CAPT SG's conduct and that the only relevant findings with respect to the period of CAPT SG's care is summarised above at [590]-[591], which concerns the lack of monitoring by the ADF of CPL Turner's compliance with the conditional release plan. Contrary to the Commonwealth's submission that no finding can be made about the conduct of the ADF because the conduct of the ADF was apparently in the hands of CAPT SG, there is no implied or express submission that it was CAPT SG who was responsible for monitoring CPL Turner's compliance with the conditional release plan. Counsel Assisting submits that the evidence did not reveal that the ADF had any particular role to play in ensuring compliance with the conditions of the conditional release plan and ought to have, which is a submission relating to the ADF's systems. As the Commonwealth submits, the ADF's current policy framework which has been reviewed since 2014 is designed to ensure that it is aware of civil charges brought against members *and* the basis on which any such charges are disposed of, including any conditions.[981]

Consideration

629. There were a variety of events occurring in 2014 which should have signalled to the ADF that CPL Turner's mental health was becoming a significant issue. The ADF failed to recognise his excessive drinking (as evidenced during the Singleton course) and his

[979] Submissions in reply of Counsel Assisting dated 22 August 2024 at [203]-[204].
[980] 21/10/2020 T189.28-31.
[981] Submissions in reply of Counsel Assisting dated 22 August 2024 at [192]-[193].

ongoing violence (as evidenced by the need for police to apply for an ADVO and commence criminal proceedings) as potential red flags for PTSD.

630. The Commonwealth submissions on this issue were somewhat confusing. On the one hand, it accepted "that there should have been a significantly greater level of circumspection and probing into CPL Turner's apparently quick return to solid mental health throughout this period"; in retrospect describing it as a "failure to connect the dots."

631. On the other hand, there is a reluctance to take responsibility for the failure of the systems which allowed those tasked with managing CPL Turner to see the significance of critical events. In the Commonwealth's submission, it "makes little sense to generalise or describe the ADF as an "entity" because at the relevant time no "single individual or group of individuals within the ADF had anything like the access to the information before this inquest." There is just no substance to the contention. As I have already stated, the Court is well aware that it possesses information gathered from a variety of sources, well after the event. That does not absolve the ADF from its corporate responsibility. The Court has been careful not to generalise, but there remains a need to analyse the institutional response.

632. I have already recorded that, in my view, Joanna Turner's attempt get help and advise the ADF of her concerns about her husband's mental state were poorly managed. There is no evidence that her concerns were formally recorded or factored into the ADF's mental health treatment response to CPL Turner. The criticism is directed towards the apparent lack of an adequate system which would have ensured the information Joanna Turner provided was understood and acted upon.

633. In my view, the ADF response to CPL Turner's court appearance and conditional release was also wholly inadequate.

634. I was disappointed by the Commonwealth's submissions on this issue. Among other things, it submitted that there was no evidence that the ADF had knowledge of the orders or terms of the conditional release and had no responsibility to monitor compliance. It is perfectly clear that the court proceedings were well known in the 2CDO. As I have already outlined above at [44], character references were provided on 2CDO letterhead, an ADF member attended proceedings with CPL Turner, and one of the conditions of the final discharge involved the provision of counselling with CAPT SG. The issue was also brought specifically to BRIG Langford's attention by Joanna

Turner. To suggest that it has not been established that the ADF had knowledge of the orders or an obligation to monitor compliance is to miss the point entirely.

635. I do not accept that senior members of 2CDO were unaware of the proceedings. If they were unaware of the terms of the conditional release, that constitutes either a disturbing lack of curiosity or a complete disregard for civilian court proceedings affecting a member of the ADF. Whichever it was, in my view the failure to take seriously the outcome of the Local Court proceedings represents a significant missed opportunity in CPL Turner's health management.

636. One of the conditions of CPL Turner's discharge was compliance with a mental health plan for 12 months. Dr Sringeri ceased treating CPL Turner after five months which he recognised as a "breach in some sense". I accept the submission put by his representatives that Dr Sringeri was entitled to put weight on the fact that an ADF psychologist was also managing CPL Turner. After Dr Sringeri ceased treatment, he also informed the ADF that he was happy to review CPL Turner if required. While I accept that he may not have seen the final orders, in my view he nevertheless had a duty to find out what they were. It is quite apparent that nobody took the Local Court orders seriously.

637. Dr Sringeri's report of 27 October 2014 stated that CPL Turner's PTSD and alcohol dependence syndrome were "in remission" and that he was "well and stable." While it is now apparent that CPL Turner was not always open with his treating doctors, I accept that at the time the ADF were entitled to place some weight on his opinion.

Adequacy of ADF's response in 2015

638. The evidence relevant to this issue is set out in the chronology above at [61]-[90].

Counsel Assisting's submissions

639. Counsel Assisting submits[982] that it was apparent that Joanna Turner continued to suffer domestic violence throughout 2015. There were warning signs which were presented to the ADF: first in CPL Turner's early RTA from the 2015 Iraq Deployment ostensibly by reason of Joanna Turner's mental health. Counsel Assisting states that, as is apparent, a simple phone call to Joanna Turner would have revealed that she was in fact terrified that CPL Turner was coming home, that she contacted the police

[982] Submissions of Counsel Assisting dated 2 November 2023 at [454]-[459].

for safety, and that when he did return, his violence and alcohol intake increased dramatically.

640. Counsel Assisting notes that there was no system in place, seemingly, for this to be recognised and dealt with by the ADF. This is particularly concerning because Joanna Turner was not someone who was unknown to the ADF or who had demonstrated a complete unwillingness to discuss her domestic issues with the ADF. There did not appear to be a system, however, whereby what CPL Turner reported to the ADF (that he was coming home because of Joanna Turner's mental health) was verified with Joanna Turner or investigated any further. Counsel Assisting submits that this appears to reflect a lack of a longitudinal approach whereby CPL Turner's entire history was taken into account at the time of his early RTA. Doing so may well have raised a red flag, noting that CPL Turner had been hospitalised for PTSD only the previous year.

641. It is also concerning that the domestic violence continued throughout 2015 and was reported to MAJ Clancy but that this information did not appear to be clearly fed into CPL Turner's mental health treatment within the ADF or his health records more generally. There did not appear to be any prominence or significance afforded to her role in decision-making within the ADF.

642. BRIG Langford's evidence was to the effect that the information reported to MAJ Clancy as to harm suffered by her in September 2015 was not brought to his attention. This was around the time that BRIG Langford signed a waiver for CPL Turner to deploy to Malaysia. He accepted that it should have been brought to his attention, and that it would have influenced his decision as to whether or not CPL Turner should have been given a medical waiver to deploy to Malaysia. [983] He also accepted that inquiries should have been made of Joanna Turner from 2014 onwards for the purpose of informing decisions about CPL Turner's deployment.[984] Counsel Assisting's view is that this lack of enquiry by BRIG Langford as to the current status of CPL Turner's domestic circumstances is especially egregious given his personal knowledge of the domestic violence and CPL Turner's mental health issues, resulting from the letter he received from Joanna Turner and the subsequent meeting he had with her in June the previous year.

643. It is also apparent that CPL Turner was effective in ensuring that people within 2CDO viewed Joanna Turner as causing the problems within their marriage. For example:

[983] 21/10/20 T189.1-11.
[984] 21/10/20 T189.28-31.

i. Speaking after CPL Turner's death in his ROI with the IGADF, WO2 DP stated that CPL Turner was "struggling to cope with the fact that he would not see those children. The wife was willing to have visitations to the daughter. But from what I understand, the son was never allowed to go and see Ian or spend any time with Ian, which wasn't nice for him".[985]

ii. BRIG Langford's evidence was that he understood, since CPL Turner's death, that there was a "sense from Ian's perspective that Joanna was not inclined to help him in his career…in his view, that she was essentially trying to damage him", and CPL Turner had requested that no-one in his unit was to contact Joanna Turner or discuss his family affairs with her.[986]

644. Counsel Assisting submits that given that CPL Turner had been charged by police, had an AVO imposed, and had been hospitalised for PTSD only a year prior, it is difficult to discern why Joanna Turner's concerns in 2015 were not given significantly more prominence in decision-making about CPL Turner throughout 2015 and leading into 2016, and why the ADF and particularly, the CO, were willing to take CPL Turner's information about CPL Turner at face value.

645. Ultimately, this was information which nearly all the decision-makers around CPL Turner's medical clearance in 2016 indicated they would have liked to have known. The difficulty is that the violence which Joanna Turner was experiencing (albeit an underreported form of it) was known to the ADF, was not taken seriously, and was not recorded in such a way that enabled it to be taken into account in treatment and deployment decisions.

Submissions of Mr and Mrs Turner

Referral to an addiction medicine specialist

646. Mr and Mrs Turner contend that there was a failure to follow the critical medical advice of Dr Wallace on 18 September 2015 to refer CPL Turner to an addiction medicine specialist and an external mental health practitioner for primary substance use and residual PTSD symptoms.[987]

[985] Tab 24 (IGADF ROI with WO2 DP dated 5 July 2018) at 8.
[986] Tab 24 (IGADF ROI with WO2 DP dated 5 July 2018) at 8.
[987] Submissions of Mr and Mrs Turner dated 28 January 2024 at [86].

Submissions of the Commonwealth

Deployment to Iraq in January 2015

647. In relation to CPL Turner's deployment to Iraq in January 2015, the Commonwealth submits there was no evidence to suggest any potentially traumatic events in this period and that the decision to deploy was made in the context of Dr Sringeri having concluded that CPL Turner's alcohol dependence and PTSD was "in remission".[988]

Referral to an addiction medicine specialist

648. The Commonwealth points out that CAPT KH discussed the potential referral to an addiction medicine specialist with Dr Sringeri who verbally advised that there was "no need for a referral to an addiction specialist".[989]

The AVO in June 2015

649. In relation to the AVO against CPL Turner that police had applied for on 29 June 2015, the Commonwealth submits that BRIG Langford sought a 'two pronged' response to this event, namely psychological counselling and support for CPL Turner and support for Joanna Turner. The Commonwealth points to evidence that counselling with CAPT KH that subsequently occurred and evidence of overtures made to Joanna Turner,[990] particularly by MAJ Clancy.[991] The Commonwealth further notes that while CAPT KH concluded that CPL Turner was not suffering from a relapse from PTSD, CAPT KH referred CPL Turner to Dr Sringeri who reported CPL was "in remission".[992]

BRIG Langford

650. The Commonwealth also objects to Counsel Assisting's criticism that BRIG Langford did not personally make enquiries of Joanna Turner. It contends that, as a matter of procedural fairness, it was necessary to put to BRIG Langford that this was "egregious".[993]

CAPT KH and the Early Return to Australia (**ERTA**)

651. The Commonwealth also objects[994] to any proposed adverse finding about the role of CAPT KH, including whether the ADF, through CAPT KH, failed to respond to the

[988] Submissions of the Commonwealth dated 7 June 2024 at [184]-[186].
[989] Submissions of the Commonwealth dated 7 June 2024 at [242].
[990] Submissions of the Commonwealth dated 7 June 2024 at [202]-[210].
[991] Submissions of the Commonwealth dated 7 June 2024 at [237]-[239].
[992] Submissions of the Commonwealth dated 7 June 2024 at [212]-[213].
[993] Submissions of the Commonwealth dated 7 June 2024 at [217].
[994] Submissions of the Commonwealth dated 7 June 2024 at [180], [181], [195], [215], [221]-[236] and [249].

domestic violence issues that arose in June/July 2015 (including the AVO) as CAPT KH was not called to give evidence. The Commonwealth submits that the documentary evidence suggests CAPT KH gave CPL Turner an appropriate standard of care in this period and actively considered the prospect of PTSD symptoms.[995] It is noted the expert evidence "did not speak with one voice" regarding the presence of PTSD symptoms in 2015.[996] The Commonwealth's objection directs attention to Counsel Assisting's submission on the fact that in 2015 the violence directed towards Joanna Turner did not form part of the ADF's decision-making in relation to deployment and the submissions that focus on the lack of a system in place for the allegations being made by Joanna Turner to be recognised and dealt with by the ADF and the absence of a longitudinal approach to CPL Turner's history which could be taken into account in deployment decisions.

652. The Commonwealth raises a similar objection in relation to findings about the ERTA in 2015 and those people involved in it.[997] The Commonwealth submits that there was a system in place for scrutinising the reasons for the ERTA and supporting Joanna Turner and CPL Turner, namely the RtAPS process and support provided by MAJ Clancy and Padre MP.[998]

Reported incident of domestic violence in September 2015

653. In relation to the incident of reported domestic violence on 17 September 2015, the Commonwealth submits that the reasons why the Subsequent Incident Report "understated" or "minimised" the incident were unknown and cannot be the subject of findings. It is submitted that Counsel Assisting's criticism of the underreporting is affected by hindsight bias but bespeaks the need for better training about PTSD, its relationship to substance abuse and domestic violence, and training on reporting obligations by ADF personnel.[999]

Submissions in reply of Counsel Assisting

Referral to an addiction medicine specialist

654. Counsel Assisting does not support a finding that the proposal to refer CPL Turner to an addiction medicine specialist was "not actioned" given that CAPT KH apparently

[995] Submissions of the Commonwealth dated 7 June 2024 at [222]-[225].
[996] Submissions of the Commonwealth dated 7 June 2024 at [227]-[231].
[997] Submissions of the Commonwealth dated 7 June 2024 at [191]-[194] and [196].
[998] Submissions of the Commonwealth dated 7 June 2024 at [192].
[999] Submissions of the Commonwealth dated 7 June 2024 at [244]-[246].

took advice from, and deferred to the view of, CPL Turner's long-term treating psychiatrist.[1000]

CAPT KH and the ERTA

655. Counsel Assisting also does not seek any adverse finding against CAPT KH.[1001] As the Commonwealth accepts, it is possible "there was a failure on the part of the ADF to 'connect the dots'" in this period.[1002] The suggestion that it was necessary to call CAPT KH to fill some evidentiary gap should be rejected, because there is no real possibility that her presence could influence the outcome of a proposed finding as to the absence of a *system.*

656. Similarly, in relation to the ERTA, Counsel Assisting does not seek a finding against any particular member of the ADF and it is submitted that it is not necessary for Counsel Assisting to call people to explain the absence of a process which plainly did not exist (and it does not seem to be contended that it did exist).[1003]

BRIG Langford

657. As for the Commonwealth's issue with the criticism of BRIG Langford, Counsel Assisting considers the complaint to be based on a false premise.

658. Counsel Assisting notes that the submission regarding BRIG Langford's evidence (above at [642]) does not suggest that any enquiry of Joanna Turner needed to be *personally* done, but rather the nature of his personal knowledge meant that such an enquiry ought to have been made (whether by BRIG Langford personally or at his instigation). The suggestion that it was necessary to put to BRIG Langford that this was "egregious" is without foundation, noting that procedural fairness does not require the adjective to be used to describe a criticism to be put to the witness. The suggestion that fairness required him to be recalled so his evidence could be given with the benefit of *his own email*[1004] should similarly be rejected. Procedural fairness does not require a witness to have shown to them all the potentially helpful documents (in this case, their own documents) that emerge after they have given evidence and then have the questions re-asked.[1005]

[1000] Submissions in reply of Counsel Assisting dated 22 August 2024 at [60].
[1001] Submissions of Counsel Assisting dated 22 August 2024 at [206].
[1002] Submissions of the Commonwealth dated 7 June 2024 at [181].
[1003] Submissions of the Commonwealth dated 7 June 2024 at [192].
[1004] Submissions of the Commonwealth dated 7 June 2024 at [217].
[1005] Submissions of Counsel Assisting dated 22 August 2024 at [208].

Consideration

659. There was a continued escalation of domestic violence throughout 2015 and an ongoing lack of curiosity by those managing CPL Turner about it. When CPL Turner returned home early from Iraq ostensibly by reason of "Joanna Turner's mental health", it is apparent that no inquiries were made into the real circumstances of Joanna's mental health or the impact of the decision to return on CPL Turner's wellbeing. As Counsel Assisting has made clear, a simple phone call to Joanna Turner would have indicated her ongoing fear and contact with police. MAJ Clancy was well aware of what was occurring, but the information did not seem to get connected to CPL Turner's health records or indeed make its way to BRIG Langford.

660. BRIG Langford told the Court that the information would have influenced his decision about whether or not CPL Turner should have been given a medical waiver to deploy to Malaysia. His lack of curiosity about what was really going on for CPL Turner is alarming given that he had met with Joanna Turner after her letter to him the previous year.

661. There are a number of really significant failures of the ADF to properly deal with the escalation of domestic violence. Firstly, there was an inadequate response to the AVO from June 2015 and then when domestic violence was reported in September 2015 it was minimised and understated.

662. I have considered whether CPL Turner should have been referred to an addiction medicine specialist as suggested by Dr Wallace in September 2015. In my view, it would have been an extremely valuable intervention. Nevertheless, I accept the Commonwealth's submission that while CAPT KH discussed the issue with Dr Sringeri, she was advised that there was "no need".

Adequacy of ADF's response in 2016

663. The evidence relevant to this issue is set out in the chronology above at [91]-[275].

Counsel Assisting's submissions

664. Counsel Assisting submits[1006] that, by 2016, the objective evidence demonstrated that CPL Turner had not engaged with mental health treatment during 2015 but rather had declined further treatment despite reporting significant PTSD symptoms to a counsellor

[1006] Submissions of Counsel Assisting dated 2 November 2023 at [460]-[481].

from the VVCS in November 2015. It was also apparent that by the end of 2015 his mental health was seriously impaired.

The 2016 waiver/clearance decision

665. According to Counsel Assisting, there were four key points of failure in the 2016 waiver/clearance, which is more accurately described as the decision by GPCAPT Ross to reverse his decision not to grant CPL Turner a medical clearance for the purposes of OP OKRA.

The Clinical Perspective Document

666. The first point of failure was the involvement of Command in the drafting of MAJ AM's Clinical Perspective Document. The evidence unequivocally demonstrates that this document was drafted by MAJ AM following an indication from Command (MAJ AF) that it was important to Command that CPL Turner deploy. It is submitted that there is no sense in which it can reasonably be described as a "clinical perspective". Rather, it was a one-sided presentation of CPL Turner's mental health prepared by someone who admitted to not having seen CPL Turner in a clinical setting, and which paid almost no regard to the volume of evidence in the ADF health records which demonstrated that CPL Turner had struggled throughout 2015 and failed to engage in any treatment. The only objective indicator of positive mental health appeared to have been his performance in the workplace throughout 2016. Counsel Assisting refers to the expert evidence, which demonstrates that this is an unreliable indicator of whether CPL Turner was experiencing symptoms of PTSD. What was then presented to GPCAPT Ross as a medical perspective was in fact MAJ AM having enacted the Command's intent, which was to have the decision reversed under the guise of a document containing medically relevant information.

The brief drafted by MAJ AF

667. The second point of failure was the brief, which was signed by COL MF and drafted by MAJ AF. That brief expressly assumed and represented a particular premise of the Iraq deployment to GPCAPT Ross, namely "the personnel best able to monitor, asses [sic] and manage his mental health are his regular team members, who he will be deployed with". Counsel Assisting maintains that this was simply not the case. CPL Turner's regular team members had a relapse of PTSD symptoms reported to them and beyond checking in with CPL Turner could not point to any substantive step they took in the face of those disclosures to manage his mental health in any meaningful way. There was no evidence that any member of CPL Turner's team had been

instructed to particularly monitor his mental health, to be on the lookout for signs of relapse, or given any instruction on how to deal with CPL Turner suffering a relapse. Indeed, asking his team members to undertake this task in theatre would have been highly unrealistic. As the evidence of MAJ BJ demonstrated, the situation in Iraq was highly unpredictable and CPL Turner's teammates were occupied with the task at hand. They appeared to have very little capacity, in the midst of their ordinary work, to perform the roles (in theory) assigned to them by the CO's brief.

668. It is further submitted that the assertion put to GPCAPT Ross that the personnel best able to monitor, assess, and manage CPL Turner's mental health were his regular team members was in itself a red flag that should have alerted him (GPCAPT Ross) to the fact that there was no realistic plan in place to monitor and support CPL Turner's mental health should the medical clearance be granted. Counsel Assisting contends that it should have been obvious to GPCAPT Ross, as an experienced member of the ADF's medical staff, that CPL Turner's regular team members would not have had the qualifications and expertise to undertake such a task even if they had the time and the wherewithal to do so.

669. As for the "ready access to coalition medical support" including psychologists, it is very difficult to see how CPL Turner's access could be described as "ready". He was located in TQ where there were no available psychologists. MAJ AF's evidence was that there was either a "psych team" or individual in AMAB (i.e. the UAE) but there was "none in Iraq".[1007] Although there was a hospital with American psychological staff at BDSC, MAJ AF's evidence was that he could not imagine that CPL Turner would have accessed psychological support from coalition partner forces' health services in Iraq.[1008] He explained that this was because he considered CPL Turner would likely want to use the Australian system as compared to a coalition partner system for medical support.[1009]

670. In those circumstances, Counsel Assisting submits that CPL Turner's access to psychological support could hardly be described as "ready". Indeed, in a message to CPL TJ on 14 October 2016, CPL Turner himself stated "the more I think about it, the more I realise that they put me in a bad position. Putting me out here so isolated from everything. Even though it clearly states on my waiver that I need access to medical support".[1010]

[1007] 03/02/23 T156. 30-34.
[1008] 03/02/23 T186.39-41.
[1009] 03/02/23 T198.
[1010] Exhibit 57 (WhatsApp and SMS messages) at 1289.

671. It is submitted by Counsel Assisting that I would comfortably find that:

i. The brief prepared by MAJ AF and signed off by COL MF was prepared for the purpose of persuading GPCAPT Ross to overturn his decision.

ii. No-one involved in the authoring of that document, nor anyone to whom it was sent, took any steps to ensure that what was represented would be done by way of support for CPL Turner in Iraq was in fact done.

iii. The document was simply an advocacy piece to achieve a result: the reversal of GPCAPT Ross' initial decision. It bore no connection to the reality which CPL Turner would face once he was actually deployed.

GPCAPT Ross' decision to reverse the initial decision not to grant medical clearance

672. The third point of failure was in the decision made by GPCAPT Ross to reverse his initial decision not to grant a clearance. It is submitted that I would comfortably find that the reason GPCAPT Ross reversed his decision was the Clinical Perspective Document which MAJ AM authored, that he ought to have been considerably suspicious of the accuracy of that document based on the records he had access to, and that he ought to have been concerned that Command was attempting to influence what every witness agreed was a medical, not Command, decision. Counsel Assisting states that I would also comfortably find that GPCAPT Ross did not subsequently interrogate the medical records to test what was being put to him in the Clinical Perspective Document. Those medical records would have given rise to significant cause for concern as to the reliability of what was being advanced in the Clinical Perspective Document.

Dr Sringeri's letter of 13 July 2016

673. The fourth point of failure was the letter which the ADF "procured" from Dr Sringeri in which Dr Sringeri represented that CPL Turner's risk of recurrence of PTSD symptoms was "very low" and that CPL Turner was "cleared to attend all duties from a psychiatric point". As to the former, it was uniformly agreed by the experts that the use of the term "very low" was problematic because CPL Turner was always at risk of relapse given the severity of the PTSD which he had suffered. As to the latter, it is noted that Dr Sringeri stated that in his correspondence he was not attempting to convey a view that CPL Turner was cleared for deployment to Iraq because this was not a matter for him, but a matter for the ADF medical board and the Chains of Command. If that is correct, Counsel Assisting opines that the language which Dr Sringeri used in his letter is highly

problematic. In Counsel Assisting's view, it is plainly open to be interpreted as Dr Sringeri clearing CPL Turner as fit to be deployed on OP OKRA. This is particularly the case in the context of the referral to Dr Sringeri which expressly asked: "I need your opinion about his deployment, is member fit to deploy?". Counsel Assisting notes that it is very difficult to accept that the ADF should have interpreted Dr Sringeri's letter in any other way than that Dr Sringeri was giving his opinion that CPL Turner was fit to deploy to Iraq. That is what a plain reading of the letter conveys and if Dr Sringeri had not intended that to be how the letter was read, he should have made this clear.

674. Moreover, given the difficulties exposed in the expert evidence as to whether CPL Turner was fit to deploy (that is, could perform his work) and the risks to him if he were deployed (that is, the risk of relapse), the letter from Dr Sringeri was highly inadequate to convey that he was only expressing an opinion about the former and not the latter. Indeed, the letter expressly stated that CPL Turner's risk of relapse was "very low" in a context in which Dr Sringeri was asked for his opinion about deployment.

675. It is submitted that I would comfortably find that Dr Sringeri's letter was "grossly inadequate" in conveying either the risks of deployment on further relapse, and the limitations which he later stated were implicit in his own opinion.

Other submissions about the waiver/clearance decision

676. The way the evidence ultimately appeared to fall was that every person in the decision-making process for the 2016 medical clearance sought to attribute responsibility for that decision somewhere else. The Chain of Command sought to shift responsibility to Dr Sringeri and GPCAPT Ross. Dr Sringeri did not consider it was his role to decide whether CPL Turner was fit for deployment at all and sought to shift responsibility back on the ADF. GPCAPT Ross relied heavily on the documents provided by MAJ AM, which included Dr Sringeri's opinion.[1011] In some respects, it appears that Dr Sringeri was relying on the ADF, and the ADF was in turn relying on Dr Sringeri, and neither had a clear understanding of the role of the other in making decisions about deployment. Counsel Assisting notes that this is concerning as there ought to have been clear roles and responsibilities in the process of decision-making such that each individual involved understood the scope and limitation of the task they were required to undertake. The failure of the system to operate effectively in this way ultimately had

[1011] In submissions in reply, Counsel Assisting notes that the point, as against GPCAPT Ross, is directed to the degree to which he relied on others to make the (medical) assessments which formed the basis of his decision, a matter which GPCAPT Ross himself contends he was entitled to do: Submissions in reply of Counsel Assisting dated 22 August 2024 at [176].

the result that critical information about CPL Turner's risk on deployment was missed in the decision-making process.

677. The way the evidence fell also revealed a significant degree of confusion about the extent to which it was appropriate for Command to be involved and the extent to which the medical clearance was a medical decision only, based on risks to CPL Turner, or if it could take into account the interests of the ADF in having CPL Turner deploy. It appeared that the Chain of Command conceived of GPCAPT Ross' role as being medical only. GPCAPT Ross at some points considered that he was making a purely medical decision but at other points considered that he needed to take into account the interests of the ADF and the operational requirements of the military. Counsel Assisting submits that I would comfortably find there was a lack of clear understanding amongst the various individuals involved in this decision of what was to be taken into account and why.

678. Finally, in relation to MAJ AF's evidence to the effect that he believed and continues to believe that deploying was in CPL Turner's best interests, including in a medical sense (i.e. for his mental health), Counsel Assisting notes that the overwhelming inference from the evidence is that MAJ AF wanted CPL Turner to deploy for operational reasons and not because of any concern about his mental health. To the extent that he believed it was better for CPL Turner to deploy than to stay in Australia, Counsel Assisting submits that this opinion was naïve at best and wilfully blind to available medical information at worst. Counsel Assisting notes that MAJ AF does not have qualifications as a mental health professional and submit that his dogged persistence in his belief, even in the face of all of the evidence now available, that the deployment was good for CPL Turner is concerning in that it tends to suggest an inadequate understanding on the part of leaders in the ADF about the nature of PTSD, the risks of recurrence, the potential triggers, and the importance of taking all these into account in making decisions in the best interests of members.

The Iraq deployment

679. Contrary to what was represented to GPCAPT Ross in the Clinical Perspective Document, there was no actual mental health support put in place for CPL Turner to minimise the risks to him during that deployment. MAJ AF's evidence was that this was limited to "routine engagement by the chain of command". What is made express in that answer is that nothing out of the ordinary was done beyond the mental health and pastoral care that would be expected of the Chain of Command in respect of every member of the ADF.

680. The failure to put supports in place at the outset was exacerbated by the experiences which CPL Turner ultimately had during the deployment, including the disciplinary proceedings, the issuing of the NTSC, being informed of a move from B Company to C Company and the body recovery mission. It is submitted that the people around CPL Turner who were apparently looking after his mental health (MAJ BJ and CAPT MH) were inadequately placed to do so – they were not properly trained and were not in fact in a position to offer the support which CPL Turner needed. CPL TJ was left to deal alone with the brunt of CPL Turner's mental health issues during that deployment. Counsel Assisting considers that she was in a compromised position given her nascent relationship with CPL Turner and was inadequately equipped to manage the significant volatility she experienced from CPL Turner. She ought not to have been put in that position and it could have been avoided by the Chain of Command doing what it had represented it would do in CO's brief.

681. The extent to which there was no real intent to enact any particular support for CPL Turner during the deployment was highlighted most starkly in COL MF's evidence, which was that once CPL Turner was deemed fit to deploy, there were no caveats on his deployment and, therefore, it was not necessary for him to take any steps to avoid the risk of relapse.

The body recovery mission

682. As for the body recovery mission, Counsel Assisting submits that this incident had a negative impact on CPL Turner that precipitated a further decline in his mental health. Noting that it is difficult to know exactly what happened and what CPL Turner was involved in, Counsel Assisting believes that it is clear beyond doubt that something did happen and that CPL Turner was triggered into relapse by it. This tends to demonstrate how unpredictable deployment to a warzone can be and that there was an overreliance on the idea that because the deployment was simply "train, advise, and assist", there was minimal risk of re-traumatisation.

683. Counsel Assisting stresses that none of this is to say that a finding or recommendation should be made that persons who have been diagnosed PTSD are not deployable. As MAJ AM stated in his evidence, the ADF has worked over a long period to reduce the stigma of a diagnosis of PTSD and he considered the ADF was at a stage now where members will admit to mental health problems and do not feel as though they will be marginalised by their peers or the system when they do. MAJ AM stated his "fear" would be that an output of the Inquest would be that the ADF never deploys anyone

who had a mental health diagnosis. In his view, those people would not come forward with symptoms if that was the potential outcome.[1012]

684. Counsel Assisting notes that whilst this was a valuable contribution from MAJ AM, the focus of his concerns tends to reveal a greater difficulty with the focus of the ADF throughout the Inquest on emphasising that just because a member has had PTSD does not mean they should not ever be deployed. Counsel Assisting submits that this was and remains a strawman. Rather, the question to be determined at the Inquest has been and remains the manner and cause of CPL Turner's death and, in that regard, the appropriateness of the decision to deploy him on OP OKRA in 2016.

685. None of the shortcomings which have been identified with that decision say anything about whether a different member who has suffered PTSD in the past should be deployed. Counsel Assisting posits that the shortcomings identified in the evidence in this Inquest are all firmly grounded in the failure, both at the unit level and the J07 HQJOC level, to adequately consider the available information in relation to CPL Turner's presentation, assess the risks associated with his personal situation, and respond appropriately in deployment and waiver/clearance decision-making.

Submissions of Mr and Mrs Turner

The 2016 waiver/clearance decision

686. Mr and Mrs Turner submit that GPCAPT Ross' reliance on MAJ AM "as a medical officer who had direct clinical knowledge" of CPL Turner was misplaced, noting that MAJ AM was not his treating physician. They also contend that MAJ AM did not have direct access to CPL Turner's medical records when he prepared the Clinical Perspective Document and, rather, he wrote this document from a remote location (which impacted the availability of clinical records to him).[1013] They consider that MAJ AM's oral evidence supports a conclusion that he did not review CPL Turner's medical records himself and, instead, he relied on a junior RMO to relay relevant information to him over the telephone.[1014] CPL Turner's parents submit this was less than satisfactory.

687. They also submit that given the Clinical Perspective Document was written outside of working hours, it would be reasonable to conclude that there was also no consultation

[1012] 06/08/21 T22.29-42.
[1013] Submissions of Mr and Mrs Turner dated 28 January 2024 at [162]-[173].
[1014] Submissions of Mr and Mrs Turner dated 28 January 2024 at [169].

with any of CPL Turner's treating clinicians (noting also that MAJ AM did not give evidence that he spoke with any clinicians).[1015]

688. CPL Turner's parents contend that MAJ AM should not have titled his document "clinical perspective" because he was not a treating clinician. They consider that in light of the document's title, it was understandable that GPCAPT Ross relied on that document as the professional opinion of MAJ AM, seemingly believing that MAJ AM had direct clinical knowledge of CPL Turner.[1016]

Submissions of the Commonwealth

689. With the benefit of hindsight, the ADF accepts that its operational personnel did not sufficiently understand, or they underestimated, the extent to which a person suffering from PTSD (or other mental health issues) can successfully conceal signs/symptoms and continue to perform at a legal level in the workplace. The ADF also accepts that further training about this matter is necessary. However, the Commonwealth notes that CPL Turner's continued high performance was not irrelevant to the question of whether he was suitable for deployment in 2016, and certainly was not regarded as irrelevant.[1017]

690. Other matters which, at the time, pointed in favour of deployment are submitted to be: CPL Turner's desire to be deployed; the fact he recently completed two training exercises (Exercise Night Tiger and Exercise Balikatan) which required pre-deployment health screening; the fact he was MEC J23 (and was in the process of being upgraded to J11); the nature of the mission being "train, advise and assist"; that there was a "no alcohol" direction; and "from the perspective of the operational personnel", "CPL [Turner] had a history of positively engaging with mental health services".[1018] The understanding at the time of the adequacy of psychological services while on deployment and the ability of CPL Turner's peers to monitor him (see below at [700]) are also relied upon in this respect.[1019] As to the monitoring by peers, the Commonwealth accepts that in hindsight that strategy failed, largely due to the decision to post CPL Turner to TQ.[1020] However, it is submitted that decisions concerning his movement were not made frivolously or without regard to CPL Turner's welfare.[1021]

[1015] Submissions of Mr and Mrs Turner dated 28 January 2024 at [169]-[170].
[1016] Submissions of Mr and Mrs Turner dated 28 January 2024 at [172].
[1017] Submissions of the Commonwealth dated 7 June 2024 at [79], [264].
[1018] Submissions of the Commonwealth dated 7 June 2024 at [259]-[278].
[1019] Submissions of the Commonwealth dated 7 June 2024 at [378]-[379].
[1020] Submissions of the Commonwealth dated 7 June 2024 at [432].
[1021] Submissions of the Commonwealth dated 7 June 2024 at [432]-[441].

The deployment decision

691. The ADF also accepts that there is force in Counsel Assisting's submissions above at [676] and [677] about "the decision-making process for the 2016 medical clearance". It notes that when the evidence is looked at as a whole and with the benefit of hindsight, there was an insufficiently clear understanding on the part of the 2CDO Chain of Command, ADF medical personnel, and Dr Sringeri about their respective "roles and responsibilities in the process of decision-making", including the "scope and limitation[s]" of their tasks.[1022] As a general submission, the Commonwealth observes that those involved in the medical clearance process did not have the benefit of hindsight and the time the Inquest has had to consider this decision and they were faced with a difficult decision (that included the decision to be made by MAJ AM),[1023] for which there was not an obviously correct answer.[1024]

692. The Commonwealth also submits that Counsel Assisting ought to have had regard to the circumstances in which MAJ AM prepared the Clinical Perspective Document, that is: his physical location at Port Wakefield; the limited time in which he had to prepare the document; that he did not have "ready access" to his email or DeHS; his lack of access to CPL Turner's medical records; and his inability to secure input from others.[1025]

693. The Commonwealth also submits that, in relation to the medical clearance process, "[i]n retrospect, the ADF accepts that the risk of relapse of CPL Turner's PTSD should have been identified as higher than it was".[1026]

694. The ADF also accepts its responsibility to ensure its medical personnel are sufficiently trained with respect to mental health issues (like PTSD) that may be expected to be present among ADF members.[1027]

695. The ADF considers it would be appropriate for it to consider reviewing its policy framework with respect to the making of deployment decisions for ADF members who have or have had a diagnosis of PTSD or another similar mental health condition, with a view to:

    i. consider implementing training programs "designed to ensure that operational personnel and medical personnel have a clear understanding of their roles and

[1022] Submissions of the Commonwealth dated 7 June 2024 at [316].
[1023] Submissions of the Commonwealth dated 7 June 2024 at [331]-[333].
[1024] Submissions of the Commonwealth dated 7 June 2024 at [312]-[314].
[1025] Submissions of the Commonwealth dated 7 June 2024 at [335]-[336].
[1026] Submissions of the Commonwealth dated 7 June 2024 at [315].
[1027] Submissions of the Commonwealth dated 7 June 2024 at [330].

responsibilities with respect to the making of deployment decisions for ADF members diagnoses with PTSD" or another similar mental health condition;[1028] and

ii. developing clear guidelines about (i) how such decisions should be made; (ii) the roles and responsibilities of operational personnel, medical personnel, and any external health practitioners in the making of such decisions; (iii) the information to which operational personnel, medical personnel, and any external health practitioners may and may not have access in making such decisions; and (iv) in the event that a decision to deploy is made, the development and implementation of risk mitigation strategies.[1029]

696. The Commonwealth considers that a review of this kind would be the best way of achieving the goals underlying Counsel Assisting's recommendations (l), (m), and (n) (see below).[1030]

697. The Commonwealth also makes the following three key submissions in relation to the deployment decision:

i. While the ADF accepts that there is evidence that there was a "failure of the system to operative effectively", it considers there to be no "proper basis" for a finding that MAJ AF and MAJ AM "did not have regard to the interests of CPL Turner" or "decided to prioritise ADF's operational interests over CPL Turner's" in the 2016 deployment decision.[1031]

ii. No finding can be made that MAJ AM, when preparing the Clinical Perspective Document, simply "enacted the [chain of] command's intent" with "almost no regard to the volume of evidence in the ADF health records".[1032] It is submitted that no findings should be made about the appropriate level of involvement by the Chain of Command given the absence of evidence on the topic.[1033]

iii. It is not open to find that the Clinical Perspective Document was the only document that GPCAPT Ross considered when making the second/reversal decision.[1034] It is submitted that the brief to GPCAPT Ross also contained new

[1028] Submissions of the Commonwealth dated 7 June 2024 at [318(b)].
[1029] Submissions of the Commonwealth dated 7 June 2024 at [318(a)].
[1030] Submissions of the Commonwealth dated 7 June 2024 at [318(a)].
[1031] Submissions of the Commonwealth dated 7 June 2024 at [319].
[1032] Submissions of the Commonwealth dated 7 June 2024 at [325].
[1033] Submissions of the Commonwealth dated 7 June 2024 at [380(a)].
[1034] Submissions of the Commonwealth dated 7 June 2024 at [381]-[384].

information in the sense of the Chain of Command's perspective about mitigation strategies.[1035]

698. It is also noted that the ADF accepts that the fact that MAJ AM did not have a clearer understanding about how he was expected to balance his various roles and responsibilities, in particular, about "what was to be taken into account and why" as part of the medical clearance decision, is a failure on the part of the ADF to sufficiently delineate roles and responsibilities and offer training accordingly.[1036]

Dr Sringeri's letter dated 13 July 2016

699. The ADF's view is that there was nothing inappropriate or unreasonable about the fact that the ADF relied on Dr Sringeri's letter and that a finding ought not be made that Dr Sringeri's review fell short of an appropriate, peer accepted standard.[1037] It is submitted that as part of GPCAPT Ross' brief, its presence and content should have particular importance given Dr Sringeri's expertise and existing clinical relationship with CPL Turner.[1038]

700. It is further submitted the Dr Sringeri's letter supported the conclusion that CPL Turner's colleagues would be capable of monitoring CPL Turner's mental health on deployment, a conclusion also supported by the proximity of those colleagues while on deployment and the fact that peers had raised concerns in the past.[1039]

Body recovery incident

701. The Commonwealth notes that the incident that appears to have triggered a relapse of PTSD during the 2016 deployment was the involvement in the body recovery incident, which in the period January to June 2016, would perhaps not have been regarded as an especially traumatic incident. With the benefit of hindsight, the ADF accepts that this view (to the extent held) was misplaced and that there is a need for better training about the risk of relapse of PTSD, including the range of potential causes of relapse. However, to say that a more nuanced understanding of the risk of relapse of PTSD needs to be developed is not to say that there was anything inappropriate or unreasonable in the fact that the relevant operational personnel took into account the

[1035] Submissions of the Commonwealth dated 7 June 2024 at [380(b)].
[1036] Submissions of the Commonwealth dated 7 June 2024 at [327]-[328].
[1037] Submissions of the Commonwealth dated 7 June 2024 at [374].
[1038] Submissions of the Commonwealth dated 7 June 2024 at [363]-[371], [385].
[1039] Submissions of the Commonwealth dated 7 June 2024 at [378].

nature of the deployment for which CPL Turner was being considered, or that they made relativistic or probabilistic decisions about the level of risk that it posed.[1040]

702. The Commonwealth submits that there is "no firm evidentiary basis for the proposition that CPL Turner's mental health was in decline" prior to the body recovery which occurred in September 2016.[1041] However, the ADF does accept that "the evidence indicates that the incident that appears to have triggered a relapse of CPL Turner's PTSD during the 2016 deployment was his involvement in the body recovery, especially his involvement in the ramp ceremony associated with that recovery".[1042]

Submissions of GPCAPT Ross

The 2016 waiver/clearance decision

703. GPCAPT Ross embraces Mr and Mrs Turner's submission in relation to the "title" of the Clinical Perspective Document (as noted at [688] above). However, in relation to Mr and Mrs Turner's submission that his reliance on MAJ AM as a medical officer who had direct knowledge of CPL Turner was "misplaced", GPCAPT Ross notes that his evidence[1043] made it clear that he was not labouring under any misapprehension that MAJ AM was CPL Turner's treating physician.[1044]

704. GPCAPT Ross submits that he was not ignorant of the information in CPL Turner's medical records, nor did he act inconsistently with it; rather, he made his initial decision to refuse to grant the clearance "in reliance on" that information, which was the best and most complete information available to him at the time.[1045]

705. GPCAPT Ross contends that in assessing his decision to grant CPL Turner clearance to deploy, it is key to bear in mind the important role played in the MEC system (in that, as CPL Turner held a MEC J23 at the time, he was *prima facie* deployable on OP OKRA but was required to obtain medical clearance).[1046]

706. GPCAPT Ross submits that the finding advocated by Counsel Assisting concerning the "third point of failure" (set out at [671(iii)]) should be rejected, noting that it cannot reasonably be found that (a) GPCAPT Ross made his appeal/reversal decision on the

[1040] Submissions of the Commonwealth dated 7 June 2024 at [84]-[89], [272].
[1041] Submissions of the Commonwealth dated 7 June 2024 at [448].
[1042] Submissions of the Commonwealth dated 7 June 2024 at [430].
[1043] 06/08/21 T36.29-37; 10.02.21 T19.12-18.
[1044] Submissions of GPCAPT Ross dated 5 June 2024 at [63].
[1045] Submissions of GPCAPT Ross dated 5 June 2024 at [19].
[1046] Submissions of GPCAPT Ross dated 5 June 2024 at [25]-[26].

Clinical Perspective Document alone and (b) GPCAPT Ross did not interrogate the medical records to test what was being put to him in that document.[1047]

707. GPCAPT Ross disagrees with any contention that he sought to assign responsibility to others for the medical clearance decision. He submits that he has at all times acknowledged and accepted that the decision first to refuse and subsequently grant the clearance was made by him (without meeting with CPL Turner).[1048] He accepts that it was his decision to make and not Dr Sringeri's.[1049] He submits that he was entitled to rely on (and did in fact rely on) material provided by MAJ AM (the Clinical Perspective Document) and Dr Sringeri's letter dated 13 July 2016 in making his appeal/reversal decision, which placed him in an invidious position in that the material "on its face addressed the matters that had caused him to make the Initial Decision and reject medical clearance, but which did not refer to limitations with that information that were apparently operating on the minds of those who drafted the documents".[1050]

708. GPCAPT Ross submits that while MAJ AF accepted that the (draft) minute was intended to influence GPCAPT Ross to change his initial decision to refuse medical clearance and that COL MF accepted that he intended for the minute to influence GPCAPT Ross as to whether CPL Turner should be granted medical clearance, it does not follow that GPCAPT Ross was *in fact* influenced by any Command imperative in making the appeal/reversal decision.[1051] Rather, his evidence was that it was not the fact that the RMO had provided information that caused him to change his decision – it was the *substance* of the information.[1052]

709. GPCAPT Ross also acknowledges that in making his appeal decision, he considered the availability of in-country psychological support in accordance with ADF risk assessment policy (noting that deployment carries an inherent risk of trauma). He submits that while the risk of trauma tragically came to pass, this does not in itself indicate any error in GPCAPT Ross' risk assessment process nor in the decision to grant medical clearance to deploy.[1053]

710. GPCAPT Ross notes that as part of the risk assessment, he took into account the risk to the ADF of CPL Turner's deployment, the medical support available to him in country, that he had recently deployed successfully, the potential risk in Iraq, the

[1047] Submissions of GPCAPT Ross dated 5 June 2024 at [88].
[1048] Submissions of GPCAPT Ross dated 5 June 2024 at [9], [46].
[1049] Submissions in reply of GPCAPT Ross dated 22 July 2024 at [13].
[1050] Submissions of GPCAPT Ross dated 5 June 2024 at [47]-[48].
[1051] Submissions of GPCAPT Ross dated 5 June 2024 at [104]-[105].
[1052] Submissions of GPCAPT Ross dated 5 June 2024 at [107].
[1053] Submissions of GPCAPT Ross dated 5 June 2024 at [120]-[121].

matters outlined in the Clinical Perspective Document, and potentially "other factors". He acknowledged that there is no good way to determine who amongst those who have had PTSD and have redeployed are at higher or lower risk of the negative outcome coming to pass once deployed. He could not have been expected to anticipate and assess the particular chain of events that occurred on and following CPL Turner's deployment.[1054]

711. GPCAPT Ross also notes that there is no counterfactual by which to assess how CPL Turner would have fared had he not been deployed in 2016 in that it is not possible to assess how his mental health might have been affected had he remained in Australia while his B Company colleagues deployed, nor what relationship issues and other stressors he might have experienced in the barracks environment during that time. In this sense, it was outside the scope of GPCAPT Ross' role to assess the consequences of an individual not deploying.[1055]

712. Lastly, GPCAPT Ross states that there is no consensus medical opinion before the Inquest to invalidate the presumption on which his reversal decision rests; namely, that a person who has suffered from PTSD in the past but is now presenting as asymptomatic or minimally symptomatic is capable of deploying and is not as an unacceptably high risk of suffering recurrence of PTSD in doing so.[1056]

The role of Dr Sringeri and his letter of 13 July 2016

713. GPCAPT Ross submits that a finding should be made that one of the documents that was before him when he made the appeal/reversal decision and which he took into account was Dr Sringeri's letter of 13 July 2016 and, furthermore, that he was entitled to rely on the opinion expressed in the letter as there was nothing on its face that would put GPCAPT Ross on notice as to any limitations or qualifications on those opinions.[1057] He further submits that it would be "extremely difficult for him not to have accepted Dr Sringeri's expert opinion as to CPL Turner's psychiatric condition" given Dr Sringeri was a qualified psychiatrist, he was CPL Turner's treating psychiatrist, and his opinions were addressed directly to the matters that had caused GPCAPT Ross to refuse clearance in his initial decision.[1058]

[1054] Submissions of GPCAPT Ross dated 5 June 2024 at [122]-[125].
[1055] Submissions of GPCAPT Ross dated 5 June 2024 at [118]-[119].
[1056] Submissions of GPCAPT Ross dated 5 June 2024 at [108]-[117].
[1057] Submissions of GPCAPT Ross dated 5 June 2024 at [67]-[71].
[1058] Submissions of GPCAPT Ross dated 5 June 2024 at [73]; Submissions in reply of GPCAPT Ross dated 22 July 2024 at [16].

714. In support of this submission, GPCAPT Ross refers to the expert evidence on this point.[1059] GPCAPT Ross also considers that he was entitled to assume that Dr Sringeri had made whatever enquiries necessary to satisfy himself as to the veracity of CPL Turner's presentation, to consider the possibility he was underreporting his symptoms, and to report anything of significance in the letter. GPCAPT Ross considers that there is nothing on the face of Dr Sringeri's letter to suggest that CPL Turner might have been downplaying his symptoms for fear of career repercussions or that CPL Turner's objective was to obtain a letter that would permit him to deploy.[1060]

715. GPCAPT Ross notes that Dr Sringeri's letter addressed the concerns he had at the time of making the initial medical clearance decision, namely CPL Turner's discontinuation of his psychological treatment, suggesting he might have poor insight into his condition (Dr Sringeri considered he required no psychiatric follow-up and opined that CPL Turner "had good insight"); CPL Turner's alcohol consumption (Dr Sringeri noted he "consumes alcohol only on the weekends and special occasions and monitors his alcohol intake"); CPL Turner was at "high risk of deterioration if deployed" (Dr Sringeri opined that the risk of his PTSD recurring was "very low"); and the risk of granting the medical clearance to deploy to a person with symptomatic PTSD (Dr Sringeri described CPL Turner as "symptom free").[1061]

716. GPCAPT Ross also states that while Dr Sringeri gave evidence that he did not recall receiving the referral letter from Dr Aftab, the fact that it is contained in ADF records suggests that it was provided to him.[1062]

717. In relation to Dr Sringeri's contention that the clearance was a matter for the ADF medical board and the Chains of Command (and not Dr Sringeri), GPCAPT Ross considers that Dr Sringeri should have known and accepted that the decision-makers in the ADF would rely on his opinion. GPCAPT Ross considers that a finding ought to be made that Dr Sringeri was aware that ADF personnel would be receiving his letter for the purposes of assessing whether CPL Turner was medically fit to deploy to Iraq and that they would read his opinion that CPL Turner was "cleared to attend all duties from a psychiatric point" as an opinion that he was psychiatrically fit to deploy.[1063]

718. Furthermore, GPCAPT Ross submits that there is nothing on the face of the letter of 13 July 2016 that conveys any limitation as to Dr Sringeri's requirement to "determine

[1059] 08.02.23 T73.33-T75.8, T74.15-32, T77.42-46, T81.14-40.
[1060] Submissions of GPCAPT Ross dated 5 June 2024 at [76], [80].
[1061] Submissions of GPCAPT Ross dated 5 June 2024 at [72].
[1062] Submissions of GPCAPT Ross dated 5 June 2024 at [77].
[1063] Submissions of GPCAPT Ross dated 5 June 2024 at [78].

whether a patient is well enough to be cleared to return to work to attend to duties", nor that his opinion about CPL Turner being cleared to attend all duties from a psychiatric perspective "was not intended to imply or suggest that [he] cleared [CPL Turner] to deploy in a combat zone".[1064] GPCAPT Ross also refers to the evidence of the experts who support the view that opining as to fitness for duty was within the scope of Dr Sringeri's role.[1065] He further submits that while the decision as to medical clearance did not ultimately rest with Dr Sringeri, this did not relieve him of the obligation to ensure that the opinion as to psychiatric fitness he provided could be accepted on its face.

719. In respect of Counsel Assisting's submission that it is difficult to accept that "the ADF should have interpreted Dr Sringeri's letter in any other way than that Dr Sringeri was giving his opinion that CPL Turner was fit to deploy", insofar as the reference to the ADF includes GPCAPT Ross, GPCAPT Ross emphasises that his evidence was that while he did not recall receiving the letter, this does not mean that he did not receive the letter, and that if he did receive the letter he would have taken it into account in making the appeal/reversal decision.[1066]

720. In respect of Dr Sringeri's submission that his letter did not express any opinion that CPL Turner was "fit to deploy" (see below at [723]), GPCAPT Ross submits that Dr Sringeri must be taken to have understood the significance of him expressing the view that CPL Turner was "well and stable", "cleared to attend all duties from a psychiatric point", that his "chances of recurrence of his PTSD symptoms [were] very low", and that his "risk of self and harm to others [were] also very low". GPCAPT Ross considers it is not plausible to relieve Dr Sringeri of responsibility for the opinion he did express simply because the decision to deploy CPL Turner was ultimately not his to make and because he did not use the phrase "fit to deploy" in the letter. Rather, if Dr Sringeri did not intend the person who *would* make that decision to take those statements at face value and to rely on them in making that decision, then his letter should have made that clear.[1067]

[1064] Submissions of GPCAPT Ross dated 5 June 2024 at [79]-[80].
[1065] Exhibit 9 (Supplementary Report of Dr Nie Issen) at 3; Tab 109 (Report of Professor Large) at 1745-6, 1789-90; 07.02.23 T83.16-28; 08.02.23 T3.49-50.
[1066] Submissions of CPCAPT Ross dated 5 June 2024 at [90]-[91].
[1067] Submissions in reply of GPCAPT Ross dated 22 July 2024 at [14]-[15].

Submissions of Dr Sringeri

Dr Sringeri's letter dated 13 July 2016

721. In relation to his letter dated 13 July 2016, Dr Sringeri objects to Counsel Assisting's use of adjectives such as "grossly" inadequate, "highly" problematic, and "highly inadequate". Dr Sringeri submits the language used is inflammatory and the adjectives are unsupported by expert evidence and are inconsistent with the purpose of an inquest, which is not to apportion blame or guilt.[1068]

722. Dr Sringeri does not dispute that the experts all expressed a similar opinion in respect of his assessment of risk recurrence of CPL Turner's PTSD symptoms as being "very low". Dr Sringeri submits that, impliedly, he accepted the expert evidence that the use of the words "very low" risk was problematic. He was invited to put on a statement responding to the expert evidence on that point and did not do so.[1069]

723. Despite the expert evidence in relation to the words "very low", it is noted that there was no actual criticism made by the experts that that terminology was "inappropriate" or that it was "highly" or "grossly" inadequate language to use in order to convey "the risks of deployment on further relapse, and the limitations which he later stated were implicit in his own opinion". Dr Sringeri's view is that Counsel Assisting's submissions do not address similar opinions expressed by Dr Large, Dr Nielssen, Dr Dinnen, and Professor Hopwood that, as at the date of 13 July 2016, it was an available view that CPL Turner was fit to deploy from a psychiatric perspective as his symptoms were mild.[1070]

724. Dr Sringeri further submits that it is unclear what evidence Counsel Assisting is referring to in the passage "the limitations which he later stated were implicit in his own opinion" above at [675]. Dr Sringeri notes that his opinion in his letter dated 13 July 2016 was "cleared for all duties" and that his opinion did not state CPL Turner "*was 'fit' for deployment*". It is apparent from the letter that the opinion was expressly noted to be from his perspective as a psychiatrist. Despite that, Counsel Assisting at various times asked whether it was reasonable for a psychiatrist to use the language "fit to deploy" point of view, or whether a psychiatrist should refrain from any view as to fitness. As stated by Professor Hopwood, there is no universally agreed standard as to how psychiatrists express themselves.[1071]

[1068] Submissions of Dr Sringeri dated 24 April 2024 at [4]-[8], [16].
[1069] Submissions of Dr Sringeri dated 24 April 2024 at [9].
[1070] Submissions of Dr Sringeri dated 24 April 2024 at [10]-[11].
[1071] Submissions of Dr Sringeri dated 24 April 2024 at [17]-[18], [23]-[24].

725. Dr Sringeri submits that it is not necessary for a finding to be made on the language or terminology used in his letter dated 13 July 2016. Rather, a finding should be confined to the fact that Dr Sringeri's opinion of a "very low" risk of recurrence of PTSD symptoms was not supported by the experts in their oral evidence.[1072]

726. Notwithstanding his decades of experience as a consultant psychiatrist, Dr Sringeri disagrees[1073] with any contention that he had "expertise" in PTSD and alcohol use disorder (as at 2014). Dr Sringeri submits that his evidence was that "the number of patients he saw with combat-related PTSD were about 15-20, the number serving in the ADF were 2, (on the evidence when it was given, at that stage) and of the 15-20 combat-related patients, 50% suffered from PTSD". Dr Sringeri also contends that any description of him being "well familiar"[1074] with the general nature of the duties that CPL Turner performed as a member of 2CDO is "highly speculative" and not supported by the evidence.

Letter from Dr Sringeri's representatives dated 11 August 2021 (Exhibit 19)

727. Dr Sringeri refers to questions posed by Counsel Assisting via email on 11 August 2021 in relation to whether: he considered the risks associated with deployment at the consult on 13 July 2016; and CPL Turner should be cleared for deployment. Dr Sringeri's response (Exhibit 19) was that he did consider the risks associated with deployment (his notes reflected this) and that he undertook a PCL-M, which scored 10, indicating little or no symptoms. Dr Sringeri submits that clearance for deployment was not a matter for him, it was for the ADF medical board and the Chains of Command.[1075]

728. In relation to the Commonwealth's complaints about the manner in which Exhibit 19 was tendered into evidence, Dr Sringeri notes that the manner in which was tendered resulted from the piecemeal production of material and the tender of pertinent, if not crucial material, after the evidence of significant factual witnesses.[1076]

729. Dr Sringeri submits that insofar as the Commonwealth alleges that *prior* to Counsel Assisting posing the questions to Dr Sringeri which led to the response which became Exhibit 19, those assisting advised Dr Sringeri's solicitors that his letter dated 13 July 2016 "did exist", that allegation ought to be rejected. Dr Sringeri seeks leave to tender

[1072] Submissions of Dr Sringeri dated 24 April 2024 at [27].
[1073] Submissions in reply of Dr Sringer dated 22 July 2024 at [55]-[60].
[1074] Submissions of the Commonwealth dated 7 June 2024 at [370].
[1075] Submissions of Dr Sringeri dated 24 April 2024 at [14]; Exhibit 19 at 1.
[1076] Submissions in reply of Dr Sringeri dated 22 July 2024 at [9]-[14].

an email chain from those assisting in December 2021 for the purpose of dispelling this allegation.[1077]

730. Dr Sringeri notes that: the letter was not tendered in evidence at the time he (or GPCAPT Ross) gave evidence; he was not recalled to give evidence in relation to the letter after its tender (which no party objected to); there was no objection to the tender of his statement dated 5 August 2021 (Exhibit 15) which responded to criticisms of the 16 July 2016 letter made by Professor McFarlane nor was Dr Sringeri recalled to give evidence in relation to Exhibit 15; there was no objection to Dr Sringeri's letter (Exhibit 19) and he was not recalled to give evidence about that letter.[1078] Dr Sringeri considers that it was open to the ADF and/or GPCAPT Ross to recall him to give evidence and because they did not, any assertion that the logic of Exhibit 15 being "illusive" and that his claim of being unfamiliar with the duties of ADF members being "unpersuasive" ought to be rejected on the grounds that this ought to have been put to Dr Sringeri at the Inquest.[1079]

The referral from Dr Ahmed

731. Dr Sringeri disputes that his letter dated 13 July 2016 was "procured" by the ADF, as described by Counsel Assisting (see above at [673]). Dr Sringeri states that the issue of whether that letter arose as a result of being "procured" by the ADF was never explored at the Inquest and at no time was Dr Sringeri asked whether he had received a letter of referral from ADF, in particular a letter from Dr Ahmed[1080] (noting that the actual letter of referral was not produced or tendered into evidence and that Dr Ahmed was not called to give evidence). Rather, Dr Sringeri submits that there is no evidence to support the proposition that Dr Sringeri ever received a referral letter dated 11 July 2016 and, to the contrary, Dr Sringeri's evidence supports an inference that he never received such a letter (his notes dated 13 July 2016 record "Ian initiated appointment"). Dr Sringeri highlights that there is no reference to a referral being provided by CPL Turner or to Dr Sringeri being in receipt of a referral from the ADF and that during the consultation there was a discussion about CPT Turner wanting to go on deployment and needing psychiatric clearance. CPL Turner advised the deployment was training Iraqi soldiers and did not involve combat.[1081]

[1077] Submissions in reply of Dr Sringeri dated 22 July 2024 at [65]-[71]. Dr Sringeri also requested that the Commonwealth's submission be redacted.
[1078] Submissions in reply of Dr Sringeri dated 22 July 2024 at [9]-[25].
[1079] Submissions of the Commonwealth dated 7 June 2024 at [147]-[148].
[1080] Tab 50 at 9.
[1081] Submissions of Dr Sringeri dated 24 April 2024 at [19]-[20], [22].

732. Dr Sringeri disagrees with GPCAPT Ross' submission that "the fact [the referral] is contained in the ADF records suggests [the referral from Dr Ahmed] was provided to him" in that what is within the ADF records is the *summary* referring to the purported referral – not the *actual referral*.[1082]

733. Dr Sringeri notes that his letter of 13 July 2016 must be considered in light of what was known to Dr Sringeri when he assessed CPL Turner that day and that even if he had been in receipt of the referral letter from Dr Ahmed (which he denies), that letter was devoid of any relevant information regarding CPL Turner's medical records.[1083]

Role in determining clearance for deployment

734. Dr Sringeri contends that Counsel Assisting's submission that Dr Sringeri "sought to shift responsibility back on the ADF" in the context of who was responsible to determine whether CPL Turner was fit for deployment is "somewhat unfair" on the basis that "this was not his evidence". Rather, Dr Sringeri's response to a question about whether his reports may be relevant to a decision made about CPL Turner's medical classification or fitness to deploy was that "I may help them, but it is just our advice-medical advice as a civilian doctor". In this sense, Dr Sringeri reiterates that the clearance was not for him to decide, as it was a matter for the ADF medical board and the Chains of Command. This accords with the evidence of Professor McFarlane that "it isn't the individual psychiatrist's role to make that recommendation".[1084]

735. Dr Sringeri submits that, in the circumstances, the inclusion of Dr Sringeri as "one or amongst one of" the decision-makers determining a medical clearance for deployment ought to be resisted as (i) the words of "fit to deploy" or "fitness for deployment" were never scribed in his letter dated 13 July 2016;[1085] (ii) his opinion was open to be accepted or rejected by the ADF; and (iii) where GPCAPT Ross did hold such concerns as to whether CPL Turner should deploy (given he was *prima facie* "deployable"), it was open to GPCAPT Ross to discuss the matter with Dr Wallace or to ring Dr Sringeri.[1086]

736. In response to GPCAPT Ross' submission that Dr Sringeri was attempting to distance himself from the opinion expressed in the 13 July 2016 letter and that GPCAPT Ross was entitled to fully rely upon the letter, Dr Sringeri's view[1087] is that the submission is

[1082] Submissions in reply of Dr Sringeri dated 22 July 2024 at [63]-[64].
[1083] Submissions in reply of Dr Sringeri dated 22 July 2024 at [52].
[1084] Submissions of Dr Sringeri dated 24 April 2024 at [28]-[29], [33]-[34].
[1085] Submissions of Dr Sringeri dated 24 April 2024 at [35].
[1086] Submissions in reply of Dr Sringeri dated 22 July 2024 at [53].
[1087] Submissions in reply of Dr Sringeri dated 22 July 2024 at [51]-[54].

unsupported by the evidence and ought to be rejected. Rather, Dr Sringeri contends that GPCAPT Ross fails to acknowledge the clear and apparent inconsistencies between what is contained with the ADF medical records and the information about the clinical review that Dr Sringeri sets out in the 13 July 2016 letter. In this regard, he refers to the evidence of Professor McFarlane (who indicated that he would have expected GPCAPT Ross to have carefully looked at the other documentation within the ADF medical records, not take Dr Sringeri's report on "face value", and scrutinise the other documents and not view Dr Sringeri's report in isolation)[1088] and Professor Hopwood (who said that GPCAPT Ross could rely upon the report "as much as any psychiatric assessment of a single session is reliably" and that assuming Dr Sringeri was competent would not "obviate the responsibility to acknowledge the limits of that assessment, as knowledge that a single assessment may not always tell the whole picture").

737. Dr Sringeri submits[1089] that it would be procedurally unfair to accept the Commonwealth's and GPCAPT Ross' submissions that parts of Exhibit 15 are an attempt by Dr Sringeri to limit, qualify, or distance himself from his 13 July 2016 letter, merely upon the same grounds that the opinion as expressed in the 27 October 2014 letter is the same opinion expressed in the 13 July 2016 letter.[1090]

738. Dr Sringeri also notes that his oral evidence that it was not the role of the individual psychiatrist to make a recommendation (as to fitness to deploy) was consistent with the evidence of Professor McFarlane's evidence that "we have a medical practitioner who is not really asking or writing an appropriate letter to a psychiatrist outside of the military, knowing the limitations of that persons' capacity, knowing-and not probably really understanding the specific information that needs to be required to actually fully answer that question".[1091]

739. Dr Sringeri also points out that Professor McFarlane saw the 13 July 2016 letter as a "red flag" in the context of the "woefully inadequate" referral letter dated 11 July 2016 (which it was assumed Dr Sringeri was in receipt of) which was not an appropriate referral letter "to a psychiatrist outside of the military, knowing the limitations of that persons capacity, knowing and not probably really understanding the specific information that needs to be required to actually fully answer the question".[1092]

[1088] 08/02/2023 T74.27-40, T78.35-45, T80.22, T80.50-T81.7.
[1089] Submissions in reply of Dr Sringeri dated 22 July 2024 at [40].
[1090] Submissions in reply of Dr Sringeri dated 22 July 2024 at [45]..
[1091] 08/02/24 T12.43-50.
[1092] Submissions in reply of Dr Sringeri dated 22 July 2024 at [50].

Submissions of CAPT MH

740. CAPT MH submits[1093] that during the Iraq deployment (where he was responsible for the operational activities of approximately 20 soldiers under his command) he was "genuinely concerned" for CPL Turner's welfare and that they had a relationship of trust that allowed CPL Turner to vent his frustrations about aspects of service in the ADF without fear of reprimand, which would have had a stabilising effect on CPL Turner. CAPT MH refers to the evidence of CPL TJ[1094] and the contemporaneous WhatsApp text messages,[1095] phone calls, and emails with CPL Turner in support of the submission of his genuine concerns and efforts to monitor CPL Turner's welfare.

Submissions in reply of Counsel Assisting

Dr Sringeri's letter dated 13 July 2016

741. In relation to Dr Sringeri's submissions concerning the description of his use of the words "very low risk" in his letter of 13 July 2016, Counsel Assisting submits that while it is correct that it is not a coroner's role to apportion blame, it is important to recognise that "this does not mean that the coroner's findings concerning manner and cause of death…will not contain matters which may reflect adversely on particular persons".[1096] Dr Sringeri appears to accept that it is open to make a finding that the use of the words "very low risk" was "problematic".[1097]

742. As to the complaint that no expert used the adjectival language about which Dr Sringeri complains, Counsel Assisting notes that the term "highly problematic" is directed to the language used in the 13 July 2016 letter in the context of what Dr Sringeri said about it, which was that he was not stating that CPL Turner was cleared for deployment to Iraq (being the "limitations which he later said were implicit in his own opinion"). What is conveyed on a plain reading of the letter, in the context in which it was given, is a matter for the tribunal of fact and not a matter for expert opinion.[1098]

743. As to Dr Sringeri's submission that no expert contended that using the language of "very low risk" was "inappropriate" in order to convey the risks of deployment on further relapse, Counsel Assisting notes that this is, in fact, contradicted by the expert evidence. Counsel Assisting raises two matters in respect of this submission:

[1093] Submissions of CAPT MH dated 7 June 2024 at [23]-[29].
[1094] T935.22-23.
[1095] Exhibit 57 at 209-451.
[1096] Abernathy et al., *Waller's Coronial Law and Practice in New South Wales* (4th ed, 2010) at [1.86].
[1097] Submissions in reply of Counsel Assisting dated 22 August 2024 at [154].
[1098] Submissions in reply of Counsel Assisting dated 22 August 2024 at [155].

i. First, Dr Sringeri's submission that the question posed during the course of expert evidence did not address whether the words "very low risk" was inappropriate to be used as a descriptor of the risk of recurrence should be rejected. The question posed was whether "there was an available view that there was a low risk of relapse of Corporal Turner's PTSD during that deployment". If there was not an available view that there was a low risk of recurrence of CPL Turner's PTSD, then it follows that describing that risk as "very low" is appropriate.

ii. Second, the answers given to that question were that: "the term 'very low' is problematic", it was a stretch to consider that there was a risk of recurrence that was "very low", and that CPL Turner was a person who "is never going to be at a very low risk" (Professor Large);[1099] it would not be accurate to say that the risk of recurrence of PTSD symptoms was very low (Professor Nielssen);[1100] and it was not an available view that the risk was low and instead the "likelihood is very high" (Professor Hopwood).[1101]

744. In these circumstances, Counsel Assisting submits that it is open to make a finding that the use of the language "very low risk" was inadequate language to convey the risks to CPL Turner to relapse.[1102]

745. As to the complaint about no expert using the language of "highly" or "grossly", Counsel Assisting notes that the expert opinion establishes that the language "very low risk" was problematic and my function includes assessing the degree of deficiency in light of all the evidence and that, accordingly, the findings proposed above at [673] to [675] are open to be made.[1103]

The procurement of the letter dated 13 July 2016

746. In response to Dr Sringeri's objection above at [731] regarding the "procurement" of his letter, Counsel Assisting notes[1104] that the language of "procured" was not intended to suggest that the ADF had, or had not, provided a referral letter to Dr Sringeri. Counsel Assisting accepts that the evidence does not permit a positive finding as to

[1099] 07/02/2023 T68.3-6 T68.18-38.
[1100] 07/02/2023 T73.4-6.
[1101] 07/02/2023 T82.44 - T83.3.
[1102] Submissions in reply of Counsel Assisting dated 22 August 2024 at [156].
[1103] Submissions in reply of Counsel Assisting dated 22 August 2024 at [157].
[1104] Submissions in reply of Counsel Assisting dated 22 August 2024 at [158].

whether the referral letter was provided to Dr Sringeri (noting that a letter in the nature of an "External Service Provider Request" dated 11 July 2017 is in evidence).[1105]

747. This is not intended to mean that the letter was not "procured" in the sense that the reason CPL Turner went to obtain it from Dr Sringeri was because the ADF required it, and Dr Sringeri was aware that CPL Turner was obtaining the letter because the ADF required it. That is clear from the "External Provider Request", which indicated that Dr Ahmed had sought to obtain an opinion from Dr Sringeri.[1106] Counsel Assisting does not submit that a finding can be made that Dr Sringeri was actually provided with this referral request – Counsel Assisting only seeks a finding from it supporting the finding as to why CPL Turner was approaching Dr Sringeri for a letter.[1107] Counsel Assisting notes that it is Dr Sringeri's own evidence that this is what precisely what CPL Turner told Dr Sringeri when he presented to him on 13 July 2016.[1108] That the point of the letter was to express an opinion to the ADF about CPL Turner is also clear from the face of the letter, which is addressed to MAJ AM (the Senior Medical Officer at Tobruk Clinic).[1109]

748. Lastly, Counsel Assisting believes that it is beside the point whether a referral letter was provided or not to Dr Sringeri and the absence of such a letter does not preclude a finding that the letter was in response to the ADF procuring an opinion about CPL Turner's fitness to deploy. Dr Sringeri's own evidence is that this was the context in which CPL Turner attended his clinic on 13 July 2016 and he accepts that there is no dispute that the opinion expressed in the letter was "available to be interpreted by the ADF and GPCAPT Ross as being fit to deploy from a psychiatric perspective". Counsel Assisting considers that this finding is open to be made.[1110]

The letter from Dr Sringeri's representatives dated 11 August 2021 (Exhibit 19)

749. As for Dr Sringeri's issues regarding the procedural history in relation to the tender of the 13 July 2016 letter and Exhibit 19, Counsel Assisting notes that the Exhibit 19 letter was tendered into evidence without objection.[1111] Counsel Assisting also notes that the complaint made by the Commonwealth[1112] that Dr Sringeri's subjective intention in

[1105] Tab 116 at 12-13.
[1106] Tab 116 at 12.
[1107] Submissions in reply of Counsel Assisting dated 22 August 2024 at [159].
[1108] Tab 111 at 90; 22/10/2020 T15.25, T325.44-49; Exhibit 19.
[1109] Exhibit 26.
[1110] Submissions in reply of Counsel Assisting dated 22 August 2024 at [161].
[1111] 12/08/2021 T3.38-39.
[1112] Submissions of the Commonwealth dated 7 June 2024 at [149].

writing the report is irrelevant is to be viewed in light of the absence of any objection to its tender at the time.[1113]

750. In relation to Dr Sringeri's objection at [729], Counsel Assisting submits that Dr Sringeri's interpretation of the Commonwealth's submission does not emerge given that what is said by the Commonwealth is that Exhibit 19 was obtained "prior to Dr Sringeri's report being discovered" and there is no dispute that this letter was discovered on 3 December 2021. It is then said that the "ADF does not know whether the assisting team corresponded with Dr Sringeri's solicitors about the report once it was discovered*"* (i.e., *after* 3 December 2021 and well after Exhibit 19 was produced). To the extent that the Commonwealth is submitting that Counsel Assisting has not tendered relevant evidence, Counsel Assisting contends this should be rejected as base speculation given that the Commonwealth submits in the first place that "the ADF does not know". In those circumstances, Counsel Assisting does not consider there to be a basis to grant leave to tender the further evidence proposed by Dr Sringeri nor does the evidence give rise to the level of significance warranting redaction from the Commonwealth's submissions.[1114]

Roles in determining clearance for deployment

751. In relation to Dr Sringeri's objection to being considered as "one or amongst one of" the decision-makers regarding CPL Turner's medical clearance (see above at [735]), Counsel Assisting considers the objection to be misconceived. Counsel Assisting's original submission is to the effect Dr Sringeri was part of a decision-making *process* and not a *decision-maker*. Further, it is submitted submit that there were not clear roles and responsibilities assigned as between the ADF and Dr Sringeri within that decision-making process.[1115]

752. Counsel Assisting also notes that whilst it is clear that Dr Sringeri considered that "clearance for deployment was not a matter for me, it was a matter for the ADF medical board and the chains of command", it is apparent that Dr Sringeri was speaking in the context of a final clearance *decision* – that is a different question from whether he was a person involved in a *process* and it is clear from the evidence that he was a person so involved.[1116]

[1113] Submissions in reply of Counsel Assisting dated 22 August 2024 at [170].
[1114] Submissions in reply of Counsel Assisting dated 22 August 2024 at [173]-[174].
[1115] Submissions in reply of Counsel Assisting dated 22 August 2024 at [163]].
[1116] Submissions in reply of Counsel Assisting dated 22 August 2024 at [164].

Deployment decision

753. Counsel Assisting's response to the Commonwealth's submission above at [691] regarding the deployment decision is that:[1117]

i. There is a clear basis for a conclusion that MAJ AF and MAJ AM did not have regard to the interests of CPL Turner based on the evidence summarised above at [103]-[197] and [665]-[676]. No submission was made that *no* regard was had to CPL Turner's interests in this process (indeed, MAJ AF's evidence was that CPL Turner's interest were a basis *for* the deployment); rather, it was the submission that operational considerations prevailed.

ii. The basis for a finding that MAJ AM, when preparing the Clinical Perspective Document, "enacted the [chain of] command's intent" with "almost no regard to the volume of evidence in the ADF health records".is established by the evidence summarised above at [114]-[151]. In addition, Counsel Assisting draws attention to the aspects of MAJ AM's evidence where it is accepted that in preparing the document he was selecting the "positive information" to "restore balance".[1118] His evidence was clear that he was not relying himself on the full ADF health records but instead intended to "trigger the J07 to have a comprehensive review" of the records; he asserted he had "absolute trust" that GPCAPT Ross would do so, but nevertheless did not ask him to do so.[1119]

iii. No finding should be made that GPCAPT Ross also had regard to the CO brief which provided the letter from Dr Sringeri of 13 July 2016.

Body recovery incident

754. Lastly, Counsel Assisting considers that the Commonwealth's submission that there is no evidence to support the proposition that CPL Turner's mental health was in decline *prior to* the body recovery on 31 September 2016 is contradicted by: the evidence of Joanna Turner of substance abuse, sleeping issues, and controlling behaviour throughout 2016 (see above at [91]-[92]); the evidence of CPL Turner's observed declined after the disciplinary proceedings (see above at [198]-[241]); and CPL Turner's prescription of temazepam on 17 September 2016 after having experienced sleep deprivation for the "last two weeks"[1120]

[1117] Submissions in reply of Counsel Assisting dated 22 August 2024 at [212]-[214].
[1118] 5/08/2021 T59.37-60.5.
[1119] 5/08/2021 T58.37-59.5.
[1120] Tab 49 at 56.

Consideration

755. I accept Counsel Assisting's submissions that by the end of 2015 it was apparent that CPL Turner's mental health was seriously impaired and that by 2016 he had not engaged in appropriate mental health treatment. The objective evidence is that in November 2015, despite reporting significant PTSD symptoms to a counsellor from the VVCS, he declined treatment.

756. The Court heard a significant amount of evidence about the 2016 clearance decision, which was at times incorrectly referred to as 'the waiver." In my view, it is a critical factor influencing the trajectory of CPL Turner's decline.

757. I accept Counsel Assisting's submission on this issue. Firstly, it is established that MAJ AM's Clinical Perspective Document was a one-sided presentation compiled by a medical practitioner who had never seen CPL Turner in a clinical setting for the sole purpose of influencing the decision. It was neither accurate nor considered. It did not take into account material in the ADF records which indicated CPL Turner's ongoing struggles and his refusal to undertake treatment. MAJ AM told the Court that he did not review the medical records himself, instead relying on a junior officer to relay the information over the telephone. I agree with Mr and Mrs Turner that this was unsatisfactory.

758. Secondly, I accept that the brief which was signed by COL MF, but drafted by MAJ AF, was inaccurate and misleading. In my view, the evidence establishes that MAJ AF prioritised operational considerations over an independent review of CPL Turner's mental health. Specifically, the assertion that "the personnel best able to monitor, asses [sic] and manage his mental health are his regular team members, who he will be deployed with" was a hollow statement and, as we have seen, entirely without substance or merit. There was just no evidence that CPL Turner's team was given any advice or support about how to monitor, assess, or manage CPL Turner's mental health symptoms if they emerged. It was an empty statement. The situation in Iraq was unpredictable and GPCAPT Ross should have understood that more would be required. There was in fact no realistic plan in place to support CPL Turner should his mental health deteriorate. Given there were no available psychologists in TQ, I accept Counsel Assisting's submission that to describe his access to psychological services as "ready" was inaccurate. The brief was prepared for the purpose of persuading GPCAPT Ross to overturn his decision and no person took responsibility for ensuring that what was represented would actually occur. I accept the submission that it was simply a piece of advocacy. The Commonwealth accepts that with hindsight the

strategy of “peer monitoring” failed. In my view, it was both ill-informed and reckless. Further, I was particularly concerned that MAJ AF gave evidence that he continues to believe that deploying was in CPL Turner’s best interests, even with the benefit of hindsight. In my view, his adherence to this position demonstrates a complete lack of insight, inadequate understanding of PTSD, and an ongoing inability to reflect usefully on factors which contributed ultimately to CPL Turner’s death.

759. Thirdly, I am also critical of the decision made by GPCAPT Ross. It is clear that he relied upon the Clinical Perspective Document which MAJ AM authored when he reversed his decision. In my view, a practitioner of his experience should have gone back to the medical records that had informed his original decision. I am comfortably satisfied that he did not, because the discrepancies are so significant that they would have alerted him to be very cautious about the new document, and he was not. The only other available explanation is that he knew the Clinical Perspective Document was flawed and he knowingly submitted to pressure from the Chain of Command. Having said that, I accept he was entitled to rely to some degree on Dr Sringeri’s opinion but not to defer to him. Unfortunately, Dr Sringeri’s letter was in certain respects inadequate for the purpose it was used for.

760. Fourthly, I am critical of Dr Sringeri’s letter of 13 July 2016 and the use it was put to by the Chain of Command. Each of the experts agreed that to describe the risk of recurrence of PTSD symptoms as “very low” was problematic. I note that in hindsight Dr Sringeri appeared to accept this.

761. In my view, Dr Sringeri’s opinion that CPL Turner was “cleared to attend all duties from a psychiatric point” was open to broad interpretation and therefore dangerous. While I understand that Dr Sringeri contends he was not attempting to convey a view that CPL Turner was cleared for a specific deployment to Iraq, which he understood was a matter for the ADF medical board and the Chain of Command, I do not accept, despite taking into account his submissions, that he could have been unaware of the way his letter would be used.

762. The Commonwealth accepts that in retrospect the risk of relapse of CPL Turner’s PTSD should have been recognised as higher than it was.

763. Fifthly, I accept Counsel Assisting’s submission that everyone involved in the decision-making process in relation to the 2016 medical clearance appeared to abrogate responsibility. In my view, Counsel Assisting sums it up accurately: “the Chain of Command sought to shift responsibility to Dr Sringeri and GPCAPT Ross; Dr Sringeri

did not consider it was his role to decide whether CPL Turner was fit for deployment at all and sought to shift responsibility back on the ADF; and GPCAPT Ross relied heavily on the documents provided by MAJ AM, which included Dr Sringeri's opinion.[1121] In some respects, it appears that Dr Sringeri was relying on the ADF and the ADF was, in turn, relying on Dr Sringeri, and neither had a clear understanding of the role of the other in making decisions about deployment."

764. The lack of clarity in relation to individual roles and responsibilities caused me considerable concern, as did the significant degree of confusion about the extent to which it was appropriate for Command to be involved and the extent to which the medical clearance decision was a medical decision only, based on medical risks. The Commonwealth appeared to accept the need for clearer guidelines about how these decisions are made. It is an issue to which I will return.

765. Sixthly, once CPL Turner was deployed, according to MAJ AF nothing out of the ordinary was done to monitor or support his mental health. I accept Counsel Assisting's submission that ultimately the brunt of support fell to CPL TJ. Others such as MAJ BJ and CAPT MH who offered support were, like CPL TJ, untrained and just doing the best they could under difficult circumstances. I accept the contemporaneous WhatsApp messages, phone calls, and emails show they were genuinely trying to provide personal support to CPL Turner. That was important but what was also required was skilled professional assistance.

766. Lastly, the body recovery mission issue took up more court time than it should have. The Commonwealth's initial questioning on the issue appeared to suggest it may be a figment of CPL Turner's mind. It was not and at least some ADF witnesses knew that at all times. In my view, the way the issue unfolded was most unfortunate. I am concerned that it was not approached with honesty and transparency. There is a clear mechanism for the making of public interest immunity claims and it does not involve witnesses such as MAJ AF withholding information or presenting a partial and misleading account. Nevertheless, while I am ultimately unable to say exactly what happened, I am able to make firm findings that CPL Turner had some involvement in a body recovery and that it triggered a relapse of his PTSD. The whole incident demonstrates the unpredictable nature of deployment in a warzone and the

[1121] In submissions in reply, Counsel Assisting note that the point, as against GPCAPT Ross, is directed to the degree to which he relied on others to make the (medical) assessments which formed the basis of his decision, a matter which GPCAPT Ross himself contends he was entitled to do: Submissions in reply of Counsel Assisting dated 22 August 2024 at [176].

overreliance on the idea that a mission to "train, advise and assist" would present minimal risk to someone in CPL Turner's position.

Adequacy of ADF's response in 2017 (up until 15 July 2017)

767. The evidence relevant to this issue is set out in the chronology above at [276]-[372].

Counsel Assisting's submissions

768. Counsel Assisting submits[1122] that CPL Turner's mental health continued to deteriorate over the course of 2017. There are two issues in this regard.

769. The first is that the ADF (in particular, COL MF) appeared to have had limited to no regard to the impact of the move from B Company to C Company on CPL Turner's mental health. Counsel Assisting considers that this was a decision made with regard to capability, not individual needs. While that is not *per se* wrong or objectionable, if the decision was *so* important to capability that no other option could have been pursued, there was plainly enough an obvious need to put a significant amount of mental health support around CPL Turner at the time the decision was made. It is submitted that the potential impact was obvious: BRIG Langford, who was not the CO at the time, accepted that it would have been humiliating for CPL Turner to be demoted and taken out of the Sergeants' Mess against his will.[1123] He acknowledged that B Company would have been important in terms of a support network to him.[1124]

770. Counsel Assisting states that it is clear that the transfer was made without any real weight being given to his mental health, nor were any supports put in place once the decision was made and when he returned to Australia and was placed in C Company. It is difficult to know if this would have made a difference to the tragic outcome.

771. The second issue is that there were clear signs throughout the start of 2017 that CPL Turner's mental state was deteriorating rapidly. This was raised by CPL TJ with the Padre and it does not appear that at critical junctures information was passed up the Chain of Command so that early intervention could occur at a high level. Again, it is difficult to know what difference this could have made to the tragic outcome.

[1122] Submissions of Counsel Assisting dated 2 November 2023 at [482]-[484].
[1123] 21/10/20 T196.11-12.
[1124] 21/10/20 T194.34-42.

The Human Performance Wing (HPW)

772. Counsel Assisting notes[1125] that, physically speaking, the HPW was located at Holsworthy, in a building that is on a central breezeway and connected to where A Company and B Company were located. It was located within the 2CDO.[1126] CPL Turner was placed under the care of Mr Cardinaels in the HPW after his first suicide attempt in early March 2017 and remained there until his death.

773. Mr Cardinaels was the "leader" of the HPW from around 2015 to at least 2018.[1127] He described the purpose of the HPW as being to "provide mentoring management of the wounded injured (sic) in a culturally relevant space and it was a by commando for commando area".[1128] Mr Cardinaels stated in his ROI that it was intended to be a "multidisciplinary approach" involving clinicians, and "having an informed environment where we do best by the member and try and service all their needs".[1129]

774. The views of other former members of 2CDO were that if a person suffered a mental illness, they would be removed from active duty.[1130] Eddie Robertson described it as a "general feeling amongst the ranks that if you were having mental health issues it would affect your career opportunities and also have you sidelined for future deployments with your Team/Platoon/Company".[1131]

775. Mr Cardinaels struggled to articulate in oral evidence what the HPW was aiming to achieve with CPL Turner.[1132] It was not clear that there was one person who had responsibility for CPL Turner's overall care during his time with the HPW. Mr Cardinaels was not aware, but imagined "it would be someone", possibly the rehab coordinator and possibly the RMO.[1133]

776. Mr Cardinaels' evidence was that during his time as part of the HPW, there was no formal evaluation or audit of its processes.[1134] His evidence as to his own qualifications to manage the HPW were limited to being "well read" and having an interest in rehabilitation.[1135] He was not a psychologist and had no psychiatric training.[1136]

[1125] Submissions of Counsel Assisting dated 2 November 2023 at [485]-[490].
[1126] 02/08/21 T17. 4-19.
[1127] Tab 15 (IGADF ROI with SGT MC on 5 June 2018) at 3; 02/08/21 T10-11.
[1128] Tab 15 (IGADF ROI with SGT MC on 5 June 2018) at 3.
[1129] Tab 15 (IGADF ROI with SGT MC on 5 June 2018) at 6.
[1130] See Tab 10 (Damien Thomlinson); Tab 12 (Eddie Robertson), both of whom deployed with CPL Turner as part of 2CDO.
[1131] Tab 12 (Eddie Robertson).
[1132] See generally 02/08/21 T19-36.
[1133] 02/08/21 T40.10-25.
[1134] 09/09/22 T41.20-22.
[1135] 02/08/21 T37.
[1136] 09/09/22 T39.

777. The evidence during the period that CPL Turner was placed in the HPW tended to suggest that it was not helpful for CPL Turner's mental health. He appeared to be isolated from his regular teammates and had little sense of purpose or direction. As Professor McFarlane emphasised, a critical issue for CPL Turner was his "sense for the future and his social engagement". CPL TJ's evidence reflected this also: she stated that having the PhD was CPL Turner's hope for a refresh, and once it was "scrapped" he was "very different man".[1137]

778. Counsel Assisting submits that it was critical for CPL Turner's ongoing wellbeing that he had a clear plan to transition into a role in the ADF where he could remain useful, or outside of the ADF into further study or employment. It was not clear that the HPW provided him with a clear direction to achieve either of those outcomes.[1138]

The PhD proposal

779. Counsel Assisting highlights[1139] that it is clear that at some point in time, a proposal that CPL Turner undertake a PhD (possibly as part of a secondment to another organisation) was made and was rejected out of hand by COL MF. Whether or not it was rejected only because of the outplacement component (as per the evidence given by COL MF), it is clear that no real consideration was given to assisting CPL Turner to transition into studying in some other way. If COL MF intended only to reject the outplacement aspect of the PhD proposal, it is clear that this was not clearly communicated to CPL Turner who perceived that his proposal to study had simply been rejected. Counsel Assisting submits that more consideration ought to have been given to supporting a study placement or assisting CPL Turner to study in some other way – the outright rejection appeared to have been significantly unhelpful for his ongoing recovery.

780. Joanna Turner also noted that if CPL Turner "had thought that [the PhD] was possible in the future, it could [have] assisted him".[1140]

The fragmented nature of the care provided to CPL Turner

781. Counsel Assisting considers[1141] that the evidence in relation to CPL Turner's care during 2017 revealed that it was fragmented in a way that was unlikely to be helpful. It

[1137] Exhibit 10 (Supplementary statement of CPL TJ dated 20 July 2021) at 3.
[1138] See, eg, Tab 50 (ADF Medical Records) at 16 which records a query from Dr Swain to the ADF on 5 July 2017 asking "what is happening with Ian from a MEC/rehab perspective … Ian states he believes he will be medically separated, but no one has directly addressed it with him as yet".
[1139] Submissions of Counsel Assisting dated 2 November 2023 at [491].
[1140] Submissions of Joanna Turner dated 17 January 2024 at [6].
[1141] Submissions of Counsel Assisting dated 2 November 2023 at [492]-[495].

appears Ms Cantwell took over as clinical case coordinator in March 2017. She referred CPL Turner to Dr Swain, an external psychologist based in Sydney CBD, on the basis that Dr Swain had knowledge of the ADF, the background to deal with CPL Turner's complex psychological needs, and the capacity to treat CPL Turner "at the appropriate frequency and intensity, consistent with his needs".[1142] Ms Cantwell then ceased as CPL Turner's clinical case coordinator at the end of March 2017 and CAPT KV took over.[1143] CAPT KV then appears to have been the clinical case coordinator from this time until CPL's death.[1144]

782. There were numerous individuals involved in CPL Turner's care throughout 2017: including Dr Hale, Dr Reppas, Dr Toma, Dr Ahmed, Andrea Cantwell and then CAPT KV, Dr Swain, Drs Malik and Sringeri, the rehabilitation coordinator Carmel Poulter (who was employed by an external consultant to the ADF) pursuant to a referral made by the ADF on 31 March 2017, Greg Frost (the ADF rehabilitation coordinator who made the referral to Carmel Poulter), and Mr Cardinaels and the HPW.

783. Dr Nielssen's evidence was that "if anything, Mr Turner's care by so many professionals might have been perceived as intrusive by a person who disclosed having little trust in the ADF hierarchy".[1145]

784. In addition to this risk, Counsel Assisting notes that the distinct impression which the overall evidence left was that there was a lack of clear responsibility for the care of CPL Turner. His care during 2017 was highly fragmented across different ADF medical professionals, external consultants, and other individuals such as Mr Cardinaels who did not have mental health training or expertise. Although it is clear that there were a great number of people who were trying to assist CPL Turner throughout this period, the fact of fragmentation and the many different consultants, many of whom were outside the ADF, was likely to have contributed to difficulties in caring for CPL Turner throughout his period of significant decline in 2017.

Submissions of Mr and Mrs Turner

785. CPL Turner's parents have expressed concern that CPL Turner went 39 days without seeing his treating psychologist after he was discharged from SJoGH on 25 May 2017, which they consider would have perpetuated the known risks associated with the previous suicide attempts. They also consider that there was a "significant failure in

[1142] Exhibit 40 (Statement of Andrea Cantwell dated 31 August 2022) at 5.
[1143] Exhibit 40 (Statement of Andrea Cantwell dated 31 August 2022) at 5.
[1144] 11/08/21 T7.9-11.
[1145] Tab 108 (Report of Dr Nielssen dated 12 August 2020) at 11.

care" by the ADF psychologists who assessed his risk of harm and stability and failed to provide any treatment. They contend that 2CDO, CAPT KV, BH, and COL MF collectively had a responsibility to ensure than CPL Turner received timely and appropriate psychological support, intervention, and treatment.[1146]

786. Mr and Mrs Turner also submit that CPL Turner found the welfare board meeting in May 2017 to be "confronting and overwhelming".[1147]

787. CPL Turner's parents also note that the 2CDO clinicians should have viewed CPL Turner's absconding in the context of distressing PTSD symptoms rather than impulsive acts requiring disciplinary action.[1148]

788. Furthermore, Mr and Mrs Turner posit that while the 2CDO was dealing with a heavy load of members requiring support in 2017, COL MF failed to effectively manage the coordination of support services and he did not seek assistance outside of 2CDO (either through his Chain of Command or CPL Turner's psychiatrist or psychologist), which was in breach of ADF policy.[1149]

The Human Performance Wing

789. CPL Turner's parents express concern about how CPL Turner was treated within the HPW, where he was assigned following his first overdose. Their concerns include that the HPW was for physically wounded ADF members (and not for members with psychological illnesses), there was a limited handover, the HPW Manager (Mr Cardinaels) did not have any formal qualifications in dealing with persons with psychological illnesses, Mr Cardinaels was not (but should have been) directly involved in CPL Turner's clinical assessments or welfare boards, and that the 2CDO medical officers and psychologists had limited training and experience with PTSD. Mr and Mrs Turner also disagree with Mr Cardinaels' evidence that the HPW was "best practice" in terms of dealing with complex medical cases on the basis that "without clinical knowledge, one simply cannot know what one does not know". They also consider that soldier-led recovery models may be appropriate for physically injured soldiers, but that is not suitable in the case of members suffering from psychological illnesses (who require fully trained and experienced clinicians).[1150]

[1146] Submissions of Mr and Mrs Turner dated 28 January 2024 at [76]-[78].
[1147] Submissions of Mr and Mrs Turner dated 28 January 2024 at [89].
[1148] Submissions of Mr and Mrs Turner dated 28 January 2024 at [93].
[1149] Submissions of Mr and Mrs Turner dated 28 January 2024 at [104]-[105].
[1150] Submissions of Mr and Mrs Turner dated 28 January 2024 at [186]-[195].

The PhD proposal

790. Mr and Mrs Turner contend that when COL MF decided that he would not support CPL Turner's proposed PhD, COL MF failed to take into consideration the years of CPL Turner's service, his performance appraisals which repeatedly found him fit for representational duty, and MAJ AF's assessment of CPL Turner in 2016 as "the number one team commander". They also contend that there is no evidence that COL MF sought any clinical opinion as to CPL Turner's fitness to undertake the PhD or how the request should be handled such that any negative response would not further impact his mental health in an adverse manner.[1151]

791. They also agree with Professor McFarlane's views that the possibility of doing a PhD should have raised issues as to what steps could have been put in place to assist him to transition from 2CDO or the ADF and that ADF members need to be informed that there is a limited period of time in which their mental health and physical capacity can be sustained in intense combat roles (which should be systematically addressed by Command by offering transitioning pathways that sustain members' morale and identity).[1152]

Submissions of the Commonwealth

792. The Commonwealth notes that the submissions of Counsel Assisting omitted many relevant details from the chronology of events in early 2017. In its submissions, the Commonwealth sets out[1153] a number of further interactions between CPL Turner and medical personnel and steps taken by those personnel in response to his worsening condition. It is submitted that at no point until 2 March 2017 did the reported symptoms "cross the threshold for non-consensual mandatory reporting to the ADF chain of command".[1154]

793. With respect to the text messages exchanged between CPL Turner and CPL TJ between 4 and 6 March 2017 which included references to suicide, the Commonwealth observes that CPL Turner had previously threatened suicide in his relationship as a means of coercive control and that there was no evidence to suggest that the ADF was aware of the breakdown of that relationship that occurred between 4 and 6 March 2017.[1155]

[1151] Submissions of Mr and Mrs Turner dated 28 January 2024 at [196]-[207].
[1152] Submissions of Mr and Mrs Turner dated 28 January 2024 at [205]-[207].
[1153] Submissions of the Commonwealth dated 7 June 2024 at [478]-[483].
[1154] Submissions of the Commonwealth dated 7 June 2024 at [481].
[1155] Submissions of the Commonwealth dated 7 June 2024 at [486]-[496].

794. The Commonwealth further submits that insufficient focus was given by Counsel Assisting to CPL Turner's admission to SSPH in March 2017 and that the evidentiary gap affected the ability to obtain a clear and complete picture of CPL Turner's mental health in this period and the ADF's response to his first suicide attempt.[1156] The Commonwealth sets out a detailed chronology of this period in its submissions.[1157]

795. The Commonwealth notes that CPL Turner met with CAPT McLean on five occasions in this period and that the evidence suggests that CPL Turner may not have been in a position to engage in more intensive therapy even if that had been considered by CAPT McLean.[1158]

The Human Performance Wing and the rehabilitation plan

796. The Commonwealth considers that none of Counsel Assisting's criticisms of the HPW (summarised above at [772]-[778]) should be accepted.[1159] Reasons in support of the Commonwealth's position include:[1160]

i. Counsel Assisting made oral submissions on 6 September 2022 that the Inquest would not investigate the HPW;

ii. the criticisms of the HPW do not explain the connection to the way in which CPL Turner was treated within the HPW;

iii. the submissions do not appreciate that CPL Turner was in the HPW for a short period of time;

iv. evidence was not obtained from those involved in the rehabilitation plan which would give rise to procedural unfairness if they were to be criticised;

v. the criticism of the plan in that it was insufficiently "engaging" and/or left CPL Turner with too much free time does not comport with the evidence of Hannah Steele;[1161]

vi. the characterisation of the rehabilitation plan as identifying "little more by way of activities than the gym and medical appointments" over-simplifies the factual circumstances in which the plan was developed;

[1156] Submissions of the Commonwealth dated 7 June 2024 at [498]-[502].
[1157] Submissions of the Commonwealth dated 7 June 2024 at [503]-[513].
[1158] Submissions of the Commonwealth dated 7 June 2024 at [639]-[640].
[1159] Submissions of the Commonwealth dated 7 June 2024 at [641].
[1160] Submissions of the Commonwealth dated 7 June 2024 at [641]-[662].
[1161] 19/10/2020 T36.11-22.

vii. the submissions ignore the reality of CPL Turner's physical and mental limitations/capacities in June-July 2017;

viii. the submissions ignore the fact that CPL Turner was involved in all decisions regarding his non-medical activities, including which activities he did and how much he did on each day (although he was not always happy about the plan);

ix. CPL Turner had conversations with personnel at the HPW about what he would be working towards at the HPW;

x. it was a matter for CPL Turner as to whether he provided health information to Mr Cardinaels; and

xi. the suggestion that "evidence during the period that CPL Turner was placed in the HPW tended to suggest that it was not helpful for CPL Turner's mental health…[h]e appeared to be isolated from his regular teammates and had little sense of purpose or direction" is made without any reference to the evidence said to support it.

The PhD proposal

797. In relation to the PhD, the Commonwealth considers that Counsel Assisting's submission that BRIG MF "rejected out of hand" the PhD proposal cannot be accepted (on the basis that CPL TJ's evidence about this is unreliable and is contrary to other evidence)[1162] and that the PhD proposal was given "no air time" or was "outright" rejected is not supported by the evidence and would be a procedurally unfair finding.[1163]

798. The Commonwealth submits that as at January 2017 the evidence suggests CPL Turner's proposal was to undertake a secondment and, while doing so, work towards a PhD (which may not be supported by the Chain of Command).[1164] Thereafter, and after BRIG MF indicated he was not supportive of the secondment, that CPL Turner continued to raise the idea of the PhD is submitted to be inconsistent with the suggestion that BRIG MF had rejected the idea "outright".[1165]

799. The Commonwealth notes that prior to 6 March 2017, all that CPL Turner raised was an idea of a secondment to an organisation such as ASPI or the Department of Prime Minister and Cabinet, together with a PhD, which, given his recent disciplinary action,

[1162] Submissions of the Commonwealth dated 7 June 2024 at [769].
[1163] Submissions of the Commonwealth dated 7 June 2024 at [735], [770].
[1164] Submissions of the Commonwealth dated 7 June 2024 at [737]-[745].
[1165] Submissions of the Commonwealth dated 7 June 2024 at [746]-[754].

the Chain of Command "understandably" did not support. There had also not been a formal application for the further study. The Commonwealth also notes that after the first suicide attempt, the idea of further study was "always seen as a protective factor and there is no evidence that it was ever rejected".[1166]

800. The Commonwealth submits that it would be procedurally unfair to accept the evidence of Hannah Steele regarding the discussion of the proposal at the 26 May 2017 IWB.[1167] Further, it is submitted that the account of CPL TJ on this issue was confused and inconsistent.[1168]

801. Rather, the Commonwealth notes that there had to be realistic expectations placed around what were protective factors and what were achievable outcomes and the idea of a PhD was never taken off the table (as seen from Dr Hale's email of 11 July 2017).[1169]

802. The Commonwealth also refers to Joanna Turner's evidence that CPL Turner was not in a fit state to study, noting that with "his mental ill health at that time, it would have been challenging for him to take on a fulltime study role or something as high pressure as a PhD".[1170]

The period of 30 March to 11 April 2017

803. The Commonwealth notes that this period was mainly consumed with (i) a resumption of serious interpersonal conflict between CPL Turner and CPL TJ [redacted] and (ii) attempts made by the medical and rehabilitation personnel to "step up" an outpatient treatment and rehabilitation for CPL Turner.[1171] [redacted]

804. The Commonwealth submits that regard must be had to the lengthy fight via text message between CPL Turner and CPL TJ on the morning of 11 April 2017, [redacted]

[1166] Submissions of the Commonwealth dated 7 June 2024 at [770(b)].
[1167] Submissions of the Commonwealth dated 7 June 2024 at [759].
[1168] Submissions of the Commonwealth dated 7 June 2024 at [765]-[768].
[1169] Submissions of the Commonwealth dated 7 June 2024 at [764], [770]-[775].
[1170] 20/10/2020 T85.30-32.
[redacted]
[1173] Submissions of the Commonwealth dated 7 June 2024 at [515(c)].

[redacted] when considering the manner and cause of CPL Turner's death.[1174]

The period of 11 April to 25 May 2017

805. The Commonwealth submits that Counsel Assisting did not advert to the efforts of the ADF to provide care for CPL Turner during the period between 11 and 21 April 2017 when CPL was admitted to St Vincent's Hospital following a second suicide attempt. It is submitted that no adverse finding could be made against the ADF for this period.[1175]

806. For the period between 21 and 27 April 2017, the Commonwealth invites a finding that CPL Turner's reason for absconding from the SSPH on 21 April 2017 was immediately caused by the fight over text message with CPL TJ that day (and her expressed views about the hospital) and that the ADF cannot be criticised for concluding that the best course was to attempt to persuade CPL Turner to accept voluntary inpatient admission at this time.[1176]

807. With respect to the period between 27 April and 25 May 2017, the Commonwealth notes there was little evidence adduced regarding CPL Turner's admission to SJoGH and to the efforts of the ADF to support him at this time. It is submitted that no adverse finding ought to be made against the ADF or any its personnel for this period.[1177]

The period of 25 May to 14 July 2017

808. In its submissions,[1178] the Commonwealth sets out a detailed chronology of events which highlight the following matters:

i. in the week between 22 May and 28 May 2017, meetings (including IWBs) were held to discuss CPL Turner's condition, attempts were made to keep him admitted at SJoGH, and meetings/assessments took place between CPL Turner and Dr Hale, Ms Poulter, and Mr Cardinaels;[1179]

ii. in the week between 29 May and 4 June 2017, there were hostile communications between CPL Turner and Joanna Turner, meetings/assessments between CPL Turner and CAPT McLean, Dr Hale, Ms

[1174] Submissions of the Commonwealth dated 7 June 2024 at [518]-[519].
[1175] Submissions of the Commonwealth dated 7 June 2024 at [520]-[521].
[1176] Submissions of the Commonwealth dated 7 June 2024 at [524]-[527].
[1177] Submissions of the Commonwealth dated 7 June 2024 at [551].
[1178] Submissions of the Commonwealth dated 7 June 2024 at [557]-[620].
[1179] Submissions of the Commonwealth dated 7 June 2024 at [557]-[562].

Poulter, and Dr Malik, and evidence of the relationship breakdown between CPL Turner and CPL TJ;[1180]

iii. in the week between 5 June to 11 June 2017, there were meetings/assessments between CPL Turner and CAPT McLean, Dr Hale, CAPT KV, Dr Malik (who prescribed prazosin), and Ms Poulter, communications suggesting Joanna Turner would not let CPL Turner see his daughter in this period, further relationship volatility between CPL Turner and CPL TJ, and a bout of drinking during a commemoration of CPL Baird;[1181]

iv. in the week between 12 June and 18 June 2017, there were meetings (including an IWB) held to discuss CPL Turner's progress, meetings/assessments between CPL Turner and Dr Hale, Carmel Poulter, CAPT McLean, and CAPT KV, and communications between CPL Turner and CPL TJ about issues CPL Turner was having with Joanna Turner (including finances and access to his daughter);[1182]

v. in the week between 19 June and 25 June 2017, there were meetings/assessments between CPL Turner and Dr Siddiqi and CAPT KV (including by phone when CPL Turner was on the Gold Coast between 21 and 26 June 2017);[1183]

vi. in the week between 26 June and 2 July 2017, there were meetings/assessments held between CPL Turner and CAPT KV, Mr Cardinaels, and Ms Poulter, further acrimonious correspondence between CPL Turner and Joanna Turner, and a breakdown in the relationship between CPL Turner and CPL TJ;[1184]

vii. in the week between 3 July and 9 July 2017, there were meetings/assessments between CPL Turner and Ms Poulter, CAPT KV, Dr Hale, Dr Malik, and Dr Swain (including what was reported as a 'dissociative episode' on 1-2 July), an IWB held on 7 July 2017, the further relationship breakdown between CPL Turner and CPL TJ, an altercation CPL Turner had at a pub, and the time spent with CPL Turner by members of 2CDO over the weekend of 8-9 July 2017;[1185] and

[1180] Submissions of the Commonwealth dated 7 June 2024 at [563]-[569].
[1181] Submissions of the Commonwealth dated 7 June 2024 at [570]-[576].
[1182] Submissions of the Commonwealth dated 7 June 2024 at [577]-[581].
[1183] Submissions of the Commonwealth dated 7 June 2024 at [582]-[587].
[1184] Submissions of the Commonwealth dated 7 June 2024 at [588]-[595].
[1185] Submissions of the Commonwealth dated 7 June 2024 at [596]-[610].

viii. in the week of 10 July 2017 until CPL Turner's death, there were meetings/assessments between CPL Turner and Mr Cardinaels, Ms Poulter, Dr Hale, Dr Malik, and Dr Swain, the decision that CPL Turner be directed to inpatient care, CPL Turner's desire for a discharge, and ongoing communication between CPL Turner and CPL TJ.[1186]

809. The Commonwealth submits that it is necessary to consider the above chronology in order to assess the adequacy of the ADF's response in this period and the submissions concerning fragmentation of care (see below).[1187] The Commonwealth notes that by the first two weeks of July 2017, the ADF was confronted with a difficult situation in which CPL Turner had suffered memory loss following a dissociative episode or overdose, was drinking excessively, had missed appointments, and was increasingly volatile.[1188]

The fragmented nature of the care provided to CPL Turner

810. The Commonwealth submits that any conclusion that "fragmentation" of CPL Turner's care was likely to have been detrimental to his care is not supported by the evidence and should not be accepted for various reasons. These include:[1189]

i. the term "fragmentation" is not defined nor is there any identification of what difficulties in caring for CPL Turner arose from such fragmentation;

ii. no evidence was obtained from various treatment providers who treated CPL Turner in 2017 on the question of any fragmentation;

iii. there were periods in late 2016 to 2017 where CPL Turner was either on post-deployment leave or an inpatient which resulted in some necessary fragmentation in his treatment;

iv. the evidence in the Inquest, such as of CAPT KV[1190] and Dr Hale,[1191] was that CPL Turner required longer inpatient admissions and a further admission in July 2017 (which CPL Turner refused);

v. CPL Turner was suffering from a number of physical and psychological issues in 2017;

[1186] Submissions of the Commonwealth dated 7 June 2024 at [611]-[620].
[1187] Submissions of the Commonwealth dated 7 June 2024 at [554]-[555].
[1188] Submissions of the Commonwealth dated 7 June 2024 at [666]/.
[1189] Submissions of the Commonwealth dated 7 June 2024 at [621]-[638].
[1190] 11/08/2021 T12.12-36.
[1191] 23/10/2020 T391.9-26.

vi. the "numerous individuals" involved in CPL Turner's care in 2017 all had different roles to play in his treatment;

vii. Dr Ahmed and Dr Toma played only an administrative role in his treatment; treatment providers are entitled to take leaves of absences or otherwise attend to their personal lives;

viii. the treatment providers took "extraordinary efforts" to communicate with each other; treatment providers went out of their way to touch base with CPL Turner if he missed an appointment; and

ix. CPL TJ's text messages suggested that medical personnel were not always being informed of the true extent of CPL Turner's issues.

811. The Commonwealth also raises[1192] a number of "practical realities" which are said to undermine the position of Counsel Assisting. These include: (i) the impracticalities of a single person managing the oversight of CPL Turner's care; (ii) the management of confidential information, which itself not an identified cause of the fragmentation; and (iii) the DeHS system used by the ADF meant CPL Turner received "far superior" coordination of treatment and care than a civilian might (however, that system does not capture external practitioners, nor was it universally accepted as being a complete and accurate record).

Submissions of CPL TJ

812. CPL TJ refers to the instance in February 2017, two weeks prior to the first suicide attempt, where she reported CPL Turner's significant deterioration in mental health to MAJ MP (who told her he would raise the issue with the CO and the RSM and was informed that the Chain of Command had his condition and welfare "under control") and also reporting her concern to the Chain of Command that CPL Turner was not getting the help he needed from SSPH. CPL TJ submits that despite these reports, it appears that nothing substantive was done by the Chain of Command to address her concerns.[1193]

813. CPL TJ submits that she and others "went well above and beyond what could be expected of anyone in their position in terms of providing support for" CPL Turner and that the ADF response "lacked appropriate engagement".[1194]

[1192] Submissions of the Commonwealth dated 7 June 2024 at [635].
[1193] Submissions of CPL TJ dated 7 June 2024 at [36]-[37].
[1194] Submissions of CPL TJ dated 7 June 2024 at [38].

The PhD proposal

814. CPL TJ submits that the decision regarding his PhD reinforced CPL Turner's perception that he was being abandoned and not supported and compounded his lonely view of his own position and role (after in fairly rapid succession being disciplined, publicly demoted, and removed from his home unit). CPL TJ considers that the Chain of Command's approach in rejecting the application was "deeply insensitive" to CPL Turner's plans for his future and they were indifferent to the consequences that such a decision may have on CPL Turner. She submits that even though the proposal was supported by the head of the High-Performance Wing, the CO appears to have rejected the proposal for no more than speculative reasons and did so admitting that he did not have regard to any mental health consequences that might flow from his decision.[1195]

Submissions of Dr Hale

815. Dr Hale submits that, in light of Dr Nielssen's evidence,[1196] the nature of the care provided to CPL Turner is to be described as "multifactorial or complex" rather than "fragmented".[1197]

816. Dr Hale further submits that insofar as it is suggested that Dr Hale's email to Dr Wallace on 14 July 2017 was deficient or that he ought to have referred CPL Turner to Dr Wallace sooner, such a suggestion should be rejected given that it was not put to Dr Hale during the inquest.[1198]

817. Dr Hale also states that in relation to the Commonwealth's submissions about his note of 11 April 2017, soon after seeing Dr Hale on 3 April 2017, CPL Turner was assessed by Dr Swain and CAPT KV shortly thereafter. Dr Hale objects to any adverse finding about the note given that he was not called to give evidence about the 3 April 2017 attendance.[1199]

818. Dr Hale also notes that, contrary to the Commonwealth's submissions, on 14 June 2017, CAPT McLean advised CAPT KV[1200] (not Dr Hale, as he was on leave) that she was particularly concerned about CPL Turner's increased alcohol intake.[1201]

[1195] Submissions of CPL TJ dated 7 June 2024 at [40]-[48].
[1196] Tab 108 (Dr Olav Nielssen) at 9-14; T405.14-19
[1197] Submissions of Dr Hale dated 31 May 2024 at [24]-[26].
[1198] Submissions of Dr Hale dated 31 May 2024 at [40].
[1199] Submissions in reply of Dr Hale dated 19 July 2024 at [3].
[1200] Exhibit 4 at 235-236.
[1201] Submissions in reply of Dr Hale dated 19 July 2024 at [4].

819. Dr Hale also objects to any criticism being aimed at the email of 16:14 to BRIG MF on 11 July 2017, which contained the recommendation that CPL Turner be directed to inpatient care given that the recommendation was not put to Dr Hale during his evidence.[1202]

820. In relation to Mr and Mrs Turner's submission about there being a "fundamental lack of clinical understanding of [CPL Turner's] mental health struggles in 2017, and this created a negative attitude toward him, which likely compounded his feelings of agitation and alienation toward the chain of command",[1203] Dr Hale rejects the submission insofar as it is intended to be a criticism of his care and treatment of CPL Turner (noting that this was not put to him at the Inquest).[1204]

The PhD proposal

821. In relation to Joanna Turner's submission that CPL Turner's "illness decline and death was preventable" and that the need for CPL Turner to have "support in the development of his sense of self separate to his identity as a soldier",[1205] Dr Hale submits that he assisted in that regard by indicating he would make a submission in support of a MEC that would allow CPL Turner to study.[1206]

Submissions in reply of Counsel Assisting

822. In relation to the appropriateness of the nature of the care that was provided to CPL Turner in the 39 days following CPL Turner's discharge from SJoGH, Counsel Assisting does not consider that any adverse finding should be made on the appropriateness of the care provided by CAPT McLean. However, the position in relation to the "fragmented" nature of CPL Turner's care during this period is maintained.[1207]

823. Counsel Assisting also does not seek an adverse findings flagged by Dr Hale above at [817]-[819].[1208] The general substance of whether or not a direction to CPL Turner to comply with treatment – including whether such directions were counterproductive – was the subject of other questions to Dr Hale (albeit not by reference to this specific email).[1209]

[1202] Submissions in reply of Dr Hale dated 19 July 2024 at [4].
[1203] Submissions of Mr and Mrs Turner dated 28 January 2024 at [90].
[1204] Submissions of Dr Hale dated 31 May 2024 at [41].
[1205] Submissions of Joanna Turner dated 17 January 2024 at [7].
[1206] Submissions of Dr Hale dated 31 May 2024 at [45].
[1207] Submissions in reply of Counsel Assisting dated 22 August 2024 at [59].
[1208] Submissions in reply of Counsel Assisting dated 22 August 2024 at [138.1].
[1209] 23/10/2020 T410.41-412.4; Submissions in reply of Counsel Assisting dated 22 August 2024 at [138.3].

The Human Performance Wing

824. Counsel Assisting submits that in relation to SGT MC's evidence which did not mention the word "ill" when noting the HPW had been set up for the "wounded and injured", significant weight should not be placed on this omission given that evidence was provided by other witnesses.[1210]

825. In relation to the objection made by the Commonwealth that the criticism of the HPW appears irrelevant to the manner and cause of death in circumstances where it was previously stated by Counsel Assisting on 6 September 2022 that the role of the Inquest was not to investigate HPW "more broadly", Counsel Assisting's position[1211] in relation to the relevance of the HPW is clear when understood in its context:[1212]

> "Your Honour, there is a concern that the role of this inquest is not to investigate the Human Performance Wing more broadly. There are clearly issues relating very specifically to Corporal Turner and the way in which he was treated within the Human Performance Wing…"

826. Counsel Assisting's initial submissions on the HPW clearly concern CPL Turner's treatment within the HPW and to the extent there are broader assessments regarding qualifications of its staff or its overall purpose, they are made in the context of assessing the appropriateness of that venue for *CPL Turner* at that time. No finding or comment is sought in which would traverse what was accepted by Counsel Assisting on 6 September 2022.[1213]

The fragmented nature of the care provided to CPL Turner

827. In response to the Commonwealth's objection to Counsel Assisting's submission that there was a "fragmentation of care", Counsel Assisting indicates that the fragmentation of CPL Turner's care prevented the fulsome disclosure of information between practitioners, prevented communication between practitioners, prevented input from external practitioners in welfare boards, prevented consistent oversight of prescription of medication, and may have been seen to be intrusive for someone in CPL Turner's position. Those matters are apparent from the evidence as previously summarised and it is submitted that it is not additionally necessary for there to be expert opinion to make such a finding.[1214]

[1210] Submissions in reply of Counsel Assisting dated 22 August 2024 at [50], referring to 1/9/22 T31.36; T31.47; T41.9; 9/9/22 T34.3.
[1211] Submissions in reply of Counsel Assisting dated 22 August 2024 at [226].
[1212] 6/09/2022 T18.48-19.1.
[1213] Submissions in reply of Counsel Assisting dated 22 August 2024 at [227].
[1214] Submissions in reply of Counsel Assisting dated 22 August 2024 at [223].

828. In relation to the Commonwealth's explanations as to *why* fragmentation of CPL Turner's care occurred, Counsel Assisting submits that the evidence does not grapple with the *impact* of the fragmentation which was the focus of Counsel Assisting's initial submissions on this point to which the Commonwealth objects. It is submitted that while it may be unavoidable that CPL Turner had to be seen by several practitioners, it is the degree to which that fragmentation occurred and the lack of wholistic coordination and oversight of CPL Turner's care which gave rise to the issues.[1215]

829. Lastly, contrary to the Commonwealth's submission at [811] above, it is not Counsel Assisting's position that fragmentation could *only* be remedied by management by a "single person".[1216]

Consideration

830. It is perfectly clear that CPL Turner's mental health deteriorated rapidly throughout the first half of 2017. The move from B Company to C Company was done in a manner which lacked attention to the potential risks for CPL Turner. Whether or not the demotion and move were necessary is not for me to judge. However, it is clear that a significant amount of mental health support would have been required. BRIG Langford accepted the steps taken would have been humiliating. In my view, the potential impact is obvious.

831. Unfortunately, even when CPL TJ communicated her concerns to the Padre, there is no evidence that this was fed up the Chain of Command. Nevertheless, she continued to try and support CPL Turner and for that she should be commended.

832. The ADF placed reliance on the fact that CPL Turner would be managed by the HPW after his first suicide attempt in early March 2017. This unit, located within the 2CDO, was described as being set up "to provide mentoring management of the wounded injured (sic) in a culturally relevant space and it was a by commando for commando area." Mr Cardinaels was the "leader" of the HPW from around 2015 to 2018. I had the opportunity to hear from him during the inquest. It was less than impressive.

833. His own qualifications for running such a unit were being "well read", talking to others in the field, and having an interest in rehabilitation. He had no psychological or psychiatric training. I make no finding on the operation of the HPW more broadly but, in my view, Mr Cardinaels struggled to articulate what the HPW was trying to achieve *for CPL Turner.* He appeared to have no idea who was case managing CPL Turner's

[1215] Submissions in reply of Counsel Assisting dated 22 August 2024 at [223].
[1216] Submissions in reply of Counsel Assisting dated 22 August 2024 at [224].

rehabilitation. In my view, the reliance the ADF placed on CPL Turner's placement with the HPW was entirely misplaced. What was required was coordinated and professional support, not amateurish mentoring in a space which was "culturally relevant" to commandos.

834. In my view, there is no question that COL MF's rejection of the PhD proposal was not sensitively handled and had very serious repercussions. Whether it was rejected or "not supported because of the outplacement component" is not a matter I will comment on. What is clear is that the proposal was one of the few things that gave CPL Turner hope at that point in his life. The fact that it was "taken off the table" at that time was unnecessary and robbed him of his dream of finding a suitable and respectful transition. I accept CPL TJ's submission that this decision reinforced CPL Turner's perception that he had been publicly abandoned.

835. I have taken into account the specific matters raised by the Commonwealth both in relation to other stresses that were affecting CPL Turner during this time that the ADF had no control over (for example, issues occurring in his relationship with CPL TJ) as well as steps the ADF took to provide care (including around the time he was admitted to St Vincent's Hospital) but it does not change my mind that his care was always largely reactive. It is not that the ADF did nothing, it is that a coordinated plan was lacking. I have considered and do not accept the submission that the IWB procedure was helpful at this time.

836. I accept that by this stage CPL Turner's health would have been difficult to manage. During the first two weeks of July he had suffered a dissociative episode or overdose, was drinking excessively, had missed appointments, and was increasingly volatile. I have considered the Commonwealth's detailed submissions which suggest that the notion of "fragmented care" should not be accepted. I am not persuaded by those submissions and, in my view, the care was both fragmented and reactive.

837. I accept all of Counsel Assisting's submissions about the fragmented nature of care provided to CPL Turner during 2017. I accept that having so many professionals involved may have been perceived by CPL Turner as intrusive. There were ADF medical personnel, external consultants, as well as people such as Mr Cardinaels who had no apparent training. There is a real difficulty in trying to ascertain who had overall responsibility. Without a clear central point, CPL Turner was able to share different information as he saw fit. Mr and Mrs Turner took my attention to the fact that after CPL Turner's discharge from SJoGH on 25 May 2017 he went 39 days without seeing his treating psychologist. I see this kind of gap as one which may have been

exacerbated by the fragmentation of his care. It is possible that individual practitioners honestly believed he was being managed elsewhere.

Adequacy of the ADF's response in the period from 15 to 17 July 2017

838. The evidence relevant to this issue is set out in the chronology above at [373]-[379].

Submissions of Counsel Assisting

839. Counsel Assisting submits[1217] that in the period of 15 to 17 July 2017 there was a great deal of confusion amongst various witnesses about whether CPL Turner was intended to have a "battle buddy", that is, someone with him 24/7, over that weekend. It ultimately transpired that he was not, and the safety plan involved him calling CPL TJ or a work mate if he had thoughts of suicide, avoiding alcohol, and following medical advice.

840. It also appears that immediately prior to this period, there were moves on the part of the ADF to use the disciplinary system in order to force CPL Turner to comply with treatment. Counsel Assisting posits that it was inappropriate to do so in the absence of any medical advice (from any person involved in the specific treatment of CPL Turner's mental health (i.e., his treating psychologist or psychiatrist))[1218] suggesting that this would be helpful. It is submitted that given that aspects of the ADF's disciplinary system had been a significant cause in CPL Turner's declining mental health and relapse, it ought to have been plainly obvious to the Chain of Command that using discipline to force treatment compliance might be counterproductive and to seek expert medical advice on the utility of it. Ultimately, this did not seem to assist CPL Turner in his recovery and was more likely to have been unhelpful to his recovery.

841. Counsel Assisting concludes that it appears that little could have been done to assist CPL Turner in his final few days, noting that the failures in treatment all occurred at an early stage. By mid-2017 he was in a critical condition and it is not clear what specific intervention at this stage might have avoided the tragic outcome.

Submissions of the Commonwealth

842. The Commonwealth considers that it is incorrect to state that the Chain of Command had no medical advice suggesting that the use of the disciplinary system would be helpful. In this regard, by not calling evidence from Dr Reppas about the advice that the disciplinary system could be used to order CPL Turner to attend an inpatient mental

[1217] Submissions of Counsel Assisting dated 2 November 2023 at [496]-[498].
[1218] Submissions in reply of Counsel Assisting dated 22 August 2024 at [228].

health facility, it would be procedurally unfair to make any adverse findings or comment about Dr Reppas' advice or the ADF's consideration of it.[1219]

Submissions in reply of the Counsel Assisting

843. Counsel Assisting does not seek an adverse finding against Dr Reppas.[1220]

Consideration

844. I accept Counsel Assisting's submission that there was confusion in the days leading up to CPL Turner's death about whether he should have someone with him 24/7. This is regrettable.

845. I was concerned that in the days leading up to his death there appears to have been consideration on the part of the ADF to use the disciplinary system to order CPL Turner to comply with treatment. In my view, even just taking into account CPL Turner's recent response to the ADF disciplinary system, the potential approach was entirely misconceived. I do not raise the issue to suggest criticism of any particular individual but rather to highlight the apparent underestimation of CPL Turner's ability at this juncture to respond rationally to ADF direction or punishment. In my view, it shows a failure to understand how critical things had become. A punitive approach was not required at this point.

Other matters raised in connection with Issue 3

(a) Clinical case management by the ADF throughout the period of 2014-2017

Submissions of Mr and Mrs Turner

846. CPL Turner's parents submit that between 2014 and 2017, CPL Turner should have been considered to have had "sub-syndrome PTSD" and that the ADF should not have considered him being "cured" of PTSD during that time. They consider that there should be better education regarding sub-syndrome PTSD, PTSD symptomology, an independent review of health files, and a policy implemented to guide future reviews.[1221]

847. I accept that submission.

848. Mr and Mrs Turner submit that there was a lack of clarity in the roles and responsibilities of the multiple participants in CPL Turner's management at 2CDO (for

[1219] Submissions of the Commonwealth dated 7 June 2024 at [665].
[1220] Submissions in reply of Counsel Assisting dated 22 August 2024 at [228].
[1221] Submissions of Mr and Mrs Turner dated 28 January 2024 at [81]-[85]

example, 2CDO MO and psychologists believed they were CPL Turner's clinical case managers), which impacted CPL Turner's confidence in 2CDO's ability to manage his clinical condition. They consider that, as per ADF policy, CPL Turner should have had a MO as his designated clinical case manager from the time of his discharge in 2014. Furthermore, CAPT KV should not have assumed the role of clinical case manager as he was not a "medical officer".[1222]

849. Mr and Mrs Turner also submit that a finding should be made that from 2014 onwards, the 2CDO Chain of Command well knew of CPL Turner's mental health condition.[1223] In this respect, they disagree with the Commonwealth's assertion that the Chain of Command was unaware of CPL Turner's mental health condition at key times between 2014-2017[1224]. They note that the Chain of Command did not know about the domestic violence in light of the evidence that:

i. CPL Turner was on the UWB between January to June 2016 and the UWB should have been monitoring his psychological wellbeing given his hospital admission in 2014;

ii. in late 2015, the Chain of Command were aware of the ongoing issues;

iii. on 18 September 2015, MAJ Clancy organised a room for CPL Turner on base when she became aware of an altercation between CPL Turner and Joanna Turner;[1225]

iv. MAJ Clancy's evidence was that she had open communication with BRIG Langford, meaning that it can be assumed that if a member moved to base in those circumstances MAJ Clancy would have raised that with the CO as an important welfare matter;[1226]

v. on 23 September 2014, an incident report recorded CPL Turner's "treating psychologist reported to the Chain of Command that [CPL Turner] and his wife had been involved in a verbal domestic dispute";[1227] and

[1222] Submissions of Mr and Mrs Turner dated 28 January 2024 at [99]-[107].
[1223] Submissions in reply of Mr and Mrs Turner dated 22 July 2024 at [54].
[1224] Submissions of the Commonwealth dated 7 June 2024 at [280]-[283].
[1225] Submissions of the Commonwealth dated 7 June 2024 at [241(a)].
[1226] Submissions of the Commonwealth dated 7 June 2024 at [176(c)].
[1227] Submissions of the Commonwealth dated 7 June 2024 at [241(c)].

vi. Joanna Turner reported that following the September 2015 domestic dispute, her Platoon Sergeant sat down with 2CDO and raised concerns about what was happening and CPL Turner's mental state. [1228]

850. Mr and Mrs Turner submit that if, notwithstanding the above, it is accepted that the Chain of Command did not know about the domestic violence, then that reflects a serious breakdown in the welfare processes at 2CDO at the time.[1229]

851. In response to any suggestion that the ADF was unaware of CPL Turner's mental health issues at the time of the decision to move him to C Company in 2016, CPL Turner's parents note:[1230]

i. the 2CDO Chain of Command actively participated in appealing the initial decision of GPCAPT Ross that CPL Turner was not fit to deploy due to mental health concerns;

ii. CPL Turner was still being reviewed by the 2CDO UWBs whilst deployed;

iii. CPL Turner had been involved in the disciplinary proceedings and the 2CDO Chain of Command knew of the demotion and move to C Company;[1231]

iv. BRIG MF gave evidence that the move to C Company would have caused some form of embarrassment;[1232]

852. They also note[1233] that during 2017, the Chain of Command did not appreciate how unwell CPL Turner was before his first suicide attempt, despite the evidence of CPL TJ[1234] and Padre MP.[1235]

853. Mr and Mrs Turner submit[1236] that questions should be asked of the ADF as to why it was that medical and operational personnel were inadequately trained to recognise symptoms of PTSD and respond to CPL Turner's PTSD given that the Commonwealth made the following concessions about the available body of knowledge the ADF had access to:

[1228] Tab 7 at 4.
[1229] Submissions in reply of Mr and Mrs Turner dated 22 July 2024 at [53(a)].
[1230] Submissions in reply of Mr and Mrs Turner dated 22 July 2024 at [53(i)].
[1231] 21/10/2020 T240.26.
[1232] 21/10/2020 T240.10-20.
[1233] Submissions in reply of Mr and Mrs Turner dated 22 July 2024 at [53(j)].
[1234] Tab 27 at 28.
[1235] 03/08/2021 T46.15.
[1236] Submissions in reply of Mr and Mrs Turner dated 22 July 2024 at [23(a)].

i. treatment of PTSD and the difficulties in treating PTSD that have existed for years;[1237]

ii. even if asymptomatic, "response rates for exposure-based therapy 'remain modest'";[1238]

iii. highest rates of remission are generally seen where the affected person has experienced a single traumatic episode and where PTSD is not complicated by comorbid conditions;[1239]

iv. "even those who return to normal function do…still have a risk of relapse of the condition, most likely in association with other stressful life events or specific reminder of their trauma";[1240]

v. the ability of some PTSD sufferers to be "able to continue performing at a high level in the workplace";[1241]

vi. the ability of some PTSD sufferers to "successfully conceal signs/symptoms and continue to perform at a high level in the workplace";[1242]

vii. "abuse of alcohol and other drugs might be a sign/symptoms of PTSD";[1243] "domestic violence and coercive controlling behaviour might be a sign/symptom of PTSD";[1244] and

viii. "reporting obligations of ADF personnel, both in respect of mental health issues and domestic violence".[1245]

854. Lastly, on the question of 2CDO resources, Mr and Mrs Turner consider that the evidence suggests that the 2CDO Chain of Command was under significant pressure at the time of managing CPL Turner from a welfare perspective. However, they consider it unfortunate that the 2CDO Chain of Command did not consult CPL Turner's psychiatrist or psychologist and that the 2CDO medical officer did not refer CPL Turner to the ADF Centre for Mental Health Second Opinion clinic until hours before his death.[1246]

[1237] Submissions of the Commonwealth dated 7 June 2024 at [86], [117], [322].
[1238] Submissions of the Commonwealth dated 7 June 2024 at [86].
[1239] Submissions of the Commonwealth dated 7 June 2024 at [86].
[1240] Submissions of the Commonwealth dated 7 June 2024 at [86].
[1241] Submissions of the Commonwealth dated 7 June 2024 at [139], [264].
[1242] Submissions of the Commonwealth dated 7 June 2024 at [87], [264].
[1243] Submissions of the Commonwealth dated 7 June 2024 at [87], [211].
[1244] Submissions of the Commonwealth dated 7 June 2024 at [87, [94], [182(c)], [211], [495].
[1245] Submissions of the Commonwealth dated 7 June 2024 at [182(c)].
[1246] Submissions of Mr and Mrs Turner dated 28 January 2024 at [179]-[185].

Submissions of the Commonwealth

855. The Commonwealth accepts that the evidence in the Inquest establishes that the operational and medical personnel who dealt with and/or treated CPL Turner in the period 2014-2017 were "not sufficiently trained, especially in relation to recognising and managing the signs/symptoms of PTSD".[1247] It is also noted that the ADF accepts that its training programs need to be reviewed to ensure that operational and medical personnel sufficiently understand that alcohol/drug abuse and domestic violence may be a sign or symptom underlying PTSD.[1248]

856. It is pleasing that the ADF made these important concessions.

Submissions of GPCAPT Ross

857. GPCAPT Ross contends that no finding should be made in accordance with the Commonwealth's concessions noted above at [855] that the operational and medical personnel who dealt with CPL Turner in 2014-2017 were not sufficiently trained in recognising and managing the symptoms of PTSD.[1249]

858. In my view, it is an important concession and one that is not aimed at any particular individual.

Submissions of Counsel Assisting

859. Counsel Assisting does not seek any finding in respect of GPCAPT Ross as raised above at [857].[1250]

860. In relation to the submission above at [848], Counsel Assisting notes that CAPT KV assumed the clinical case manager role on or around 31 March 2017 at the request of CPL Turner.[1251] The policy on which Mr and Mrs Turner rely for indicating breach is the "Management of Post-Traumatic Stress Disorder and Acute Stress Disorder in the Australian Defence Force for Primary Care Providers", in which "Mental Health Professional" is defined to include (1) medical officers, (2) nursing officers, (3) psychologists and (4) social workers.[1252] Mr and Mrs Turner refer to the obligation for a "non-medical" mental health professional to refer a member suspected of having PTSD to a medical officer for further assessment. Counsel Assisting disagrees with Mr and Mrs Turner's suggestion that CAPT KV was a "non-medical" professional (noting

[1247] Submissions of the Commonwealth dated 7 June 2024 at [85].
[1248] Submissions of the Commonwealth dated 7 June 2024 at [90], [94], [211].
[1249] Submissions in reply of GPCAPT Ross dated 22 July 2024 at [5]-[8].
[1250] Submissions in reply of Counsel Assisting dated 22 August 2024 at [182].
[1251] Exhibit 40 at [31]; 10/08/2021 T70.19.
[1252] Tab 84 at 2.

he is a psychologist with clinical training), noting that there is an insufficient basis to make a finding that there was a breach of this policy.[1253]

Consideration

861. As noted, I accept Mr and Mrs Turner's general submission that CPL Turner should have been identified as having had subsyndromal PTSD at an earlier time. To later suggest he was "cured" indicates a superficial understanding of the nature of the condition. I accept their submission that there should be better education regarding sub-syndrome PTSD, PTSD symptomology, and stronger reviews of health files review policy.

862. I do not accept their specific contention that there was a breach of policy because CAPT KV was not a "medical officer." I accept Counsel Assisting's submissions on this issue.

(b) The role of the padre

Submissions of Counsel Assisting

863. Counsel Assisting notes[1254] that the role of the padre in providing mental health support emerged as an issue in the provision of mental health support to CPL Turner by the ADF. Padre MP was the padre (or "chaplain") at 2CDO from 2015 to 2017.[1255] By training, Padre MP is a Baptist Minister.[1256] The role of the padre in providing mental health support was described by Padre MP as being "to provide pastoral care and support and walk alongside those who are hurting, definitely those who have got some mental health issues" but that "we are not decision makers" and do not provide "direct mental health support".[1257] He described this "walking alongside" as being "when someone's struggling I'll walk alongside them, be with them, I'm not leaving them, I'm not making any managerial or leadership decisions" but rather "It's purely just support at a lateral point. With whatever they're going through, I'm with them."[1258]

864. Padre MP did not have significant training in mental health. His evidence was that he had attended a two day "mental health first aid course" which teaches "initially awareness of someone who is struggling with mental health". He stated it was "done

[1253] Submissions in reply of Counsel Assisting dated 22 August 2024 at [71]-[73].
[1254] Submissions of Counsel Assisting dated 2 November 2023 at [499]-[503].
[1255] 03/08/2021 T3.
[1256] 03/08/2021 T3.
[1257] 03/08/2021 T16-17.
[1258] 03/08/2021 T50.

at a very lay level".[1259] This course included suicide prevention training.[1260] He had not received training in alcohol abuse or PTSD but was aware of the symptoms of PTSD.[1261] He explained that his role was not to manage mental health disorders, but rather to "walk with a member to get the mental health…get them to the right provider" but not to make decisions or manage, just to "support".[1262]

865. The evidence in the Inquest revealed that the Padre was relied on to a significant extent to assist CPL Turner. For example, BRIG Langford's evidence was that part of improving the ability for members of the ADF to obtain mental health support was by "strengthening our capacity to offer alternative pathways for members", including through the Padre.[1263]

866. It was also apparent that the Padre was providing a level of support to Joanna Turner and was aware of some of the issues which Joanna Turner was facing in the home.[1264] CPL TJ's evidence was that she also took her concerns about CPL Turner's mental health in early 2017 to the Padre.[1265] The Padre was also flown to AMAB around the time of the disciplinary proceedings to provide support to the members who were being investigated.[1266] However, it also appeared that there was very little interaction between mental health and medical professionals and the Padre. For example, MAJ AM stated that he did not remember talking to the Padre about CPL Turner around the time of the 2016 medical clearance,[1267] and neither MAJ AF nor COL MF spoke to the Padre around the time of making that decision in relation to his views about CPL Turner's mental health (notwithstanding it would appear he had relevant information about the difficulties Joanna Turner was facing in the home at that time).[1268] Similarly, the Padre did not appear to have been involved in welfare boards, notwithstanding he was a person providing pastoral support to CPL Turner (noting the obviously blurred line between pastoral support and mental health support).

867. Professor McFarlane noted that chaplains faced difficulties when placed in roles where they were expected to manage mental health disorders in the ADF without necessary expertise and training. He considered that Padre MP's role as an intermediary was fraught with complexities.[1269] He noted that the relationship between the chaplain who

[1259] 03/08/2021 T11.
[1260] 03/08/2021 T12.
[1261] 03/08/2021 T12-13.
[1262] 03/08/2021 T51.
[1263] 21/10/2020 T178.
[1264] 20/10/2020 T96-97.
[1265] 12/08/2021 T28.
[1266] Tab 19 (IGADF ROI with Padre MP on 18 September 2018) at 1-2.
[1267] 06/08/2021 T15.
[1268] 03/085/2021 T15.
[1269] Exhibit 12 at 21.

had been a personal friend of CPL Turner highlighted the complexity in the role of the Padre in taking issues further up the Chain of Command to ensure optimal interventions occur. Professor McFarlane noted that at times, "service personnel see their interactions with the chaplain as being provided mental health care and therefore do not take further steps to receive appropriate treatment".[1270]

868. The evidence revealed that, at various times, the Padre was relied upon as a person who could provide mental health support to CPL Turner and to Joanna Turner in the context of CPL Turner's declining mental health. There was little by way of formal records of these interactions. However, Counsel Assisting highlights that there is a real question as to the role of the padre in providing mental health support in circumstances where those interactions did not appear to ultimately be communicated or taken into account in medical decision-making or decision-making around whether CPL Turner should be deployed. Counsel Assisting notes that these questions provide a basis to make a finding that this role is inadequately scoped or defined and a recommendation to review the role of a padre in providing mental health support.

869. Counsel Assisting does not seek an adverse finding about the Padre's conduct in receiving information from Joanna Turner. It is submitted that there is nothing to suggest the Padre did so for any other reason than attempting to obtain a wholistic view of CPL Turner's circumstances in order to support CPL Turner (as was his role). In the same way, the Padre liaised with CPL TJ in relation to CPL Turner's care. This is particularly relevant in the context of the ADF having been aware of issues of domestic violence and having had a history of at least some engagement with Joanna Turner through MAJ Clancy. Counsel Assisting accepts that the Padre carried out substantial engagement with CPL Turner without formal mental health qualifications and in circumstances where CPL Turner's condition did not appear to ultimately be communicated or taken into account in medical and operational decision-making.[1271]

Submissions of the Commonwealth

870. The Commonwealth considers[1272] there to be no basis to make a finding or recommendation about the scope of the role of the padre, noting that the role is "scoped" and "defined" in various policy and guidelines documents which have been updated since 2017, which were not requested to be produced in the Inquest nor flagged as an issue to be explored at the Inquest.

[1270] Exhibit 12 at 24.
[1271] Submissions in reply of Counsel Assisting dated 22 August 2024 at [68]-[70].
[1272] Submissions of the Commonwealth dated 2 June 2024 at [668].

Submissions of Mr and Mrs Turner

871. Mr and Mrs Turner submit that, at the time CPL Turner notified the ADF that he had separated from Joanna Turner, the Chain of Command should have had no further interaction with her in relation to his care and management. In particular, Mr and Mrs Turner are critical of the Padre's role of acting as a conduit of information between CPL Turner and Joanna Turner, which they submit gave rise to a "very real risk" that the Padre would have been given inaccurate information which would then have been fed into the Chain of Command.[1273]

Submissions in reply of Counsel Assisting

872. Counsel Assisting considers that it is not clear whether Mr and Mrs Turner's submission is intended to assert the identified "risk" *in fact* led to inaccurate information impacting CPL Turner's care.[1274]

Consideration

873. I found Professor McFarlane's evidence about the difficulties chaplains face when they are expected to assist in managing mental health disorders compelling. They do so without proper training or expertise. Specifically, Professor McFarlane identified the intermediary role Padre MP played at times was one which was fraught with complexities. He was a personal friend of CPL Turner's and he was also relied upon by Joanna Turner. There appeared to be no clarity around when information given to him was or should have been sent up the Chain of Command. Both Counsel Assisting and Counsel for Mr and Mrs Turner, for different reasons, identified issues with the Padre's undefined role and responsibilities.

874. The Commonwealth considered I had no basis to make a finding about the scope of the role of the padre without having had access to the various policies and guidelines which exist. I agree it would be improper for me to make a finding that Padre MP did not act in accordance with his duties. I have no intention to do that.

875. Nevertheless, the reliance on the Padre to assist the Chain of Command in the management of CPL Turner's mental health, something he had no qualifications to attend to, was in my view misplaced. There was also a reliance by some on the Padre to feed information back to the Chain of Command. This was always fraught with difficulty given the conflicting loyalties involved.

[1273] Submissions of Mr and Mrs Turner dated 28 January 2024 at [97]-[98].
[1274] Submissions in reply of Counsel Assisting dated 22 August 2024 at [67].

876. I understand the historical place of the padre in the ADF; however, it should not be confused as a role which offers an alternative to professional medical support.

(c) Coercive control

Submissions of the Commonwealth

877. The Commonwealth submits that no finding should be made that ADF personnel can or should have recognised CPL Turner's behaviour as "coercive controlling behaviour" or interpreted any such behaviour above as a sign or symptom of PTSD (referring to Counsel Assisting's summary of the facts at [26], [91], [260], [327], and [480]). The Commonwealth posits that "coercive control" is a relatively new concept in the fields of medicine, social sciences, and law and none of the experts in the Inquest (who are not even experts in coercive controlling behaviour) gave evidence about such behaviour.[1275]

Submissions in reply of Counsel Assisting

878. Counsel Assisting emphasises that the submissions above at [583]-[586] make the point that domestic violence was known to the ADF but not recognised as a symptom of PTSD. The indicia of what might now be *described* as "coercive controlling behaviour" did not occur in a vacuum or in a form unrecognisable even ten years ago as a form of domestic violence. When CPL Turner was charged in 2014, the offences and facts showed indicia of what might now be described as coercively controlling behaviour in the form of actual criminal charges: stalking and menacing use of a carriage service. It is accepted by Counsel Assisting that members of the ADF could not have been expected to recognise the indicia of coercive control as a discrete phenomenon, however, this misses the point that such indicia which occurred in the context of what conduct amount to domestic violence, however described.[1276]

Consideration

879. I am perfectly comfortable in describing some of the behaviour which took place as "coercive controlling behaviour." While it is true that the term is now better understood, it has been used to describe behaviour which has been recognised by psychologists as domestic violence for many years.

[1275] Submissions of the Commonwealth dated 7 June 2024 at [97].
[1276] Submissions in reply of Counsel Assisting dated 22 August 2024 at [190].

(d) Welfare board meetings

Submissions of Mr and Mrs Turner

880. In relation to the welfare boards, it is submitted that there were "blurred lines of responsibility" in the communications and there should be ADF policy about who is responsible for providing the member with details of the proceeding and the outcome of welfare boards. They state that because CPL Turner was not present or represented at every welfare board meeting or even informed of the outcome of these meetings, he did not fully understand his predicament and the welfare boards lacked insight into CPL Turner's condition and treatment. They also believe that ADF policy *DIG PERS 16-24 Mental Health* was breached by not having CPL Turner in attendance at every welfare board meeting.[1277]

Submissions of Counsel Assisting

881. Counsel Assisting considers that the evidence is insufficiently clear to base a finding that ADF policy was breached by not having CPL Turner in attendance at welfare board meetings. There is evidence that CPL Turner attended IWBs (where his attendance was required) and other times he did not.[1278] Where it was permissible under ADF policy for a member to have a nominated representative on the IWB, his absence does not in and of itself suggest a lack of representation. Without identification of *which* IWB CPL Turner did not attend and what information was *not* provided to him, it is submitted that no useful conclusion can be drawn about any particular causative influence on his supervision or treatment. [1279]

Consideration

882. I accept Counsel Assisting's submissions on this issue.

(e) Shifting of blame to CPL Turner

Submissions of Mr and Mrs Turner

883. Mr and Mrs Turner consider that the Commonwealth's submissions convey a subtext that CPL Turner was to blame for the way in which his PTSD evolved. They submit that the Commonwealth's references to CPL Turner deliberately concealing or under-reporting his PTSD[1280] fail to contextualise CPL Turner's actions and must be

[1277] Submissions of Mr and Mrs Turner dated 28 January 2024 at [88]-[96], [103], [108].
[1278] Tab 38 (Welfare Board Minutes) at 13, 16.
[1279] Submissions in reply of Counsel Assisting dated 22 August 2024 at [64].
[1280] Submissions of the Commonwealth dated 7 June 2024 at [74]-[83], [125], [135], [151], [158], [182], [195], [214], [226], [232], [241], [282], [329], [374].

understood in the context of the known stigma in the ADF of mental illness as being a barrier to members seeking care.[1281]

884. They also submit[1282] that the Commonwealth's submissions regarding CPL Turner's intimate relationships are condescending and judgmental in that they refer to selective texts that label CPL Turner as being "aggressive", "demeaning", "self-piteous", and "ostensibly loving and caring",[1283] which fails to properly acknowledge the expert evidence regarding CPL Turner's intimate relationships.[1284] They also note that the text messages referred to by the Commonwealth are written by someone suffering from severe PTSD (and that insofar as the Commonwealth contends that the text messages depict the behaviour of someone who is not suffering from a significant illness, such a contention should be rejected).[1285]

Submissions of Counsel Assisting

885. In relation to Mr and Mrs Turner's submission that the Commonwealth appear to be shifting blame to CPL Turner for not being forthcoming with his symptoms, Counsel Assisting acknowledges the expert evidence concerning the difficulties arising from underreporting of symptoms (summarised above at [486]-[489]) and notes that Counsel Assisting's recommendations in relation to this Inquest (discussed below) promote longitudinal management of ADF members' mental health, training on the recognition of PTSD, and alternative career paths within and outside the ADF (career advancement being a consideration which may impact upon a member's willingness to disclose).[1286]

886. In relation to Mr and Mrs Turner's complaint about the Commonwealth's submissions seeking to shift blame or focus to CPL Turner's intimate relationships, Counsel Assisting refers to the evidence (as summarised above at [199]) regarding the interaction between PTSD, alcohol abuse and relationship breakdowns and domestic violence.[1287]

887. As for Mr and Mrs Turner's submission that a finding ought to be made that from 2014 onwards, the 2CDO Chain of Command knew of CPL Turner's mental health condition, Counsel Assisting emphasises that it is not merely an awareness of diagnosis that is relevant for such a finding, but the awareness of the deteriorating status of that

[1281] Submissions in reply of Mr and Mrs Turner dated 22 July 2024 at [49]-[51].
[1282] Submissions in reply of Mr and Mrs Turner dated 22 July 2024 at [52(b)].
[1283] Submissions of the Commonwealth dated 7 June 2024 at [488].
[1284] 07/02/2023 T40.1-25, T41.5; Exhibit 12 at 6, 11.
[1285] Submissions in reply of Mr and Mrs Turner dated 22 July 2024 at [48].
[1286] Submissions in reply of Counsel Assisting dated 22 August 2024 at [103].
[1287] Submissions in reply of Counsel Assisting dated 22 August 2024 at [104].

diagnosis over time, and, to the extent certain information or events were not conveyed up the Chain of Command, it is the absence of systemic oversight and management of the diagnoses that is particularly relevant.[1288]

Consideration

888. It is necessary to be very careful when describing CPL Turner's under-reporting of PTSD symptoms. I accept Mr and Mrs Turner's submission that this behaviour must be viewed in context. I accept that there was considerable stigma surrounding having a mental illness in the ADF. It must also be remembered that he had a genuine desire to serve his country at all costs.

889. CPL Turner was very unwell and that is reflected in his behaviour and in his relationships.

Issue 4 – Whether there was any disincentive to CPL Turner raising mental health issues or seeking mental health treatment by reason of ADF policies or procedures

Submissions

Submissions of Counsel Assisting

890. Counsel Assisting[1289] submits that BRIG Langford's evidence was that during 2014-2015, the time he was the CO of 2CDO, there was an attempt to destigmatise members seeking help for mental health and that he tried to make it clear to members that there was a process where members could seek mental health support with a view to returning to active service when they were fit to serve.[1290] This attitude appears to have continued under the command of COL MF who said in his ROI for the IGADF that "…to be honest, at that point, [CPL Turner] was almost a good news story… organisationally as well, to display that just because you did put your hand up and say you had an issue, it wasn't a one-way ticket to medical discharge."[1291] This answer was given in the context of questions about the granting of the medical clearance for CPL Turner's deployment on OP OKRA in 2016.

891. Ms Cantwell, clinical psychologist, formed the view during her treatment of CPL Turner that he was "willing to put on a 'brave face' and deny certain aspects of his presentation despite clinical symptoms and/r reports that would indicate otherwise". She stated she was "acutely aware of this tendency of Mr Turner's through my experience working

[1288] Submissions in reply of Counsel Assisting dated 22 August 2024 at [105].
[1289] Submissions of Counsel Assisting dated 2 November 2023 at [504]-[517].
[1290] 21/10/20 T178.33-44.
[1291] Tab 17 (IGADF ROI with COL MF on 22 August 2018) at 9.

with ADF members for several years prior" and that her experience was "that this was a common feature of ADF members, particularly members of the SF (Special Forces)".[1292]

892. Dr Malik gave evidence that he felt CPL Turner was being open and honest with him when he had consultations with him.[1293] Dr Malik explained that doctors have tools to try and cross-check whether the information a patient is giving is accurate: by checking their history and then checking their hands to see if the patient's hands are sweating which can demonstrate hyperarousal, and to consider whether the patient has a change in their physical appearance when they talk about trauma.[1294] However, he accepted that there were limitations to a doctor's ability to know whether a patient is being truthful and that, ultimately, "you have to trust the patient… otherwise you risk breaking the therapeutic lines."[1295]

893. Dr Malik was asked about an email which Patricia Turner had written to Dr Malik on 1 May 2017 in relation to CPL Turner's treatment, at the end of which she had stated: "He is well known for being able to answer all tests as to being completely well, when it has been proven not to be the case".[1296] He stated that "I had to engage him really well…knowing this doesn't mean that I can tell him that and he's going to open up. That breaks our relationship because he thinks I'm, you know, working against him". Dr Malik stated that CPL Turner gave him no reason to think that CPL Turner was lying, having stayed in the inpatient facility for four weeks, attending appointments and reviews, and that "you rely on what you see and you try to engage the patient rather than trying to question or interrogate them".[1297]

894. Dr Sringeri was adamant in his oral evidence that CPL Turner was honest with him.[1298]

895. The experts generally agreed that it is possible for an individual to hide symptoms of PTSD. If someone is acutely unwell, it may be more difficult for them to hide symptoms. In general, the experts agreed that it was important for maintaining a therapeutic relationship that clinicians are not overly sceptical of what their clients are telling them and that it was necessary to rely on what the patient was saying.[1299]

[1292] Exhibit 40 (Statement of Andrea Cantwell dated 31 August 2022) at 3.
[1293] 20/10/20 T124.
[1294] 20/10/20 T125.1-11.
[1295] 20/10/20 T20-24.
[1296] Tab 56 (St John of God records) at 170.
[1297] 20/10/20 T127.18-31.
[1298] 22/10/20 T321.6-7.
[1299] See 08/02/23 T25-27, 89-90.

896. It is clear that CPL Turner was motivated to hide his mental health issues and that there were obvious disincentives in raising mental health issues in that it would have an immediate effect on the suitability of a soldier for continued service as a commando. Counsel Assisting notes that, ironically, the attitude of those in command that mental health issues should be destigmatised, provided an incentive for them to seek a review of the decision to not grant a medical clearance to CPL Turner without adequately investigating the risks to CPL Turner's health in doing so.

897. Counsel Assisting does not submit that mental health issues should prevent a serving member of the ADF from being deployed. The demands of service as a commando are extreme and it is obviously important that commandos are sufficiently mentally fit to undertake their duties. However, a way has to be found for soldiers to raise issues relating to their mental health as soon as they arise without the fear that their ongoing career in the military will be immediately compromised. Rather than creating an incentive to hide their symptoms, the aim should be for ADF members to raise concerns and engage in treatment so they can return to good mental health.

898. Counsel Assisting notes that this objective is made difficult to achieve by the failure of Command to create alternative and attractive career paths for members whose identity and sense of purpose is inherently linked to their service as an active combat soldier. It is submitted that consideration should be given to the creation of alternative career paths for Special Forces soldiers either after a fixed period of deployment to combat zones or after they had developed mental health issues that meant further combat deployments were of risk to their health. This is reflected in the recommendations proposed by Counsel Assisting below.

Security clearances

899. Another issue that arose in the Inquest was whether CPL Turner was able to disclose information about the activities in which he was involved to his treating doctors or whether he was limited in what he could disclose because that information was security classified. Dr Malik stated that CPL Turner was not able to talk about some matters because of security classifications.[1300]

900. Dr Malik's opinion was that he did not need to engage in specifics and that, in any event, CPL Turner was not ready at the time he was engaging him to engage in discussions about traumatic events.[1301] However, he acknowledged that "maybe later

[1300] 20/10/20 T142.13-22.
[1301] 20/10/20 T142-143.

down the track when you want to engage them in exposure therapy", access to security classified information could be useful.[1302]

901. Dr Sringeri's evidence was that he had experienced a situation where a person who was a serving member had said to Dr Sringeri that he could not talk about particular matters because it is "classified or secret".[1303]

902. The experts were asked about this issue in the expert conclave. Dr Large, Dr Nielssen, Dr Hopwood, and Professor McFarlane agreed with the proposition that there may be difficulties in providing diagnoses and treatment to members of the military and particularly Special Forces soldiers where the member cannot provide security classified information to the clinician.[1304] Dr Dinnen disagreed; however, his opinion focussed on whether the examination of a person indicated the presence of a serious psychiatric disorder as compared to the ability to engage in effective treatment.[1305]

903. It is submitted that the issue of security classified information does present a barrier to the effective treatment of members with PTSD.

Submissions of Mr and Mrs Turner

904. Mr and Mrs Turner submit that the obvious disincentive for members disclosing that they are struggling mentally is that it can seriously limit a career.[1306] They contend that the only remedy to this is for the ADF to formulate alternative career pathways that lead from combat roles to other ADF roles once a member suffers traumatic injuries such as PTSD.[1307]

905. In the case of CPL Turner, Mr and Mrs Turner consider that he did not want to show any weakness or let his regiment down by openly admitting that his PTSD was not fully under control and that he was not coping. They consider that CPL Turner was used as a "good news story" in that he was deployed after being treated for PTSD.[1308]

Submissions of Dr Sringeri

906. Dr Sringeri objects to the proposed finding that the issue of security classified information "does" present a barrier to the effective treatment of members with PTSD

[1302] 20/10/20 T157.25-32.
[1303] 22/10/20 T335.26-31.
[1304] 08/02/23 T15-16.
[1305] 08/02/23 T16.
[1306] Submissions of Mr and Mrs Turner dated 28 January 2024 at [110].
[1307] Submissions of Mr and Mrs Turner dated 28 January 2024 at [110]-[111].
[1308] Submissions of Mr and Mrs Turner dated 28 January 2024 at [114]-[115].

on the basis that the language of "does" may be "a bit strong" and that the evidence supports a finding that the issue "may" present a barrier to effective treatment.[1309]

Submissions in reply of Counsel Assisting

907. Counsel Assisting submits that it was not intended to suggest that the issue of security classified information would prevent the effective treatment of members in *all* cases and there is no issue with a finding being expressed in terms of "may" to avoid any such implication.[1310]

Consideration

908. I accept that there were clear disincentives for CPL Turner to raise the full extent of his mental health difficulties. It would have had an immediate impact on his career as a commando. He would not have been deployed. Without stronger pathways for alternative careers supported by the ADF, this kind of reluctance will remain the case. This is an issue to which I will return.

909. In my view, it is likely that the fact CPL Turner was regarded as "a good news story" made honesty even more difficult. Unfortunately, his intelligence (and his superior's complete lack of curiosity) appears to have made it possible for him to conceal the extent of his injury from the Chain of Command for an extended period.

910. I also accept the weight of the expert evidence that there may be a particular problem for Special Forces soldiers in relation to diagnosis and treatment where members cannot talk openly about classified operations.

Issue 5 – The extent to which the investigation and laying of charges arising from an incident involving a pornographic playing card affected CPL Turner's mental health, the extent to which CPL Turner's mental health history was taken into account in this process and whether adequate support was provided in these circumstances.

Evidence

911. The evidence relevant to this issue is set out in the chronology above at [198]-[211].

[1309] Submissions of Dr Sringeri dated 24 April 2024 at [49]-[51].
[1310] Submissions in reply of Counsel Assisting dated 22 August 2024 at [168].

Submissions

Submissions of Counsel Assisting

912. Counsel Assisting submits[1311] that CPL Turner's mental health was not taken into account during the disciplinary proceedings because it was not put to the summary authority. BRIG Langford accepted that if a person had PTSD, one would expect it to be put to the summary authority as part of their plea in mitigation.[1312] CAPT MH's evidence was that CPL Turner did not instruct him to put his mental health issues before the summary authority.[1313] It is not ultimately clear why this happened: it may have been because CPL Turner was concerned about the effect on his career of formally raising his mental health problems is such a forum or it may have been because he did not expect the outcome of the hearing to be as severe as it was.

913. It is clear, however, that little to no regard was had for CPL Turner's mental health in the process of the disciplinary proceedings and in its aftermath, and no specific mental health support was put in place for him when he returned to Iraq. Instead, he returned to TQ in a relatively isolated role and was left to deal with the further consequences of the disciplinary proceedings, namely the NTSC and the move from B Company to C Company, which were clearly likely to compound his distress.

914. Counsel Assisting submits that the failure to put in place mental health support in these circumstances is all the more stark when regard is had to the basis on which it was represented to GPCAPT Ross that the risk of CPL Turner deploying was low, because of his apparently "ready" access to psychologists and assessment and management of his mental health by his regular team members. As MAJ AF's evidence revealed, he simply was not tracking the significant decline in CPL Turner's mental health during this time. This cannot be attributed to CPL Turner's determination to hide it because he revealed it to two superior officers, who ultimately did little with that information by way of substantive steps to mitigate the harm to CPL Turner.

915. Counsel Assisting submits that it is not my role to review the disciplinary proceedings themselves or the punishment which was imposed. However, it is submitted that it is open to make a finding that CPL Turner's mental health was severely compromised as a result of those proceedings and by the subsequent failure to support him. In particular, MAJ AF, who had been involved in preparing the brief to GPCAPT Ross to justify the granting of a medical clearance to CPL Turner, should have been aware of

[1311] Submissions of Counsel Assisting dated 2 November 2023 at [518]-[519].
[1312] 21/10/20 T196.36-T197.7.
[1313] Exhibit 13 (letter from CAPT MH dated 31 July 2021) at 1.

the likely effect of the disciplinary proceedings on CPL Turner's mental health and done more to monitor and support him.

Submissions of Mr and Mrs Turner

916. Mr and Mrs Turner take no issue with the proposition that it not the role of this Court to review the disciplinary proceedings. Rather, the issue is the "importance of the offer of an amnesty and its subsequently withdrawal which significantly impacted [CPL Turner's] mental health".[1314] They submit that the ADF seems unwilling to acknowledge the full impact of the disciplinary proceedings on CPL Turner's mental health and that any suggestion that the disciplinary proceedings were "an amusing sideshow" for CPL Turner should be emphatically rejected. They also reject the assertion that the "cock-card" was pornographic in nature.[1315]

917. Mr and Mrs Turner submit that the cock-carding matter was mismanaged by the Chain of Command and that it had devastating effects on CPL Turner's mental health in that he felt betrayed and abandoned, which caused him to have an intense mistrust of his Chain of Command. They consider that CPL Turner's mental health was not taken into account in the investigation, the process of laying charges, the hearing or sentencing, the reduction in rank, or his return to Australia (when he was removed from B Company).[1316]

918. Mr and Mrs Turner refer to the ADF Policy *DIG PERS 16-24*, which states that all ADF commanders have a duty to their subordinates to protect mental health and submit that the ADF failed to discharge this responsibility to CPL Turner.[1317]

919. In terms of the punishment of the reduction of rank, CPL Turner's parents consider this was "harsh" and "unjust", particularly in circumstances where CPL Turner and others believed that an amnesty was offered.[1318]

920. Mr and Mrs Turner are also critical of the legal advice that CPL Turner received in relation to the disciplinary proceedings. They are critical of the fact that his Defending Officer had not been a Defending Officer in any previous summary proceedings; he had also participated in the cock-carding practice; he was a witness to the incident; and he was also involved in the investigation.[1319] They are also critical of the substance of the advice provided by MAJ JG about not petitioning the outcome of the disciplinary

[1314] Submissions in reply of Mr and Mrs Turner dated 22 July 2024 at [32].
[1315] Submissions in reply of Mr and Mrs Turner dated 22 July 2024 at [33].
[1316] Submissions of Mr and Mrs Turner dated 28 January 2024 at [116]-[119].
[1317] Submissions of Mr and Mrs Turner dated 28 January 2024 at [130].
[1318] Submissions of Mr and Mrs Turner dated 28 January 2024 at [116]-[119].
[1319] Submissions of Mr and Mrs Turner dated 28 January 2024 at [124].

proceedings (in particular, advice that he should "keep quiet" and "hope for luck"), as well the impropriety of MAJ JG providing such advice given she was not acting for CPL Turner in the disciplinary proceedings.[1320] As a result of receiving MAJ JG's advice, Mr and Mrs Turner believe that CPL Turner would have felt targeted by the ADF, disempowered, and that he was being used as a scape goat.

The Austin Report

921. Mr and Mrs Turner refer to the CJTF 633 Inquiry Officer Inquiry report dated 6 October 2016 (**Austin Report**),[1321] which noted that: there was a broad acceptance and tolerance within 2CDO Regt of the practice of cock-carding dating back over five years and the Company leadership team did not take appropriate action to stop the practice; MAJ AF was aware of the practice within his sub-unit and had been cock-carded himself and took no action to stop the practice; CAPT MH was aware of the practice within his platoon, had been cock-carded himself, and had participated in the cock-carding practice and had not taken action to stop the practice; the person who placed a card in passports never came forwarded. The Austin Report also recommended that no administrative action be taken against CPL Turner and that MAJ AF and CAPT MH be formally counselled for failing to act earlier to stamp out the practice within 2CDO Regt.[1322]

922. The Austin Report was only mentioned in the IGADF report into the circumstances of CPL Turner's death[1323] in a footnote. The IGADF Inquiry Report on Military Justice Issues Concerning Corporal Turner[1324] also fails to mention the Austin Report other than in footnotes. Mr and Mrs Turner submit that the IGADF reports failed to properly consider the Austin Report into the disciplinary proceedings and in the impact those proceedings had in the lead up to CPL Turner's death.[1325] They are also critical of the fact that the ADF did not produce the IGADF reports in their entirety, as the Austin Report was not provided along with the reports.[1326]

923. Further to the above, Mr and Mrs Turner are critical of the fact that the Austin Report (without annexures) was provided to the parties in the Inquest in October 2022 in response to subpoenas issued in December 2021 and March 2022. They submit that the Austin Report did not fall within the ambit of the documents mistakenly excluded

[1320] Submissions of Mr and Mrs Turner dated 28 January 2024 at [125]-[127].
[1321] Exhibit 31, Tranche 11, 47-82.
[1322] Submissions in reply of Mr and Mrs Turner dated 22 July 2024 at [36].
[1323] Tab 13 (IGADF Report).
[1324] Tab 125 (IGADF Inquiry Report on Military Justice Issues).
[1325] Submissions in reply of Mr and Mrs Turner dated 22 July 2024 at [38]
[1326] Submissions in reply of Mr and Mrs Turner dated 22 July 2024 [40].

from production in relation to the 2019 subpoena (see above at [128]-[133]) and ought to have been produced in its entirety given it was a "highly relevant" report regarding the common practice of "cock-carding" within the 2CDO Regt and the significant implications regarding CPL Turner's representation at the disciplinary proceedings.[1327]

Submissions of CAPT MH

924. CAPT MH submits[1328] that in all the circumstances it was not unreasonable that CPL Turner's mental health issues were not raised during the disciplinary proceedings. He notes that: participation in the summary disciplinary system differs from other proceedings where mitigating factors are taken into account; CPL TJ gave evidence that CAPT MH was "the only person that really went in to protect"[1329] CPL Turner in relation to the cock-carding incident; CAPT MH had no legal training, qualifications, or experience as a Defending Officer in summary proceedings; CAPT MH was a witness to the incident, involved in the investigation of the offence, and raised concerns about being CPL Turner's Defending Officer but was told to "crack on"; CPL Turner, CAPT MH, and CSM worked together to prepare the plea in mitigation and supporting materials; the plea in mitigation template document had no heading entitled "mental health"; CAPT MH sent the draft plea in mitigation to a former Army lawyer who thought it was good; and CAPT MH was not instructed by CPL Turner to raise his mental health issues during the plea in mitigation.

Submissions of CPL TJ

925. CPL TJ submits that the "cock-carding" series of events represented "one", if not "the", genesis for much of the deterioration in CPL Turner's health. She contends that the handling of the affair by the Chain of Command in offering and then failing to follow through with the "amnesty" was "impressively unjust" and left CPL Turner feeling "deeply aggrieved, isolated and untrusting of his superiors". CPL TJ submits that findings ought to be made that:

    i. CPL Turner's pre-existing mental health condition was seriously adversely impacted by his demotion to CPL and the disciplinary process;

    ii. the very public impact of his demotion, while he was still on operations and in theatre, was a disproportionately severe outcome which left CPL Turner with a "justifiably cynical view of the Army and…his chain of command"; and

[1327] Submissions in reply of Mr and Mrs Turner dated 22 July 2024 at [37]-[44].
[1328] Submissions of CAPT MH dated 7 June 2024 at [13]-[22].
[1329] T937.2-3.

iii. to CPL Turner's mind, the outcome of the proceedings was the catalyst for the Chain of Command in taking the step of removing CPL Turner from B Company (which represented a further form of punishment) and transferring him to C Company.[1330]

Submissions of the Commonwealth

MAJ JG

926. The Commonwealth submits that it would be a breach of procedural fairness to make the adverse finding against MAJ JG proffered by Mr and Mrs Turner.[1331] Counsel Assisting accepts that submission.[1332]

The disciplinary proceedings

927. The Commonwealth submits that, in addition to the matters raised by Counsel Assisting, the following four matters[1333] are relevant to the question of why CPL Turner's health was not raised during the disciplinary proceedings.

928. *Firstly*, there is a gap in the evidence given CAPT MH, WO2, and CAPT Lippis did not provide evidence on this point.

929. *Second*, Counsel Assisting's explanations for CPL Turner not raising his mental health issues (either because he was concerned about the effect of doing so on his career or because he did not expect the outcome of the hearing to be as severe as it was) are speculative and are not supported by the evidence (i.e., the possibility of a demotion was canvassed prior to the disciplinary hearing).[1334]

930. *Third*, CAPT MH's claims of not having known about CPL Turner's mental health issues during the disciplinary hearings, provided in Exhibits 13 and 66, are undermined by the documentary records,[1335] CAPT MH's IGADF interview,[1336] the text messages,[1337] and his acknowledgement that his recollection of events was affected by the passage of time.[1338]

931. *Fourth*, both CAPT MH and CPL Turner were aware that the "personal background" and "health" were matters that could be put to the summary authority. The

[1330] Submissions of CPL TJ dated 7 June 2024 at [12]-[19].
[1331] Submission of the Commonwealth dated 7 June 2024 at [406].
[1332] Submissions in reply of Counsel Assisting dated 22 August 2024 at [83].
[1333] Submissions of the Commonwealth dated 7 June 2024 at [397]-[406].
[1334] Tab 24 (ROI of WO2 DP) at 24.
[1335] Exhibit 31 at 3.
[1336] Tab 18 (ROI of CAPT MH) at 14, 23-26.
[1337] Exhibit 57 at 209-451, 990.
[1338] Exhibit 66 at [iii].

Commonwealth submits that no finding should be made to the effect that CPL Turner was improperly or inadequately advised by CAPT MH, WO2 DP, or CAPT Lippis or that he received "questionable legal representation at the disciplinary proceedings".[1339]

Impact of the disciplinary proceedings

932. The ADF accepts "that the evidence in this Inquest established that the disciplinary proceedings had a negative impact on CPL Turner's mental health".[1340] However, it is submitted that there is not an evidentiary basis for a finding that the disciplinary proceedings "severely compromised" CPL Turner's mental health and "caused a relapse of his PTSD or otherwise triggered symptoms of PTSD".[1341] In support of this position, the Commonwealth refers to:[1342] (i) other events that took place between the conclusion of the disciplinary proceedings and the end of the Iraq deployment which make it difficult, if not impossible, to separate the mental health impact of one event from that of another (a point echoed by the experts);[1343] (ii) CAPT MH's and CPL TJ's evidence concerning the impact of the disciplinary proceedings are "consistent with CPL Turner having experienced an understandable emotional reaction to a stressful event rather than with him having experienced 'severe compromise' to his mental health"; and (iii) there is little evidence of CPL Turner mentioning the disciplinary proceedings.

Submissions in reply of Counsel Assisting

The Austin Report

933. In relation to Mr and Mrs Turner's criticism that the IGADF and/or AAR processes did not contain references to the Austin Report or "background knowledge regarding suicide and risk associated with multiple deployments".[1344] Counsel Assisting does not consider it a necessary part of my role to assess the substance and content of these processes or comment on how those bodies performed as against their mandates.[1345]

934. Insofar as Mr and Mrs Turner submit that the ADF "must be held accountable" for failing to produce both IGADF reports in their entirety, Counsel Assisting notes that they have not articulated what prejudice the delay in the production caused, nor did they raise

[1339] Submissions of the Commonwealth dated 7 June 2024 at [406].
[1340] Submissions of the Commonwealth dated 7 June 2024 at [419].
[1341] Submissions of the Commonwealth dated 7 June 2024 at [419].
[1342] Submissions of the Commonwealth dated 7 June 2024 at [420]-[425].
[1343] Tab 109 (Report of Dr Matthew Large) at 49; Tab 108 (Report of Dr Olav Nielssen) at 11; Tab 110 (Report of Dr Malcolm Hopwood) at 9.
[1344] Submissions in reply of Mr and Mrs Turner dated 24 July 2024 at [36]-[47].
[1345] Submissions in reply of Counsel Assisting dated 22 August 2024 at [102.1].

this matter at an earlier stage to afford the Commonwealth an opportunity to respond.[1346]

935. Counsel Assisting considers that the proposed findings submitted by CPL TJ above at [925] are appropriate and consistent with Counsel Assisting's submissions save for (ii), in relation to which Counsel Assisting notes that "it is not the role of the Coroner to review the disciplinary proceedings themselves or the punishment which was imposed".[1347]

The disciplinary proceedings

936. Counsel Assisting points out that the Commonwealth's submissions on this point seek a conclusion about CPL Turner's state of mind, which is unknowable absent a contemporaneous record. On that basis, Counsel Assisting concludes (as per [912] above) that any exact reasons the information was withheld is "unclear" and, accordingly, no particular positive finding in that respect is sought.[1348]

937. Counsel Assisting considers that the matters raised by the Commonwealth as to CAPT MH not knowing about CPL Turner's mental health condition do not provide a compelling basis to reject what are clear and unequivocal statements by CAPT MH to the Court that he was unaware of the mental health issues at the time of the summary proceedings. Further, the reliance on statements made by CAPT MH after CPL Turner's death to the effect that he was aware that CPL Turner's mental health issues pre-dated the 2016 deployment do nothing to establish that CAPT MH was aware of this *at the time* of the summary proceedings.[1349]

938. Finally, Counsel Assisting opines that it is not clear why, if CAPT MH knew about the mental health condition during both the summary and NTSC processes (as the Commonwealth suggests), CAPT MH would raise it only in the latter context. (It is also not apparent on what basis the Commonwealth submits that the two processes "overlapped"[1350] in circumstances where the disciplinary decision was delivered on 16 August 2016 but the NTSC response was sent on 19 August 2016). Counsel Assisting contends that the obvious explanation is that he received those instructions after the disciplinary decision was delivered.[1351]

[1346] Submissions in reply of Counsel Assisting dated 22 August 2024 at [102.2].
[1347] Submissions in reply of Counsel Assisting dated 22 August 2024 at [147].
[1348] Submissions in reply of Counsel Assisting dated 22 August 2024 at [232].
[1349] Submissions in reply of Counsel Assisting dated 22 August 2024 at [233]-[234].
[1350] Submissions of the Commonwealth dated 7 June 2024 at [403(d)].
[1351] Submissions in reply of Counsel Assisting dated 22 August 2024 at [235].

Impact of the disciplinary proceedings

939. Counsel Assisting does not identify the disciplinary proceedings as a *singular causative factor* of CPL Turner's PTSD symptoms in this period nor does Counsel Assisting identify this matter as causing a "relapse" given that it is apparent CPL Turner was suffering from symptoms of PTSD prior to the proceedings when they deteriorated further after those proceedings.[1352] For the reasons outlined above at [198]-[235], Counsel Assisting submits that CPL Turner's mental health was "severely compromised" by the proceedings in the sense of expediting the deterioration.[1353]

Consideration

940. Having carefully considered all the submissions on the impact of the investigation and laying of charges over the "cock card" incident, I have no trouble in finding that it severely compromised CPL Turner's mental health. I accept that there were a number of factors involved. The offer of some kind of amnesty, which was later withdrawn, left him feeling understandably angry and betrayed. The public impact of his demotion while still on operations and his later transfer to C Company affected him greatly. All this occurred without, it seems, sufficient thought being given by the Chain of Command to the likely effect this would have on CPL Turner's pre-existing condition. MAJ AF's evidence makes it abundantly clear that he was not tracking CPL Turner's mental health during this period. In my view, it should have been obvious that mental health assessment and perhaps ongoing mental health support was required.

941. I accept Mr and Mrs Turner's submission that the events surrounding the cock-carding incident were mismanaged by the Chain of Command and that this had a devastating impact on CPL Turner. In saying that, I am sympathetic to CAPT MH who was, in my view, placed in an invidious position. He had no legal training, qualifications, or experience as a defending officer in summary proceedings. He was a witness to what had occurred, involved in the investigation and yet when he raised concerns about being the defending officer he was told to "crack on". Given that he was not instructed to raise mental health issues by CPL Turner, I understand why he did not. I accept that CAPT MH was a friend to CPL Turner and he did what he could in difficult circumstances.

[1352] Submissions of Counsel Assisting dated 2 November 2023 at [90]-[98].
[1353] Submissions in reply of Counsel Assisting dated 22 August 2024 at [236].

Issue 6 – The move from B Company to C Company

Evidence

942. The evidence relevant to this issue is set out in the chronology above at [276]-[288].

Submissions

Submissions of Counsel Assisting

943. Counsel Assisting's submissions on this Issue are generally dealt with in the submissions as summarised above at [769]. Counsel Assisting notes that it is apparent that the move from B Company to C Company had a significant negative impact on CPL Turner and that little or no support was put in place for him in circumstances where the negative effect on his mental health was entirely foreseeable.[1354]

Submissions of the Commonwealth

944. The Commonwealth contends that Counsel Assisting's submissions that (i) the transfer decision was based "solely" on the effective delivery of "capability" (i.e., solely on military/operational considerations), (ii) the transfer decision was made without regard to CPL Turner's interests or individual needs and no mental health support was put in place at the time the decision was made or implemented, and (iii) the transfer decision had a "significant negative" impact on CPL Turner, should not be accepted, at least without significant qualifications.[1355]

945. In support of this position, the Commonwealth makes a number of submissions.[1356] *Firstly*, the Commonwealth posits that the evidence indicates that the transfer decision was well considered and was readily defensible from a military and organisational/administrative perspective, noting that BRIG MF explained[1357] that the reasons for the transfer included operational requirements/role that B Company was scheduled to perform in 2017 (namely, complex and dangerous training), CPL Turner's personal situation/role that C Company was scheduled to perform in 2017 (namely, supporting educational courses), the management of CPL Turner's "influence" following from his demotion (which was consistent with MAJ AF's[1358] and SGT NA's[1359]

[1354] Submissions of Counsel Assisting dated 2 November 2023 at [520].
[1355] Submissions of the Commonwealth dated 7 June 2024 at [672].
[1356] Submissions of the Commonwealth dated 7 June 2024 at [673]-[733].
[1357] 21/10/2020 T240 to T244; 22/10/2020 T252; Tab 17 (ROI of COL MF) at 14-18.
[1358] Tab 16 (ROI of MAJ AF) at 28; 04/08/2021 T55.15-49.
[1359] Tab 14 (ROI of SGT NA) at 14.

evidence), and "other movements/transfers" within the regiment (which was supported by evidence from others such as MAJ AF and BRIG Langford).[1360]

946. *Second*, the Commonwealth points out that no evidence was provided by WO1 EL (who had input into the decision-making process and the most senior non-commissioned officer in the regiment) on the transfer decision, noting that his answers to the questions in the interview with the IGADF were generally consistent with BRIG MF's evidence.[1361]

947. *Third*, the Commonwealth highlights that CPL Turner's "interests" and "individual needs" were among a number of considerations that needed to be taken into account, with others including military/operational matters and the interests and individual needs of other members of 2CDO and, accordingly, there was nothing illogical, inappropriate, or unreasonable about BRIG MF placing emphasis on the safety of other members of B Company in the context of the dangerous training scheduled for 2017 as a primary consideration.[1362]

948. *Fourth*, the Commonwealth indicates that at the time of the decision, BRIG MF and MAJ AF did not know all of the information that we know now about CPL Turner's mental state in October 2016 (although BRIG MF was aware of the potential for the transfer to be perceived by CPL Transfer as a further punishment for his disciplinary offence[1363] and MAJ AF agreed that CPL Turner was "angry and annoyed" at the time of the decision).[1364]

949. *Fifth*, the Commonwealth notes that BRIG MF disagreed with Counsel Assisting's suggestions that the move to C Company would be "highly traumatic" for CPL Turner (although he acknowledged it was "likely to have some form of embarrassment") and that moving CPL Turner would remove him from his social supports.[1365] MAJ AF also considered that the move would not have "dislocate[d] him from his support network".[1366]

950. *Sixth*, the Commonwealth considers that the evidence indicates that the Chain of Command within B Company gave careful consideration to the question of who would

[1360] 21/10/2020 T240 to T244; 22/10/2020 T252; Tab 17 (ROI of COL MF) at 14-18.
[1361] Tab 23 (ROI of WO1 EL).
[1362] Submissions of the Commonwealth dated 7 June 2024 at [697].
[1363] 22/10/2020 T257.49-258.9.
[1364] 4/8/2021 T56.45-57.5.
[1365] 21/10/2020 T240.6-19, T240.35-41.
[1366] 4/8/2021 T55.15-49.

tell CPL Turner about the transfer decision and who would be present at TQ to support him at the time he was told.[1367]

951. *Seventh*, the Commonwealth submits that the text messages from CPL Turner indicate he was aware that the Chain of Command considered the transfer to C Company would offer him "a break" because of its work schedule for 2017 and his transfer was one of a number of transfers occurring across the regime in 2017.[1368]

952. *Eighth*, the Commonwealth posits that most of CPL TJ's evidence summarised above at [288]-[293] was wrong, noting that it is clear from the text messages and emails that CPL Turner knew of the transfer on 9 October 2016 and there were conversations between CPL Turner, MAJ AF, WO2 DP, and MAJ BJ about the transfer.

953. *Ninth*, the Commonwealth notes that there is a "real question whether CPL Turner was deeply affected by the transfer decision at the time that it was made…or whether it subsequently took on more significance as 2017 progressed." The Commonwealth notes that the text messages and the discharge email demonstrate that after being told about his transfer, CPL Turner was upset and angry; however, the text messages also demonstrate that CPL Turner then calmed down and came to accept the transfer decision, even if he was still not happy about it. Being angry and resentful about the decision is, in the Commonwealth's view, not clear evidence that the decision, as a standalone event, had an impact on CPL Turner's mental health.[1369]

954. Lastly, the ADF accepts that the evidence indicates that once CPL Turner's mental health deteriorated as a result of other matters, his perception of the transfer decision became one of the factors which contributed to the decline in his mental health.[1370]

Submissions of Mr and Mrs Turner

955. Mr and Mrs Turner contend that the Chain of Command should have had a reasonable understanding of what might happen from a mental health perspective if CPL Turner was moved from B Company, particularly in light of the length of time he had spent in B Company and the comments CPL Turner made in his response to the NTSC.[1371] They are of the view that COL MF gave little, if any, consideration to the impact of

[1367] Submissions of the Commonwealth dated 7 June 2024 at [710].
[1368] Submissions of the Commonwealth dated 7 June 2024 at [721].
[1369] Submissions of the Commonwealth dated 7 June 2024 at [729].
[1370] Submissions of the Commonwealth dated 7 June 2024 at [730].
[1371] Submissions of Mr and Mrs Turner dated 28 January 2024 at [133]-[134].

removal from B Company on CPL Turner's mental health despite being aware that this would have had a detrimental impact on his mental health.[1372]

956. Mr and Mrs Turner are of the view that the impact of CPL Turner's removal from B Company was "unsurprisingly significant" in that he felt betrayed, isolated, embarrassed, angry, and it affected his sense of self-worth and identity.[1373]

957. In response to the Commonwealth's submission that there is no evidence that the transfer decision was made to punish CPL Turner (see above at [945]), Mr and Mrs Turner refer[1374] to: MAJ AF's email stating "I will protect and support this Coy with everything I have mate, and this Coy's valuable resource is its people…Any forthright member of this Coy will have my support at all times, unless…you betray the Coy or Rgt"[1375] (which they submit highlight that the Company comes first and people second); RSM WO1 EL, who was involved in the transfer decision, said "COL MF was obviously very distressed about the reputational damage that had been caused not only to B company but 2 Commando Regiment, Special Operations Command and the whole of Army";[1376] and MAJ AF's opinion on the transfer decision was that "going to C was also the RSM's way of saying 'grow up. Grow a regimental experience'".[1377]

958. Mr and Mrs Turner disagree with the Commonwealth's submission that there is "evidence establishing that one of the reasons for the transfer was to give CPL Turner more time and space to focus on his personal life/personal stressors. Further, to the extent that mental health was not taken into account, this really reflects the state of knowledge that the relevant decision-makers had at the time they made the decision".[1378] Rather, they submit[1379] that the claim that the Chain of Command did know of CPL Turner's mental health challenges are undermined by MAJ AF's evidence[1380] and that if CPL Turner's mental health was truly given serious consideration, a position in a non-combat role would have been considered (there is no evidence to suggest that any other option was considered other than the one that BRIG MF knew or should have known[1381] would embarrass CPL Turner). They also consider that the Commonwealth's submission on this point is contradicted by the

[1372] Submissions of Mr and Mrs Turner dated 28 January 2024 at [136].
[1373] Submissions of Mr and Mrs Turner dated 28 January 2024 at [138].
[1374] Submissions in reply of Mr and Mrs Turner dated 22 July 2024 at [55].
[1375] Submissions of the Commonwealth dated 7 June 2024 at [413(d)].
[1376] Tab 23 (ROI of WO1 EL) at 16.
[1377] Tab 16 (ROI of MAJ AF) at 30.
[1378] Submissions of the Commonwealth dated 7 June 2024 at [673(b)].
[1379] Submissions in reply of Mr and Mrs Turner dated 22 July 2024 at [55(d)].
[1380] Tab 16 (ROI of MAJ AF) at 30.
[1381] 21/10/2020 T240.10-20.

further submission that "ADF agrees…CPL Turner viewed the transfer as a form of further punishment for the card incident".[1382]

Submissions of CPL TJ

959. CPL TJ does not accept BRIG Langford's evidence that the move from B Company to C Company was something that "occurred routinely" or was "common practice".

960. CPL TJ posits that having regard to CPL Turner's strong connection and commitment to B Company, CPL Turner was left feeling "humiliated" after his move to C Company and this should have been perfectly obvious to the Chain of Command. CPL TJ considers that the Chain of Command either were so uncaring as to CPL Turner's welfare that they did not turn their minds to how CPL Turner might react to the move to C Company or did turn their mind to his reaction and accepted that notwithstanding that the move would more than likely have had a profoundly negative impact on CPL Turner, they chose to accept that risk and proceed anyway.[1383]

961. CPL TJ agrees with Counsel Assisting in that the decision to move CPL Turner to C Company was, at least in CPL Turner's mind, "just a continuation of the punishments flowing from the 'cock-carding incident'".[1384]

962. CPL TJ submits that it was reasonable for CPL Turner to view the transfer as being directly connected to the outcome of the disciplinary proceedings, that the transfer to C Company was at the very least "imprudent" where there was a lack of any prior consultation about the decision and the decision to move him was made while he was on deployment, and that it was "manifestly careless" for the Chain of Command to make the decision to move him to C Company knowing the importance of B Company to CPL Turner[1385] and the foreseeability of the risk to his mental health presented by such a move.

Submissions in reply of Counsel Assisting

963. Counsel Assisting does not consider that the evidence supports a finding that the move between companies was *intended* to be punishment on CPL Turner (as opposed to it being *perceived* as such by CPL Turner).[1386] The evidence summarised above at [275]-[288] supports this position.

[1382] Submissions of the Commonwealth dated 7 June 2024 at [727].
[1383] Submissions of CPL TJ dated 7 June 2024 at [20]-[28].
[1384] Submissions of CPL TJ dated 7 June 2024 at [29].
[1385] Submissions of CPL TJ dated 7 June 2024 at [30].
[1386] Submissions in reply of Counsel Assisting dated 22 August 2024 at [106].

964. Counsel Assisting emphasises that it was CPL Turner's *mental health* that was outweighed by operational considerations (as noted above at [280] and [769]). The high point of the evidence that CPL Turner's mental health played any material role in the decision would seem to be a statement by COL MF that he considered the move would provide CPL Turner with "a bit more time to focus on his issues, including his medical issues".[1387] When this is considered against his explicit acceptance that he did not turn his mind to the potential adverse impacts of the transfer on CPL Turner's mental health (in CPL Turner's potential perception of it being further punishment)[1388] and against the balance of the evidence summarised on this topic above, Counsel Assisting considers that the conclusion that "[a]t base, the decision was made with "capability" at the front of mind, not the interests of CPL Turner" is plainly open.[1389]

Consideration

965. In my view, it is beyond question that the move from B Company to C Company had a significant negative impact on CPL Turner. He experienced it as humiliating and as a punishment. I accept that it was a decision made primarily on the basis of the effective delivery of "capability". In my view, the evidence establishes that the Chain of Command was primarily concerned about the potential of CPL Turner's "influence" following his demotion.

966. I accept that there are also indications that the decision was made without regard for CPL Turner's mental health. MAJ AF, for example, spoke of supporting company members unless they "betray the company." He appeared angry at the reputational damage CPL Turner had brought to the company. He spoke of the transfer decision as the RSM's way of saying "grow up. Grow a regimental experience." I am unable to find that teaching CPL Turner a lesson did not influence his thinking.

Issue 7 – Lack of communication and/or cooperation between prescribing doctors

Submissions

Submissions of Counsel Assisting

967. Counsel Assisting[1390] submits that the evidence suggested there was a great deal of fragmentation in the care which CPL Turner received during 2017. There was a disjunct between ADF medical practitioners and external providers. This appeared to

[1387] Tab 17 (Col MF – Record of interview) at 17.
[1388] 22/10/2020 T258.7-9.
[1389] Submissions in reply of Counsel Assisting dated 22 August 2024 at [238].
[1390] Submissions of Counsel Assisting dated 2 November 2023 at [521]-[524].

be most significant in relation to psychiatrists. For example, Dr Sringeri gave evidence that he did not receive clinical information from Holsworthy Health Centre or from the ADF in relation to CPL Turner, and that his identification of CPL Turner's clinical presentation was based on his own clinical assessment.[1391] He accepted that it would have assisted him in getting an accurate picture of CPL Turner's presentation and history if he had been provided information by Holsworthy Health Centre or the ADF.[1392]

968. Dr Hale's evidence was that the only direct contact he had with Dr Malik was while CPL Turner was an inpatient, and he did not recall discussing CPL Turner's care with any external psychiatrist after he was discharged on 25 May 2017. Similarly, Dr Hale gave evidence that, with the benefit of hindsight, there would have been benefit in providing Dr Malik with information about CPL Turner's presentation and symptoms to ensure that he had the fullest possible picture of CPL Turner in the period after 25 May 2017.[1393]

969. Dr Hale also gave evidence that it was not standard practice to have external specialists present (or ring in) at welfare boards, and that he did not think he had ever been to a welfare board where that had happened.[1394]

970. Counsel Assisting submits that I would comfortably find that difficulties arose in the treatment of CPL Turner's mental health by reason of a lack of coordination between his various prescribing doctors.

Submissions of Dr Hale

971. Dr Hale submits that his level of care for CPL Turner is not only demonstrated by the contents of his thorough medical records, but also the "extensive and fulsome communication" by Dr Hale to others in 2CDO and to outside care providers.[1395]

972. Dr Hale submits that "there is no evidence of any lack of cooperation between the prescribing doctors" and/or that difficulties did not arise in the treatment of CPL Turner's mental health "by reason of a lack of 'coordination' between the prescribing doctors."[1396] In support of this, Dr Hale refers to the evidence of Dr Nielssen that the absence of PBS records suggested that the medications were dispensed by ADF suppliers; all the prescriptions should have been visible to the ADF prescribing doctors;

[1391] 22/10/20 T317.44-48.
[1392] 22/10/20 T318.1-3.
[1393] 23/10/20 T355.34-36.
[1394] 23/10/20 T406-407.
[1395] Submissions of Dr Hale dated 31 May 2024 at [7]-[8].
[1396] Submissions of Dr Hale dated 31 May 2024 at [30]-[31], referring to Exhibit 4.

and while there was a risk of stockpiling his medication, Dr Nielssen did not consider there to be a lack of communication, cooperation, or coordination between prescribing doctors.[1397]

Submissions in reply

973. Counsel Assisting considers that to the extent there is a conceptual difference between *cooperation* and *coordination*, the latter is to be understood as an aspect of the former and, thus, the prescribing doctors could not have been cooperating if they were not coordinating.[1398]

974. To the extent that Dr Hale's reference to Dr Nielssen's evidence is used to support the presence of coordination and/or cooperation, Counsel Assisting notes that (a) this does not appear to be supported by the evidence of Dr Malik;[1399] (b) if a non-ADF practitioner prescribed medication after a referral from the ADF, this would not appear on the ADF's Defence eHealth System (**DeHS**);[1400] (c) Dr Hale did not necessarily agree that all previous prescriptions from ADF practitioners were visible on the DeHS system;[1401] and (d) Dr Malik gave evidence that he agreed it would be highly desirable for him to have had direct liaison with Dr Hale about medication.[1402]

975. In those circumstances, Counsel Assisting considers that the strength of the example used by Dr Hale to demonstrate cooperation and/or coordination is undermined.[1403]

Consideration

976. I am satisfied that the evidence reveals a lack of coordination and information exchange by doctors involved in CPL Turner's care.

Issue 8 - The circumstances by which CPL Turner came to have significant supplies of medication available to him at the time of his death.

Submissions

Submissions of Counsel Assisting

977. Counsel Assisting[1404] submits that the evidence shows that CPL Turner had large supplies of prescription medication available to him at various points during 2017. CPL

[1397] Submissions of Dr Hale dated 31 May 2024 at [32].
[1398] Submissions in reply of Counsel Assisting dated 22 August 2024 at [135].
[1399] 20/10/2020 T132.35.
[1400] Tab 117 at [6].
[1401] 23/10/2020 T373.1.
[1402] 20/10/2020 T134.24.
[1403] Submissions in reply of Counsel Assisting dated 22 August 2024 at [135].
[1404] Submissions of Counsel Assisting dated 2 November 2023 at [525]-[537].

TJ provided to the IGADF a photo she had taken of prescription medication after CPL Turner's second overdose.[1405] The police investigation of CPL Turner's apartment after his death similarly demonstrates significant quantities of prescription medication were available to him at the time of his death.[1406]

978. Hannah Steele gave evidence that she had raised a concern about the supply of medication that CPL Turner had available to him to Mr Cardinaels and Kristy Watson (who was CPL Turner's DVA advocate) but that nothing was done about it. CPL Turner was told that she had spoken to the ADF about the medication, and this "basically just crumbled his trust with me" and he was not honest about what was going on after that.[1407] Mr Cardinaels did not recall having a conversation about this to Hannah Steele, or with CPL Turner about what Hannah Steele had said.[1408]

979. There was also evidence that the availability of prescription medication to CPL Turner was an issue of concern identified by both the medical practitioners involved in his care and the Chain of Command, and that steps were taken to ameliorate the risk of him accumulating large amounts.[1409]

980. Counsel Assisting submits that the evidence in the Inquest fell in such a way that it is not necessary to delve into the detail of the supplies of medication available to CPL Turner during 2017. Although he may have had access to more medication than he actually needed, the evidence suggests that this was not a matter which contributed in any material way to CPL Turner's death. Notwithstanding the fact that CPL Turner's suicide was caused by his overdose on prescription (and other) medication, the significant supplies of medication he had available to him could have just as easily been accumulated by his failure to take his prescribed medication over time. It is submitted that the superficial attraction of linking the possible over-supply of medication as a direct cause of CPL Turner's death should be resisted.

981. Counsel Assisting considers that the evidence in the Inquest suggests that: (a) if CPL Turner did not have access to prescription medication at the time of his death, he would have easily had access to other medication by which he could suicide; (b) there would have been risks to CPL Turner's health in attempting to limit his access to prescription medication during 2017, and particularly around July 2017 in that it might have destroyed his trust in Dr Malik, caused him to disengage from treatment, or put him in

[1405] Tab 27 (IGADF ROI with CPL TJ on 14 August 2018) at 38-39.
[1406] Tab 5 (Statement of Senior Constable Tim Giblett) at 2-3.
[1407] 19/10/20 T36.29-43.
[1408] 02/08/21 T55.25-28.
[1409] See, e.g., Exhibit 4 (Email communications produced by Dr Hale) at 97.

danger of not having access to medication he needed; and (c) even if CPL Turner's access to medication had been limited in some way, he could have relatively easily stockpiled that limited supply of medication without detection, achieving the same result of ultimately having a large supply available to him. These conclusions arise predominantly from the evidence of Dr Malik.

982. Dr Malik's evidence was that he did not impose limitations on CPL Turner's access to medication around June/July 2017, because he was getting better and he "didn't have any concern". Dr Malik also noted that even if he gave CPL Turner a weekly supply, he could stockpile every week's supply. He considered this would have irritated CPL Turner and would not have "prevented anything" and he could have very easily "stockpiled daily supply, weekly supply".[1410]

983. Dr Malik gave evidence that the "commonest cause of overdose is Panadol", and if CPL Turner had wanted to, he could have got "40 tablets from Woolworths, that's enough". In his view, the more one tried to "control" CPL Turner's behaviour in relation to prescription medication, it was "not useful because there's many other ways he could have hurt himself". He explained:[1411]

> "If his plan was overdosing, he could have gone to any pharmacy and bought enough Panadol; more than 12 grams is almost fatal, less than 40 tablets. In Woolworths or Chemist Warehouse you can get 100 tablets; so you know, that's the risk, but it's not just the medication I give him; there are other means he could have done it. So the more you push on that side with him, the more you would have pushed him away. That's what my assessment was. As you can see, obviously, I did a risk assessment, and if he's denying any - there's no reason for me to mistrust him and put him on a schedule, and all of that."

984. Dr Malik was unshaken in his conviction, broadly speaking, that it was important for him to treat CPL Turner in relation to the symptoms with which he was presenting, that it was important not to undermine CPL Turner's trust in him by limiting access to medications and that, ultimately, limiting CPL Turner's access to medications would not have "worked" in the sense of preventing the risk of suicide because he could have either stockpiled daily, or weekly supplies, or he could have simply used Panadol, other chemicals or other methods to suicide.[1412]

985. Dr Malik's evidence in this regard went broadly unchallenged. Dr Nielssen's evidence was that dispensing medications daily or with a maximum of three days' supply did not guarantee that medication would be taken as prescribed, nor prevented CPL Turner

[1410] 20/10/20 T130.
[1411] 20/10/20 T133.35-44.
[1412] See generally 20/10/20 T134.

from stockpiling medication.[1413] Dr Hopwood's evidence was to the effect that it was clear that all prescribers were acting in a reasonable fashion to assist CPL Turner and that the risk of stockpiling was difficult to avoid.[1414] Dr Dinnen's evidence was that "not to prescribe medication" would have been "more negligent" and that if a person is determined to suicide, they will "find the means one way or another".[1415]

986. In those circumstances, it is submitted that I would not make any findings as to the impact on the manner and cause of CPL Turner's death of the supplies of prescription medication available to CPL Turner around the time of his death. Counsel Assisting states that the evidence does not suggest that the supplies of medication available to CPL Turner were a factor which contributed to the cause of his death, save for the obvious point that this was the method he ultimately chose to take his life.

Submissions of the Commonwealth

987. The Commonwealth submits that there was a significant question as to how CPL Turner came to have significant supplies of medication available to him at the time of his death. However, it is submitted that the ADF made extensive efforts to ensure only small amounts were dispensed to CPL Turner (accepting it could not control dispensers outside its own medical system). The Commonwealth agrees with Counsel Assisting's submissions that I would not be in a position to make any findings about this topic.[1416]

Submissions of Mr and Mrs Turner

988. Mr and Mrs Turner submit that the evidence shows that CPL Turner used prescription medication to overdose and did not doctor shop.[1417] Their view is that despite Dr Hale's assessment that only 20% of the medication CPL Turner used to overdose was from legitimate sources and the rest was sourced via other means, all the medication used to overdose was medication prescribed by Dr Hale and Dr Sringeri.[1418]

989. Mr and Mrs Turner support the recommendation in the ADF After-Action Report to "amend defence policy to ensure that ADF members being managed with restricted access to prescription medication" and to "have this clearly articulated to all health

[1413] Report of Dr Nielssen dated 12 August 2020 (Tab 108) at 12-13.
[1414] Report of Dr Hopwood dated 12 October 2020 (Tab 110) at 9.
[1415] Report of Dr Dinnen dated 17 September 2020 (Tab 110A) at 10.
[1416] Submissions of the Commonwealth dated 7 June 2024 at [669]-[670].
[1417] Submissions of Mr and Mrs Turner dated 28 January 2024 at [142], [146]; Submissions in reply of Mr and Mrs Turner dated 22 July 2024 at [52(a)-(b)].
[1418] Submissions of Mr and Mrs Turner dated 28 January 2024 at [147].

providers including the requirement that no external prescriptions are to be provided to the member".[1419]

Submissions of Dr Hale

990. Dr Hale submits that he was at pains to strike a balance between limiting CPL Turner's opportunity to hoard medication and ensuring that he had sufficient medication to alleviate his physical and mental suffering.[1420] He notes that the risk assessment regarding CPL Turner's medication is best exemplified in his decision to limit the medication CPL Turner could access, namely a three day supply and a four day supply per week.[1421]

991. Dr Hale objects to any suggestion that he was dispensing too much medication, noting the referrals to CPL Turner's psychologist and psychiatrist and that he was not questioned about whether he was dispensing too much medication and/or ought to have referred CPL Turner to Dr Wallace sooner.[1422]

Submissions in reply

992. Counsel Assisting considers that there would be insufficient evidence to make a finding that CPL Turner "doctor shopped" in order to stockpile medication[1423] and that findings ought not be made in relation to the impact of supplies of prescription medication available to CPL Turner at the time of his death.[1424]

Consideration

993. There is no evidence of "doctor shopping" or that any doctor involved in CPL Turner's care prescribed recklessly. I accept the submission that CPL Turner could at any time have obtained over the counter medication which he could have used to kill himself. Indeed, he could have got a private prescription from a local doctor which would not have been visible on PBS records or known to his treating doctors.

994. Having considered all the evidence, I accept Counsel Assisting's submission that while there is a superficial attraction to link the possibility of over-supply of medication as a cause of CPL Turner's death, it should be resisted as it has little explanatory power.

[1419] Submissions of Mr and Mrs Turner dated 28 January 2024 at [140].
[1420] Submissions of Dr Hale dated 31 May 2024 at [34]-[36].
[1421] Submissions of Dr Hale dated 31 May 2024 at [35].
[1422] Submissions of Dr Hale dated 31 May 2024 at [40].
[1423] Submissions in reply of Counsel Assisting dated 22 August 2024 at [86].
[1424] Submissions in reply of Counsel Assisting dated 22 August 2024 at [136].

Issue 9 – The removal of items from CPL Turner's premises after his death (sanitisation)

Evidence

995. The issue of "sanitisation" originally arose by reason of a concern on the part of CPL Turner's family that either a USB or a laptop, or both, were removed from CPL Turner's apartment after his death. CPL TJ's evidence was that he did have a laptop and hard drive at home.[1425] Steven Turner gave a statement in which he stated that CPL Turner had a laptop which had videos, including video of footage taken from a helmet camera.[1426] CPL Turner also sent text messages demonstrating he had a computer as late as 7 June 2017.[1427] The whereabouts of his laptop and any hard drive/thumb drive are presently unknown.

996. A PowerPoint which it appears was presented at the AAR conducted on 21 August 2017 was in evidence in the Inquest and contained the following statement:[1428]

> "Sanitisation of the site will be required post CIVPOL investigation requirements before family enter the scene
> - Are we traumatising our people?
> - Should we establish a national protocol with Police?"

997. The evidence in the Inquest suggested that the term "sanitisation" had a number of different meanings in usage in the ADF. It could mean, in operational circumstances, the cleaning of an area to ensure intelligence is not left behind, and it could also mean in the context of a suicide, the removal of "suicide paraphernalia" so as to minimise harm that a family might experience on returning to the scene of the member's suicide.[1429] BRIG MF's evidence was that the use of "sanitisation" in the PowerPoint had the meaning of tidying/cleaning of a scene of a suicide of an ADF member by the ADF after police had released the scene.[1430]

998. Evidence was given from Person 1 in relation to this matter. His evidence was ultimately that he had a recollection of "sanitisation" being mentioned on one occasion in a meeting at 3:30pm on the day of CPL Turner's death, that he recalled someone talking about "operational security" and a "thumb drive",[1431] but that he had no recollection of anything that suggested there had been sanitisation of CPL Turner's

[1425] 12/08/21 T75.21-33.
[1426] Exhibit 49 (Statement of Steven Turner dated 11 August 2022) at [20].
[1427] Exhibit 57 (WhatsApp and SMS Messages) at 3095.
[1428] Exhibit 31 (Tranche 1) at 172. See also Exhibit 65 (Supplementary Statement of BRIG MF dated 22 December 2022) at [25].
[1429] Exhibit 65 (Supplementary Statement of BRIG MF dated 22 December 2022) at [12]. See also 09/09/22 T50.47-50 (Cardinaels).
[1430] Exhibit 65 (Supplementary Statement of BRIG MF dated 22 December 2022) at [26].
[1431] 06/09/22 T27.17-24.

apartment.[1432] His evidence in relation to the use of the term "sanitisation" in the AAR PowerPoint was that he was using the term "sanitisation" in a broader sense – to remove potentially sensitive items from a location.[1433]

999. Person 1 recalled that he had sent an email to BRIG GD raising his concerns about "sanitisation". The email which was ultimately produced by the ADF did not refer to sanitisation.[1434] It referred, rather, to a "series of issues and incidents since arrival at 2 Cdo Regt" and described the "basic issue is what I perceive to be ongoing and sustained marginalisation, unacceptable behaviour, harassment, bullying and intimidation".[1435]

1000. Person 1 also gave evidence he had raised concerns about sanitisation with LTCOL EB.[1436] LTCOL EB's evidence was that she had not had a conversation to that effect with Person 1.[1437]

1001. BRIG GD gave oral evidence in the Inquest. BRIG GD was the Commander of SOCMD as at April 2018. He referred to an email which he sent to Person 1 following a meeting in person at Holsworthy in which he described the issues discussed at that meeting. His oral evidence was that he was confident the email described the "crux of the conversation" although it was ultimately unclear from his oral evidence whether he had an independent recollection of the meeting or not.[1438] The email which was sent referred to "some issues in relation to the cultural [sic] of 2 CDO, particularly regarding the treatment of support staff compared to CDO qualified folk, and that the HPW, and SGT Cardinaels in particular, has been one of the main areas of concern that has led you to feel like you and other staff filling supporting roles are being isolated from the unit". It recorded that Person 1 did not want any specific instances of unacceptable behaviour investigated further. It also recorded that "considerable work" had been done on the issue about "HPW being an entity unto itself" and that LTCOL NB had invested "quite a lot of time in addressing how that entity is managed across the Command".[1439]

1002. BRIG GD's oral evidence was to the effect that Person 1 did not suggest to him that CPL Turner's possessions were removed from his apartment by the ADF following his death, and he stated he had not heard the word "sanitisation" used in the context of

[1432] 06/09/22 T2530-38.
[1433] 06/09/22 T29.40.
[1434] Exhibit 61 (Documents produced by ADF on 3 November 2022).
[1435] Exhibit 61 (Documents produced by the ADF on 3 November 2022) at 33.
[1436] 01/09/22 T39-40.
[1437] 09/09/22 T14-15.
[1438] 01/02/23 T23.40-T24.6.
[1439] Exhibit 61 (Documents produced by the ADF on 3 November 2022) at 32.

the ADF seeking to ensure that security classified items were properly dealt with in the aftermath of the death of a special forces member.[1440]

1003. Mr Cardinaels' evidence was that he did not see a laptop or USB stick at CPL Turner's apartment after his death. Mr Cardinaels rejected the proposition that he took steps to sanitise CPL Turner's apartment in the sense of seeking to find and remove anything that he saw that might contain confidential or security-classified information.[1441]

1004. COL MF was also asked about the issue of sanitisation. His only association with that term in the context of CPL Turner's death was in cleaning up the apartment after it was handed back by the NSW Police Force and he had never heard a suggestion that a thumb drive had been removed from CPL Turner's house.[1442]

1005. A number of members of the ADF gave evidence broadly to the effect that they would not be concerned that CPL Turner would have had security classified or sensitive information on his computer or at home, simply because members were not permitted to take classified material home. For example, COL MF's evidence was that it is not expected that members are taking classified information home, and that "one of the key things of the job is maintaining, you know, operational security".[1443] LTCOL EB was asked, for example, whether in the era of mobile phones there would be a practice to find out what sensitive information a deceased member of the ADF might have in their home.[1444] Her evidence was that "any imagery we would capture on a personal device, it requires clearance by our security officer before it can, in fact, be retained. Even if it's just a photograph".[1445]

Submissions

Submissions of Counsel Assisting

1006. Counsel Assisting submits[1446] that I would have great difficulty in accepting, uncritically, evidence that suggested there was no concern in the ADF about information a member might have in their home because members were not permitted to have security classified information at home. That evidence had a distinct air of unreality. Indeed, large portions of CPL Turner's diary, which were tendered in evidence in the Inquest, were redacted for public interest immunity. COL MF accepted

[1440] 01/02/23 T26.10-38.
[1441] 09/09/22 T65.36-43.
[1442] 06/02/23 T266-267.
[1443] 06/02/23 T266-267.
[1444] 09/09/22 T10-11.
[1445] 09/09/22 T10-11.
[1446] Submissions of Counsel Assisting dated 2 November 2023 at [549]-[551].

in his oral evidence that there were concerns around written information in CPL Turner's diary.[1447] Similarly, the Commonwealth made claims for public interest immunity over material contained in CPL Turner's personal phone, and although images in that phone were redacted, it is readily apparent from the time at which those images were taken that a number of images were taken by CPL Turner whilst he was deployed in Iraq. It is a matter of reality in this proceeding, and obvious logic, that a member of the ADF may have material in their personal possession which might contain matters which are security classified or sensitive. It is difficult to comprehend why this risk was not one which any member of the ADF was willing to accept the obvious existence of.

1007. As regards the issue of sanitisation of CPL Turner's apartment, it is submitted that there is insufficient information before the Inquest to form a positive conclusion that any member of the ADF removed CPL Turner's property from his apartment after his death. It is submitted that, in those circumstances, no finding in respect of this matter should be made.

1008. Counsel Assisting submits that, nevertheless, it is of significant concern that the Inquest has been unable to determine the present whereabouts of CPL Turner's laptop computer, in circumstances where the evidence demonstrates that he had such a device and members of the NSW Police Force and the ADF were present in his apartment after his death. It is submitted that this issue goes to the proper exercise of my function in investigating this death under the *Coroners Act*.

Submissions of Mr and Mrs Turner

1009. Mr and Mrs Turner allege that a personal computer, USB hard drive(s), thumb drives, and a black book were "removed" following CPL Turner's death.[1448] While they are sceptical about whether Defence were involved in the removal of the missing items, they accept that it is beyond the scope of this Inquest to reach any concluded view on this aspect.[1449]

1010. Mr Turner is adamant that he did not collect the black book from police and, rather, a person claiming to be him attended police to collect the book on 27 July 2017. He submits that evidence of him being in Tasmania on the date supports that conclusion.[1450]

[1447] 06/02/23 T267-268.
[1448] Submissions of Mr and Mrs Turner dated 28 January 2024 at [148].
[1449] Submissions of Mr and Mrs Turner dated 28 January 2024 at [155].
[1450] Submissions of Mr and Mrs Turner dated 28 January 2024 at [153].

Submissions of the Commonwealth

1011. The Commonwealth advances various submissions on this Issue. *First*, in relation to Counsel Assisting's submission about the purported lack of concern within the ADF that members might have classified material at home, the Commonwealth notes that diary notes are "distinctly different" to the removal of documents and electronic material and that handwritten notes are "difficult for the ADF to control" and that it "must be recalled that CPL Turner was very mentally unwell and his actions cannot be said to reflect the norm of what might be expected of a member who is acting rationally". [1451]

1012. *Second*, the Commonwealth submits that it is not possible to base any submission on risk on the redacted photos as they are not in evidence and that merely because a photo was taken in Iraq does not mean it is security classified information.[1452] Moreover, it is submitted that a concern that classified information may have been held on CPL Turner's devices would not necessarily arise as one is entitled to assume ADF members are law abiding.[1453]

1013. *Third*, it is submitted that in circumstances where there is no evidence and where the only witness who was asked about the laptop was Mr Cardinaels, it would be procedurally unfair to make a finding or comment consistent with [1008] above.[1454]

1014. *Fourth*, the Commonwealth contends that there is "no evidence" CPL Turner was still in possession of his laptop, hard drive, or a USB just prior to his death.[1455] The Commonwealth agrees with Counsel Assisting that no findings or comments should be made on this issue.[1456]

Submissions in reply of Counsel Assisting

1015. Counsel Assisting considers that Mr Turner's theory concerning the removal of the "black book" is without an evidentiary basis and ought to be disregarded.[1457]

1016. Counsel Assisting submits that there is insufficient information to make a positive conclusion that any member of the ADF removed CPL Turner's apartment after his death.[1458]

[1451] Submissions of the Commonwealth dated 7 June 2024 at [778].
[1452] Submissions of the Commonwealth dated 7 June 2024 at [779].
[1453] Submissions of the Commonwealth dated 7 June 2024 at [780]-[783].
[1454] Submissions of the Commonwealth dated 7 June 2024 [795].
[1455] Submissions of the Commonwealth dated 7 June 2024 at [786]-[794].
[1456] Submissions of the Commonwealth dated 7 June 2024 at [784].
[1457] Submissions in reply of Counsel Assisting dated 22 August 2024 at [87].
[1458] Submissions in reply of Counsel Assisting dated 22 August 2024 at [89].

1017. In response to the four matters raised by the Commonwealth above, Counsel Assisting submits that, in relation to the first point, it is not clear on what basis this addresses the risk that sensitive material might be recorded in such diaries. Indeed, if it is difficult to monitor, there is perhaps a greater risk that that particular means might be utilised. In addition, it is not apparent why the mere fact of keeping a diary is connected to his mental illness or why there might be a reduced risk that a diary would contain classified material for someone who was not mentally unwell.[1459]

1018. On the second point, Counsel Assisting notes[1460] that while certain photos in evidence were redacted, their context (that is, beyond the mere fact they were taken in Iraq) does highlight the risk emphasised above at [1006]. For example, text messages accompanying photos sent by CPL Turner to another ADF member on 10 November 2016 indicate he was identifying a particular member of the Iraqi Hostage Recovery Team that CPL Turner was training at that time.[1461] It is submitted that even if the subject matter were not sensitive, clearly the ability to take such photos underscores the risk referred to in Counsel Assisting's original submission.

1019. In relation to the third submission, Counsel Assisting considers[1462] that the objection seems to be on the basis of the use of the language "where … the evidence demonstrates that he had such a device and members of the NSW Police Force and the ADF were present in his apartment after his death". While the concern of the Commonwealth appears to be that the comment is intended to some way cast any aspersion on members of the ADF or the NSW Police Force, Counsel Assisting notes that it does not. The point of noting the circumstances is that notwithstanding that this scene of death was relatively *well* secured (as compared, for example, to inquests involving deaths where bodies are not recovered for weeks or months), some of CPL Turner's personal items have been unable to be located. That is why it is of "concern", as compared to a situation where it might be readily explicable that items would go missing with the passage of time at an unattended scene of death.

1020. As for the fourth point, Counsel Assisting contends[1463] that it is open to find, on the basis of the evidence as to CPL Turner's possession of such items (and an absence of evidence as to their disposal), that he remained in possession of them at the time of his death.

[1459] Submissions in reply of Counsel Assisting dated 22 August 2024 at [239].
[1460] Submissions in reply of Counsel Assisting dated 22 August 2024 at [240].
[1461] Exhibit 57 at 51-52.
[1462] Submissions in reply of Counsel Assisting dated 22 August 2024 at [241].
[1463] Submissions in reply of Counsel Assisting dated 22 August 2024 at [242].

Consideration

1021. I find the evidence given by ADF witnesses about the possibility that CPL Turner may have had sensitive information in his home very troubling. It did not appear to me to be altogether frank. As Counsel Assisting carefully set out, large portions of CPL Turner's diary and material (including images) on his mobile telephone were the subject of public interest immunity claims. The suggestion that there would have been no concern because members were "not allowed" to have security classified information at home is entirely implausible.

1022. CPL Turner's death occurred at a time when the existence of combat head-cam footage was already well known in the public arena. Steven Turner's statement also referred to it,[1464] as did Mr Cardinaels in his evidence.[1465] I would be surprised if CPL Turner's superiors, knowing his combat history, would not have given consideration to the possibility that CPL Turner held information or at least images which could attract a security rating. My concerns were exacerbated by the misleading way MAJ AF dealt with other issues, such as the body recovery issue, which he believed (or had been advised) should not be revealed in court.

1023. The issue of whether "sanitisation" (meaning the removal of restricted information or images) was ever discussed at a formal meeting was explored. Ultimately, while I am of the view that Person 1 was trying to honestly assist the Inquest, his recollection could not be relied upon to make firm findings on this Issue.

1024. I remained very troubled by the fact that CPL Turner's laptop could not be found. In my view, there is strong evidence that he had one at the relevant time. While I accept its apparent disappearance may go beyond the proper exercise of my coronial function, I remain disturbed by the complete lack of a plausible explanation of its whereabouts given the scene was supposedly controlled by NSW Police and then the ADF from an early time.

[1464] Exhibit 49.
[1465] 9/9/22 T52.47-T53.31; T88.39-T89.13.

Issue 10 – Allegations made in late June 2017 reported to ADF and NSWPF

Submissions

Submissions of Counsel Assisting

1025. Counsel Assisting submits[1466] that on or around 22 May 2017, an allegation was reported to the ADF that an "unknown former member" of the ADF had used his Defence issued mobile telephone to procure prohibited substances (anabolic steroids) from an interpreter, including trenbolone acetate, clenbuterol and oxandrolone.[1467] A document dated 26 May 2017 reports that the individual "most likely associated" with the handset was CPL Turner. It was noted that CPL Turner had "ongoing issues since his deployment", which led to him attempting suicide. The writer sought the "support" of the person he/she was writing to (which appears to be the CO of Task Group 632) that "the ADFIS investigation and any follow up is treated with due sensitivity given the circumstances".[1468]

1026. It does not appear from the evidence in the Inquest that CPL Turner was made aware of this allegation prior to his death.[1469] It therefore does not appear to have had an impact on the manner and cause of his death. Counsel Assisting submits that no finding should be made in relation to this issue.

Submissions of the Commonwealth

1027. The ADF agrees that no findings should be made about this issue.[1470]

Consideration

1028. I make no finding on this Issue.

Issue 11 – Whether any other factors arising during CPL Turner's service contributed to his death

(a) The ADF's reliance on CPL TJ

Submissions of Counsel Assisting

1029. Counsel Assisting[1471] submits that one issue which deserves some particular attention is the inappropriate reliance by the ADF on CPL TJ to assist CPL Turner. CPL TJ was

[1466] Submissions of Counsel Assisting dated 2 November 2023 at [552]-[553].
[1467] Tab 42 (Conduct & Disciplinary records) at 63, 75.
[1468] Tab 42 (Conduct & Disciplinary Records) at 60-63.
[1469] See Exhibit 63 (Letter from AGS to CSO dated 15 December 2022).
[1470] Submissions of the Commonwealth dated 7 June 2024 at [798].
[1471] Submissions of Counsel Assisting dated 2 November 2023 at [554]-[555].

25 years old in 2017, had never been in a situation of the volatility she experienced with CPL Turner, and had no training in what was going on.[1472] Counsel Assisting considers that it was evident from the messages between CPL TJ and CPL Turner which ultimately came to be in evidence that she also suffered significantly throughout the period she was involved with CPL Turner by reason of his poor mental health. It was also apparent from those messages that CPL TJ provided a significant level of support to CPL Turner throughout his severe decline in mental health, and her support likely had the effect of prolonging CPL Turner's life. Counsel Assisting submits that it should be recognised that she was a victim of the circumstances that engulfed her partner and will have to live with the trauma of those events for the rest of her life.

Submissions of CPL TJ

1030. In addition to agreeing with Counsel Assisting's submissions regarding her relationship with CPL Turner during and following the deployments, CPL TJ submits that the support she provided to CPL Turner extended to the periods of their return from deployment, which came at significant personal cost to her.[1473]

Submissions of the Commonwealth

1031. The Commonwealth submits that no finding in line with Counsel Assisting's submission above at [1029] is available.[1474] The Commonwealth refers to the ADF's lack of knowledge as to the extent of the abusive behaviour from CPL Turner towards CPL TJ, that the ADF became more interventionist over time, and that CPL TJ was receiving support from an ADF psychologist during this time and was "in regular contact" with Padre MP.[1475]

Submissions in reply of Counsel Assisting

1032. Counsel Assisting notes[1476] that the submission that the ADF was giving CPL TJ adequate support and ensuring appropriate intervention in the circumstances is difficult to reconcile with the evidence that CPL TJ raised concerns in February 2017 about CPL Turner's mental health (to which she received no response from the CO and RSM),[1477] and that even after CPL Turner's first suicide attempt in March 2017 "both the CO and RSM" contacted CPL TJ "regularly after that to find out what was going on

[1472] 12/08/21 T39.48-40.2.
[1473] Submissions of CPL TJ dated 7 June 2024 at [50]-[52].
[1474] Submissions of the Commonwealth dated 7 June 2024 at [820].
[1475] Submissions of the Commonwealth dated 7 June 2024 at [821]-[828].
[1476] Submissions in reply of Counsel Assisting dated 22 August 2024 at [244].
[1477] Submissions of Counsel Assisting dated 2 November 2023 at [250].

with [CPL Turner]."[1478] Further, it is submitted that the ADF's reliance on CPL TJ having seen an ADF psychologist does little to counter the clear evidence from CPL TJ herself that "I've never been so close to someone who was so sick and I hadn't had any training in what was going on".[1479] Importantly, in response to the question as to whether "anybody" had offered her support given that she was "so close to another member who had indicated to you he had suicidal feelings", CPL TJ's answer was unequivocally "not until after".[1480]

Consideration

1033. I have no hesitation in accepting Counsel Assisting's submissions on this issue. It is apparent that the ADF relied on CPL TJ to provide support to CPL Turner. I accept the evidence that she was frequently contacted about "what was going on" after CPL Turner's first suicide attempt in March 2017. I accept CPL TJ as a witness of truth and believe her account that she was not offered support "until after" CPL Turner's death.

1034. She was 25 years of age and facing problems of her own. In my view, she was treated poorly. While I accept that the ADF did not know the internal details of her relationship with CPL Turner, given what they knew of his mental state, supports should have been put in place.

(b) The ADF's treatment of Joanna Turner

Submissions of Counsel Assisting

1035. As the evidence has revealed, at critical junctures Joanna Turner sought to raise issues with the ADF and the response was largely to take CPL Turner's word at face value, and for Joanna Turner to be viewed as someone who was seeking to exact revenge on CPL Turner by harming his career: that is, not to believe her. The evidence reveals unequivocally that Joanna Turner in fact minimised the suffering she was experiencing so as not to harm CPL Turner's career, whilst trying to take steps to assist him through the ADF. It is regrettable that her concerns were not taken into account at an early point. Her involvement may well have revealed to the ADF the extent of the difficulties CPL Turner was in fact facing, particularly in 2015 and 2016.

[1478] 12/08/2021 T30.4-9. See also Exhibit 10 at [4(d)].
[1479] 12/08/2021 T40.1-2.
[1480] 12/08/2021 T41.10-12.

Consideration

1036. Joanna Turner was treated poorly by the ADF when she tried to raise concerns about her husband's mental health at an early stage. She was vilified, disrespected, and at times ignored. While she hid some of the traumatic events which occurred in her home to protect her husband, she was nevertheless characterised as a vengeful woman. In my view, nothing could be further from the truth.

1037. At some point, she realised that to protect her children she must leave her marriage, but it is very clear to me that she had also felt great love for CPL Turner, despite the changes in his behaviour she witnessed as his PTSD and substance issues took hold.

1038. I respected her ongoing participation in these difficult proceedings.

Final Issue: The production of documents by the ADF

Submissions of Counsel Assisting

1039. Counsel Assisting notes that the production of documents by the ADF in this matter was an issue of considerable concern. During the first two tranches of the Inquest, a document of critical importance being the letter from Dr Sringeri to MAJ AM dated 13 July 2016 clearing CPL Turner to attend all duties, was not able to be located.

1040. On 12 November 2021, the AGS wrote to the Solicitor Assisting and indicated that following questioning during the August 2021 hearings and in the context of work being undertaken in response to the Royal Commission into Defence and Veteran Suicide (**the Royal Commission**), the Department of Defence was "continuing to review its records to determine whether it holds any additional, relevant material that may assist the Coroner".[1481]

1041. The letter from Dr Sringeri to MAJ AM was subsequently located (seemingly as a result of that further review) and provided to the solicitor assisting on 3 December 2021. At that time, the ADF indicated that it was still searching and reviewing various repositories and its best estimate was that this search and review process would not be completed until March 2022. The ADF was asked to, and did, provide an explanation of why this material was not produced in response to a subpoena issued on 30 October 2019. It explained that when searching for relevant material, the Department of Defence interpreted the subpoena as requiring production of records relating to CPL Turner held on "Objective", Defence's official document management

[1481] Exhibit 23 (Letter from AGS to the CSO dated 12 November 2021).

system and other systems such as the Defence eHealth system.[1482] Emails are not automatically saved on Objective and if a person had not manually saved an email (noting that only a small number of relevant emails were apparently saved on Objective when the first subpoena was answered in 2019)), then it would not have been produced.[1483]

1042. The scope of the subpoena issued to the ADF on 30 October 2019 was broad and made no mention of the call being limited to documents stored in a particular location. It would plainly enough be beyond the knowledge of those framing the subpoena to be able to specify specific internal ADF systems. No objection was taken to the scope of the subpoena at the time and no clarification sought as to the nature of the material required to be produced. When production was made, no comment was included about assumptions made by the ADF about the scope of the call being limited in any way.

1043. For the sake of clarification, a further subpoena was served on the ADF on 15 December 2021 with an extended return date of 1 April 2022. This return date was set after consultation with the AGS about a realistic timeframe for the production of the material. The material that was subsequently produced was provided in a number of tranches, the first of which was not delivered to the Court until nearly three weeks after the return date of 1 April 2022. A further 12 tranches were received (13 in total) with the last one being made available on 9 December 2022: more than eight months after the return date of the new subpoena and over three years after the issue of the initial subpoena. In total, a further 1834 pages of material was produced, all of which arguably fell within the scope of the original subpoena.

1044. During the course of questioning of Person 1 on 1 September 2022, further documents which were relevant to the issues in the Inquest were put to Person 1 by Senior Counsel for the ADF. These documents had not previously been produced in response to the two subpoenas issued to the ADF but were later provided in a further tranche of documents produced by the ADF.[1484] Counsel Assisting notes that this is a matter of significant concern in respect of the compliance by the ADF with the subpoenas served on it.

1045. Given the ongoing disclosure by those representing the ADF that further relevant material might be available, it is submitted that I cannot be confident that all the

[1482] Exhibit 29 (Statement of COL Melanie Cochbain dated 10 December 2021) 4-5.
[1483] Exhibit 29 (Statement of COL Melanie Cochbain dated 10 December 2021) at 5-6.
[1484] 01/09/22 T63.

material falling within the scope of the two subpoenas has been produced and put into evidence.

1046. Counsel Assisting notes that it is apparent from the evidence in the Inquest, and the haphazard process of document production, that the manner in which documents are stored by the ADF render it difficult to access them from archived repositories and that the internal process of classifying documents adds some complexity to the process (although the classification of a document is prima facie irrelevant to whether it is responsive to a subpoena and should be produced). Counsel Assisting considers that these matters are not conducive to an open review of deaths, or indeed, external scrutiny at all. Counsel Assisting states that this is relevant to the ability of a coroner to perform the function, under the *Coroners Act,* of investigating deaths.

Consideration

1047. I was wholly dissatisfied with the ADF's production of documents during this Inquest. The convoluted process gave me no confidence that *all* relevant documents were eventually produced. From my perspective, the process was made unnecessarily difficult and took an inordinate amount of time. At the conclusion of proceedings, it appeared to me that either the ADF's capacity to manage its own documents was severely compromised or there was a concerning lack of appetite on behalf of those in charge of searching for documents to take this Court's requests seriously. Neither option is attractive.

RECOMMENDATIONS

1048. Section 82 of the *Coroners Act* confers on a coroner the power to make recommendations that he or she may consider necessary or desirable in relation to any matter connected with the death with which the inquest is concerned.

1049. Counsel Assisting proposes 18 recommendations addressed to the Chief of the Defence Force for consideration to be given to various matters. Mr and Mrs Turner, Joanna Turner, CPL TJ, CAPT MH, and GPCAPT Ross have also proposed a number of recommendations. Recommendations proposed by Counsel Assisting and the interested parties are set out below, together with a consideration of them.

Counsel Assisting's proposed recommendations

Proposed recommendation (a)

1050. Counsel Assisting proposes that the Chief of the Defence Force give consideration to introducing a systematic process for mapping the history of an ADF member's deployments, their RtAPS and POPS screens data, and other reported psychiatric diagnoses and treatment, that forms part of the member's health record and including systems to record and action such notifications and to ensure that they are taken into account in decisions relating to deployment.[1485]

Submissions

1051. The ADF supports this recommendation on the basis that any consideration of this issue would need to take account of legal, ethical, and policy restrictions concerning patient privacy/confidentiality and the sharing of ADF members' health information.[1486]

1052. Mr and Mrs Turner accept this recommendation.[1487]

1053. Dr Sringeri appears to accept this recommendation.[1488]

1054. Dr Hale neither supports nor opposes this recommendation.[1489]

1055. GPCAPT Ross neither supports nor opposes this recommendation.[1490]

1056. CAPT MH neither supports nor opposes this recommendation.[1491]

1057. CPL TJ embraces this recommendation.[1492]

1058. In submissions in reply, Counsel Assisting notes that no objection is taken by the interested parties to this recommendation and, accordingly, Counsel Assisting maintains this recommendation in its current form.[1493]

Consideration

1059. I note the recommendation arises directly out of the evidence before me and I make the recommendation in its suggested form.

[1485] Submissions of Counsel Assisting dated 2 November 2023 at 167-169.
[1486] Submissions of the Commonwealth dated 7 June 2024 at p.1.
[1487] Submissions of Mr and Mrs Turner dated 28 January 2024 at [208].
[1488] Submissions of Dr Sringeri dated 24 April 2024 at [2].
[1489] Submissions of Dr Hale dated 31 May 2024 at [38].
[1490] Submissions of GPCAPT Ross dated 5 June 2024
[1491] Submissions of CAPT MH dated 7 June 2024 at [6], [46].
[1492] Submissions of CPL TJ dated 7 June 2024 at [53].
[1493] Submissions in reply of Counsel Assisting dated 22 August 2024.

Proposed recommendation (b)

1060. Counsel Assisting proposes that the Chief of the Defence Force give consideration to the inclusion of a mandatory annual training for all Special Forces members in recognising the symptoms of and managing PTSD.[1494]

Submissions

1061. Mr and Mrs Turner accept this recommendation but propose a modification for mandatory annual training to also focus on *destigmatising* the symptoms of PTSD.[1495]

1062. The ADF supports a recommendation to this effect, including the Turner family's suggestion that the recommendation be modified to read "including a mandatory annual training for all Special Forces members in recognising and destigmatising the symptoms of and managing PTSD". The ADF agrees that the evidence in this Inquest establishes a need to give consideration to its PTSD/mental health training programs.[1496]

1063. The Commonwealth refers to its submissions regarding mental health training and the reduction of stigma, where it has identified some particular issues (arising from the evidence) that could be addressed in revised training programs, including the speed and efficacy of PTSD treatment; the capacity of people with mental health issues to conceal signs/symptoms and continue performing well in the workplace; and the complex interrelationship(s) between PTSD, abuse of alcohol/drugs, and domestic violence.[1497]

1064. Dr Sringeri appears to accept this recommendation.[1498]

1065. Dr Hale neither supports nor opposes this recommendation.[1499]

1066. GPCAPT Ross neither supports nor opposes this recommendation.[1500]

1067. CAPT MH neither supports nor opposes this recommendation.[1501]

1068. CPL TJ accepts this recommendation.[1502]

[1494] Submissions of Counsel Assisting dated 2 November 2023 at 167-169.
[1495] Submissions of Mr and Mrs Turner dated 28 January 2024 at [208].
[1496] Submissions of the Commonwealth dated 7 June 2024 1.
[1497]Submissions of the Commonwealth dated 7 June 2024 at [84]-[89].
[1498] Submissions of Dr Sringeri dated 24 April 2024 at [2].
[1499] Submissions of Dr Hale dated 31 May 2024 at [38].
[1500] Submissions of GPCAPT Ross dated. 5 June 2024 at [126].
[1501] Submissions of CAPT MH dated 7 June 2024 at [6], [46].
[1502] Submissions of CPL TJ dated 7 June 2024 at [53].

1069. In submissions in reply, the ADF states that it would not oppose an amendment to the recommendation by adding "which appropriately includes simulations of real-life scenarios and recommendations about methods of decision making" to the end of the recommendation.[1503]

1070. In submissions in reply, Counsel Assisting notes that the amendments to the recommendation proposed by Mr and Mrs Turner and the ADF are supported and the recommendation is otherwise maintained.[1504]

Consideration

1071. There is a strong evidentiary basis for the recommendation. In my view, it is important to additionally refer specifically to training which focusses on destigmatising the symptoms of PTSD and I make the recommendation in its amended form.

Proposed recommendation (c)

1072. Counsel Assisting proposes that the Chief of the Defence Force give consideration to establishing a system by which psychological distress in the home environment can be communicated to an ADF member's unit by family members, including systems to record and action such notifications and to ensure that they are taken into account in decisions relating to deployment.[1505]

Submissions

1073. The ADF does not oppose a recommendation to this effect but notes that there are already various methods in place which allow a family member to obtain support for psychological distress in the home environment. These methods include: the 24/7 Defence Member and Family Support (**DMFS**) Helpline, which includes advice and support in instances of family and domestic violence; 24/7 Military Police contacts; the Sexual Misconduct Prevention and Response Office (SEMPRO); All hours support; 1800 IMSICK; and 24/7 chaplaincy support. However, while DMFS can request welfare checks in response to a notification of distress and then report to the Chain of Command about the outcome of a welfare check, the ADF accepts that these methods are not primarily directed towards the communication of psychological distress in the home environment to the Chain of Command for the purposes of informing decisions by the Chain of Command about deployment. While the issues surrounding the establishment of such a communication system are likely to be very complex, it is noted

[1503] Submissions in reply of the Commonwealth dated 22 July 2024 at 2.
[1504] Submissions in reply of Counsel Assisting dated 22 August 2024 at [42],[143].
[1505] Submissions of Counsel Assisting dated 2 November 2023 at 167-169.

that the ADF does not oppose a recommendation to the effect that these issues be considered.[1506]

1074. Mr and Mrs Turner accept this recommendation.[1507]

1075. Dr Sringeri appears to accept this recommendation.[1508]

1076. Dr Hale neither supports nor opposes this recommendation.[1509]

1077. GPCAPT Ross neither supports nor opposes this recommendation.[1510]

1078. CAPT MH neither supports nor opposes this recommendation.[1511]

1079. CPL TJ accepts this recommendation.[1512]

1080. In submissions in reply, Counsel Assisting notes that no objection is taken by the interested parties to the recommendation and, accordingly, it is maintained.[1513]

Consideration

1081. I note that there is no objection to the proposed recommendation which, in my view, arises directly from the evidence. I make the recommendation.

Proposed recommendation (d)

1082. Counsel Assisting proposes that the Chief of the Defence Force give consideration to providing opportunities for ADF families to be notified of and involved in treatment programs provided to ADF members for PTSD and other combat-related psychological conditions.[1514]

Submissions

1083. The ADF supports a recommendation to this effect. While the ADF's health services have an occupational focus, the ADF acknowledges that involving family in treatment programs is an important part of member-centric healthcare and rehabilitation. The ADF has existing policies about engaging families in members' health services. It also has resources to support family involvement, including guidance about family engagement in health services for members and health personnel and a family

[1506] Submissions of the Commonwealth dated 7 June 2024 at 13.
[1507] Submissions of Mr and Mrs Turner dated 28 January 2024 at [208].
[1508] Submissions of Dr Sringeri dated 24 April 2024 at [2].
[1509] Submissions of Dr Hale dated 31 May 2024 at [38].
[1510] Submissions of GPCAPT Ross dated. 5 June 2024 at [126].
[1511] Submissions of CAPT MH dated 7 June 2024 at [6], [46].
[1512] Submissions of CPL TJ dated 7 June 2024 at [53].
[1513] Counsel Assisting submissions in reply dated 22 August 2024 at Annexure A.
[1514] Submissions of Counsel Assisting dated 2 November 2023 at 167-169.

engagement in health care course for health personnel. The ADF notes that any consideration of this issue would need to take account of legal, ethical, and policy restrictions concerning patient privacy/confidentiality and the sharing of ADF members' health information. Furthermore, member consent is required for disclosure of health information to family and cannot be implied. Consent is not enduring and should be obtained for each engagement with family.[1515]

1084. Mr and Mrs Turner accept this recommendation.[1516]

1085. Dr Sringeri appears to accept this recommendation.[1517]

1086. Dr Hale neither supports nor opposes this recommendation.[1518]

1087. GPCAPT Ross neither supports nor opposes this recommendation.[1519]

1088. CAPT MH neither supports nor opposes this recommendation.[1520]

1089. CPL TJ accepts this recommendation.[1521]

1090. In submissions in reply, Counsel Assisting notes that no objection is taken by the interested parties to this recommendation and, accordingly, it is maintained in its present form.[1522]

Consideration

1091. I note that no objection was taken to the recommendation. I make the recommendation which arises directly from the evidence before me.

Proposed recommendation (e)

1092. Counsel Assisting proposes that the Chief of the Defence Force give consideration to requiring that impact upon mental health be taken into account in decisions relating to deployment, change of company, or support of members' study plans.[1523]

[1515] Submissions of the Commonwealth dated 7 June 2024 at 13.
[1516] Submissions of Mr and Mrs Turner dated 28 January 2024 at [208].
[1517] Submissions of Dr Sringeri dated 24 April 2024 at [2].
[1518] Submissions of Dr Hale dated 31 May 2024 at [38].
[1519] Submissions of GPCAPT Ross dated 5 June 2024 at [126].
[1520] Submissions of CAPT MH dated 7 June 2024 at [6], [46].
[1521] Submissions of CPL TJ dated 7 June 2024 at [53].
[1522] Counsel Assisting submissions in reply dated 22 August 2024 at [79].
[1523] Submissions of Counsel Assisting dated 2 November 2023 at 167-169.

Submissions

1093. Mr and Mrs Turner support this recommendation and propose a modification to include after "study plans" the words "or transitional plans to non-combat roles within the ADF or employment roles outside the ADF."[1524]

1094. The ADF supports a recommendation to this effect, including the Turner family's suggestion. The ADF notes that decisions relating to, *inter alia*, deployment and change of company are necessarily multifactorial. Various military, operational, resourcing, organisational, and administrative matters also need to be considered when making such decisions. The ADF also notes that any consideration of this issue would need to take account of legal, ethical, and policy restrictions concerning patient privacy/confidentiality and the sharing of ADF members' health information.[1525]

1095. Dr Sringeri appears to accept this recommendation.[1526]

1096. Dr Hale neither supports nor opposes this recommendation.[1527]

1097. GPCAPT Ross neither supports nor opposes this recommendation.[1528]

1098. CAPT MH neither supports nor opposes this recommendation.[1529]

1099. CPL TJ accepts this recommendation.[1530]

1100. In submissions in reply, Counsel Assisting supports the modification proposed by CPL Turner's parents[1531] and otherwise maintain the proposed recommendation.

Consideration

1101. I make the recommendation in its amended form.

Proposed recommendation (f)

1102. Counsel Assisting proposes that the Chief of the Defence Force give consideration to a requirement for psychological screening and support automatically be offered to ADF members who are undergoing disciplinary proceedings.[1532]

[1524] Submissions of Mr and Mrs Turner dated 28 January 2024 at [196]-[207].
[1525] Submissions of the Commonwealth dated 7 June 2024 at 14.
[1526] Submissions of Dr Sringeri dated 24 April 2024 at [2].
[1527] Submissions of Dr Hale dated 31 May 2024 at [38].
[1528] Submissions of GPCAPT Ross dated 5 June 2024 at [126].
[1529] Submissions of CAPT MH dated 7 June 2024 at [6], [46].
[1530] Submissions of CPL TJ dated 7 June 2024 at [53].
[1531] Submissions in reply of Counsel Assisting dated 22 August 2024 at [79].
[1532] Submissions of Counsel Assisting dated 2 November 2023 at 167-169.

Submissions

1103. The ADF supports a recommendation to this effect. The ADF notes that psychological support is currently available to ADF members undergoing disciplinary proceedings if the member seeks that support or the Chain of Command makes a command-initiated referral (if that is considered necessary). To ensure that the command-initiated referral process is effective, the ADF considers that it may be desirable to incorporate additional training into its Pre-Command Course about the possible psychological impacts of disciplinary proceedings on affected members and the appropriate steps to be taken to address those impacts.[1533]

1104. Mr and Mrs Turner accept this recommendation.[1534]

1105. Dr Sringeri appears to accept this recommendation.[1535]

1106. Dr Hale neither supports nor opposes this recommendation.[1536]

1107. GPCAPT Ross neither supports nor opposes this recommendation.[1537]

1108. Captain MH neither supports nor opposes this recommendation.[1538]

1109. CPL TJ accepts this recommendation.[1539]

1110. In submissions in reply, Counsel Assisting notes that no objection is taken by the interested parties to this recommendation and, accordingly, it is maintained in its present form.[1540]

Consideration

1111. I note there was no objection. I make the recommendation which arises directly from the evidence before me.

Proposed recommendation (g)

1112. Counsel Assisting proposes that the Chief of the Defence Force give consideration to providing psychological screening and support whilst on deployment to ADF members who have previously been diagnosed with PTSD.[1541]

[1533] Submissions of the Commonwealth dated 7 June 2024 at 14.
[1534] Submissions of Mr and Mrs Turner dated 28 January 2024 at [208].
[1535] Submissions of Dr Sringeri dated 24 April 2024 at [2].
[1536] Submissions of Dr Hale dated 31 May 2024 at [38].
[1537] Submissions of GPCAPT Ross dated 5 June 2024 at [126].
[1538] Submissions of CAPT MH dated 7 June 2024 at [6], [46].
[1539] Submissions of CPL TJ dated 7 June 2024 at [53].
[1540] Counsel Assisting submissions in reply dated 22 August 2024 at Annexure A.
[1541] Submissions of Counsel Assisting dated 2 November 2023 at 167-169.

Submissions

1113. The ADF does not oppose a recommendation to this effect. The ADF notes that psychological support is currently available to deployed members if the member seeks that support or at the request of the Chain of Command (regardless of whether the member has received a PTSD or other mental health diagnosis). The ADF notes that it is duty-bound to observe that the ADF is currently facing significant workforce/recruitment challenges, including in relation to medical and health personnel. This means that there may be a relatively small pool of persons available for psychologist roles within the ADF. Further, and in any event, it may not be possible for psychologists to be embedded with deployed units depending on military and operational considerations.[1542]

1114. Mr and Mrs Turner accept this recommendation.[1543]

1115. Dr Sringeri appears to accept this recommendation.[1544]

1116. Dr Hale neither supports nor opposes this recommendation.[1545]

1117. GPCAPT Ross neither supports nor opposes this recommendation.[1546]

1118. CAPT MH neither supports nor opposes this recommendation.[1547]

1119. CPL TJ accepts this recommendation.[1548]

1120. In submissions in reply, Counsel Assisting notes that no objection is taken by the interested parties to this recommendation and, accordingly, it is maintained in its present form.[1549]

Consideration

1121. I note there was no objection. I make the recommendation.

Proposed recommendation (h)

1122. Counsel Assisting proposes that the Chief of the Defence Force give consideration to the employment of enlisted ADF psychiatrists with:

[1542] Submissions of the Commonwealth dated 7 June 2024 at 14.
[1543] Submissions of Mr and Mrs Turner dated 28 January 2024 at [208].
[1544] Submissions of Dr Sringeri dated 24 April 2024 at [2].
[1545] Submissions of Dr Hale dated 31 May 2024 at [38].
[1546] Submissions of GPCAPT Ross dated 5 June 2024 at [126].
[1547] Submissions of CAPT MH dated 7 June 2024 at [6], [46].
[1548] Submissions of CPL TJ dated 7 June 2024 at [53].
[1549] Counsel Assisting submissions in reply dated 22 August 2024 at Annexure A.

i. specialist training in military and veterans' psychiatry; and

ii. security clearances at a level consistent with the clearances of the ADF members who are being treated by them.[1550]

Submissions

1123. The ADF does not oppose a recommendation to this effect. The ADF already employs a number of ADF uniformed psychiatrists who hold different levels of security clearances. The ADF submits it is also duty-bound to make a number of observations:

i. The ADF is currently facing significant workforce/recruitment challenges, including in relation to medical and health personnel. This means that there may be a relatively small pool of persons available for psychiatrist roles within the ADF.

ii. The ADF does not assess or determine whether a person is eligible and suitable to hold a security clearance. This is an independent process, conducted by the Australian Government Security Vetting Agency (**AGSVA**). It involves AGSVA considering an applicant's integrity, maturity, trustworthiness, honesty, resilience, tolerance, and loyalty and conducting prescribed minimum personal security checks. While the process undertaken depends upon the level of clearance being applied for (with higher clearance levels requiring a more onerous vetting process), the process can be time-consuming and resource-intensive. The process is also intrusive for the applicant, which may affect the number of psychiatrists who are willing to undertake it.

iii. There would be significant practical impediments to conducting psychiatric and/or psychological treatment involving the communication of security classified information. For example, treatment sessions would need to be held in secure facilities; case notes and information would need to be stored on secure systems and may not be able to be stored electronically; and any security classified information disclosed during a treatment session would not be able to be disclosed to another clinician who did not hold an appropriate security clearance, potentially causing coordination/fragmentation issues.[1551]

1124. Mr and Mrs Turner accept this recommendation.[1552]

[1550] Submissions of Counsel Assisting dated 2 November 2023 at pp 167-169.
[1551] Submissions of the Commonwealth dated 7 June 2024 at 15.
[1552] Submissions of Mr and Mrs Turner dated 28 January 2024 at [208].

1125. Dr Sringeri appears to accept this recommendation.[1553]

1126. Dr Hale considers that this recommendation has merit.[1554]

1127. GPCAPT Ross neither supports nor opposes this recommendation.[1555]

1128. CAPT MH neither supports nor opposes this recommendation.[1556]

1129. CPL TJ accepts this recommendation.[1557]

1130. In submissions in reply, Counsel Assisting notes that no objection is taken by the interested parties to this recommendation and, accordingly, it is maintained in its present form.[1558]

Consideration

1131. Notwithstanding the resourcing issues raised by the ADF, I make the recommendation.

Proposed recommendation (i)

1132. Counsel Assisting proposes that the Chief of the Defence Force give consideration to ensuring that enlisted psychologists and contracted psychologists have security clearances at a level consistent with the clearances of the ADF members who are being treated by them.[1559]

Submissions

1133. The ADF supports a recommendation to this effect. The ADF notes that it already employs or engages ADF uniformed, Australian Public Service, and contracted psychologists who hold different levels of security clearances. The ADF also repeats the observations made in relation to proposed recommendation (h).[1560]

1134. Mr and Mrs Turner accept this recommendation.[1561]

1135. Dr Sringeri appears to accept this recommendation.[1562]

1136. Dr Hale considers that this recommendation has merit.[1563]

[1553] Submissions of Dr Sringeri dated 24 April 2024 at [2].
[1554] Submissions of Dr Hale dated 31 May 2024 at [38].
[1555] Submissions of GPCAPT Ross dated. 5 June 2024 at [126].
[1556] Submissions of CAPT MH dated 7 June 2024 at [6], [46].
[1557] Submissions of CPL TJ dated 7 June 2024 at [53].
[1558] Counsel Assisting submissions in reply dated 22 August 2024 at Annexure A.
[1559] Submissions of Counsel Assisting dated 2 November 2023 at pp 167-169.
[1560] Submissions of the Commonwealth dated 7 June 2024 at 16.
[1561] Submissions of Mr and Mrs Turner dated 28 January 2024 at [208].
[1562] Submissions of Dr Sringeri dated 24 April 2024 at [2].
[1563] Submissions of Dr Hale dated 31 May 2024 at [38].

1137. GPCAPT Ross neither supports nor opposes this recommendation.[1564]

1138. CAPT MH neither supports nor opposes this recommendation.[1565]

1139. CPL TJ accepts this recommendation.[1566]

1140. In submissions in reply, Counsel Assisting notes that no objection is taken by the interested parties to this recommendation and, accordingly, it is maintained in its present form.[1567]

Consideration

1141. Notwithstanding the resourcing issues raised by the ADF, I make the recommendation.

Proposed recommendation (j)

1142. Counsel Assisting proposes that the Chief of the Defence Force give consideration to establishing systems and a culture of transition from Special Forces, including providing adequate support for transitions:

i. to non-combat roles within the ADF; and

ii. to employment roles outside the ADF.[1568]

Submissions

1143. The ADF does not oppose a recommendation to this effect. However, the ADF notes that issues concerning discharge/separation/transition were not a particular focus during this Inquest and were the subject of only limited evidence. The ADF notes that it already has systems/mechanisms which provide considerable support to transitioning members, including: transition training; transition centres; employment assistance; financial support; and health centre support.[1569]

1144. Mr and Mrs Turner accept this recommendation.[1570]

1145. Dr Sringeri appears to accept this recommendation.[1571]

1146. Dr Hale neither supports nor opposes this recommendation.[1572]

[1564] Submissions of GPCAPT Ross dated. 5 June 2024 at [126].
[1565] Submissions of CAPT MH dated 7 June 2024 at [6], [46].
[1566] Submissions of CPL TJ dated 7 June 2024 at [53].
[1567] Counsel Assisting submissions in reply dated 22 August 2024 at Annexure A.
[1568] Submissions of Counsel Assisting dated 2 November 2023 at 167-169.
[1569] Submissions of the Commonwealth dated 7 June 2024 at 16.
[1570] Submissions of Mr and Mrs Turner dated 28 January 2024 at [208].
[1571] Submissions of Dr Sringeri dated 24 April 2024 at [2].
[1572] Submissions of Dr Hale dated 31 May 2024 at [38].

1147. GPCAPT Ross neither supports nor opposes this recommendation.[1573]

1148. Captain MH neither supports nor opposes this recommendation.[1574]

1149. CPL TJ accepts this recommendation.[1575]

1150. In submissions in reply, Counsel Assisting notes that no objection is taken by the interested parties to this recommendation and, accordingly, it is maintained in its present form.[1576]

Consideration

1151. In my view, there was sufficient evidence before me to consider the issues raised. I make the recommendation.

Proposed recommendation (k)

1152. Counsel Assisting proposes that the Chief of the Defence Force give consideration to undertaking an evidence-based review as to whether and how the ADF should limit the number of combat deployments upon which an ADF member can deploy during their career before being required to transition to non-combat roles.[1577]

Submissions

1153. The ADF supports a recommendation to this effect.[1578]

1154. Mr and Mrs Turner accept this recommendation.[1579]

1155. Dr Sringeri appears to accept this recommendation.[1580]

1156. Dr Hale neither supports nor opposes this recommendation.[1581]

1157. GPCAPT Ross neither supports nor opposes this recommendation.[1582]

1158. Captain MH neither supports nor opposes this recommendation.[1583]

1159. CPL TJ accepts this recommendation.[1584]

[1573] Submissions of GPCAPT Ross dated 5 June 2024 at [126].
[1574] Submissions of CAPT MH dated 7 June 2024 at [6], [46].
[1575] Submissions of CPL TJ dated 7 June 2024 at [53].
[1576] Counsel Assisting submissions in reply dated 22 August 2024 at Annexure.
[1577] Submissions of Counsel Assisting dated 2 November 2023 at 167-169.
[1578] Submissions of the Commonwealth dated 7 June 2024 at 16.
[1579] Submissions of Mr and Mrs Turner dated 28 January 2024 at [208].
[1580] Submissions of Dr Sringeri dated 24 April 2024 at [2].
[1581] Submissions of Dr Hale dated 31 May 2024 at [38].
[1582] Submissions of GPCAPT Ross dated. 5 June 2024 at [126].
[1583] Submissions of CAPT MH dated 7 June 2024 at [6], [46].
[1584] Submissions of CPL TJ dated 7 June 2024 at [53].

1160. In submissions in reply, Counsel Assisting notes that no objection is taken by the interested parties to this recommendation and, accordingly, it is maintained in its present form.[1585]

Consideration

1161. I accept this recommendation arises directly from the evidence before me. I make the recommendation.

Proposed recommendation (l)

1162. Counsel Assisting proposes that the Chief of the Defence Force give consideration to requiring that prior to deployment of an ADF member who has had a diagnosis of PTSD:

i. an independent clinical assessment be made by a psychiatrist not involved in the individual's treatment or Chain of Command; and

ii. a risk analysis be undertaken based on a review of the history referred to in recommendation (a) above; and

iii. the ADF introduce clear guidelines indicating the factors which are to be taken into account in a decision whether the member should be permitted to deploy, including whether capability requirements are intended to have any influence on that decision (and if so, in what way).[1586]

Submissions

1163. Mr and Mrs Turner accept this recommendation.[1587]

1164. Dr Sringeri appears to accept this recommendation.[1588]

1165. Dr Hale neither supports nor opposes this recommendation.[1589]

1166. GPCAPT Ross neither supports nor opposes this recommendation.[1590]

1167. CAPT MH neither supports nor opposes this recommendation.[1591]

1168. CPL TJ accepts this recommendation.[1592]

[1585] Counsel Assisting submissions in reply dated 22 August 2024 at Annexure A.
[1586] Submissions of Counsel Assisting dated 2 November 2023 at 167-169.
[1587] Submissions of Mr and Mrs Turner dated 28 January 2024 at [208].
[1588] Submissions of Dr Sringeri dated 24 April 2024 at [2].
[1589] Submissions of Dr Hale dated 31 May 2024 at [38].
[1590] Submissions of GPCAPT Ross dated. 5 June 2024 at [126].
[1591] Submissions of CAPT MH dated 7 June 2024 at [6], [46].
[1592] Submissions of CPL TJ dated 7 June 2024 at [53].

1169. The ADF's view is that proposed recommendations (l), (m) and (n) raise closely related issues which should be considered together. While the ADF supports the intent behind the proposed recommendations, it does not support them in their current form. The ADF considers the more appropriate course would be for a recommendation that "it give consideration to reviewing its policy framework with respect to the making of deployment decisions for ADF members who have or have had a diagnosis of PTSD or another similar mental health condition, with a view to developing clear guidelines about:

    1. How such decisions should be made (including whether and how they can be "appealed");

    2. The roles and responsibilities of operational personnel, medical personnel and any external health practitioners in the making of such decisions;

    3. The information to which operational personnel, medical personnel and any external health practitioners may and may not have access in making such decisions; and

    4. In the event that a decision to deploy is made, the development and implementation of risk mitigation strategies."

1170. The ADF also notes that any review would need to take account of legal, ethical, and policy restrictions concerning patient privacy/confidentiality and the sharing of ADF members' health information. In proposing a less prescriptive and more holistic recommendation, the ADF is conscious of the work of the Royal Commission and the need to avoid "universalising" from one case.[1593]

1171. Joanna Turner agrees with the ADF's alternative and proposes that the ADF policy should require a trained mental health professional to be the primary decision maker; noting that her view is that medical officers do not always have comprehensive mental health training and are therefore not well positioned to be the clinical lead in relation to such issues.[1594]

1172. Counsel Assisting does not oppose the ADF's alternative recommendation, subject to the consideration of matters raised by GPCAPT Ross and Mr and Mrs Turner in relation to proposed recommendations (l), (m), and (n).[1595]

[1593] Submissions of the Commonwealth dated 7 June 2024 at 16.
[1594] Submissions in reply of Joanna Turner 15 July 2024 at [1(a)].
[1595] Submissions in reply of Counsel Assisting dated 22 August 2024 at [246.1].

Consideration

1173. Having considered the submissions made on this issue, I accept the general approach of the Commonwealth and intend to deal with recommendations (l), (m) and (n) together.

Proposed recommendation (m)

1174. Counsel Assisting proposes that the Chief of the Defence Force give consideration to requiring that any decision as to a medical clearance or waiver on mental health grounds be the subject of an independent review by a suitably qualified health professional who, for that purpose, is provided with full access to the member's health care records held by the ADF (including the mapping referred to in recommendation (a)) and any records of psychological distress in the home environment.[1596]

Submissions

1175. Dr Sringeri appears to accept this recommendation.[1597]

1176. Dr Hale neither supports nor opposes this recommendation.[1598]

1177. CPL TJ accepts this recommendation.[1599]

1178. Captain MH neither supports nor opposes this recommendation.[1600]

1179. GPCAPT Ross indicates that this recommendation would introduce "potentially significant logistical impediments" and that in order to be "suitably qualified" for the role it would be necessary for the health professional to have military experience and there are few such health professionals. He also notes that requests for medical clearance are often submitted close to the dates of deployment (meaning that independent review may not be feasible).[1601]

1180. Mr and Mrs Turner accept this recommendation but propose a modification that the recommendation also "provides that formal procedures are to be instigated regarding the process of appealing a negative medical clearance and how that appeal is reviewed".[1602]

[1596] Submissions of Counsel Assisting dated 2 November 2023 at 167-169.
[1597] Submissions of Dr Sringeri dated 24 April 2024 at [2].
[1598] Submissions of Dr Hale dated 31 May 2024 at [38].
[1599] Submissions of CPL TJ dated 7 June 2024 at [53].
[1600] Submissions of CAPT MH dated 7 June 2024 at [6], [46].
[1601] Submissions of GPCAPT Ross dated 5 June 2024 at [127(a)].
[1602] Submissions of Mr and Mrs Turner dated 28 January 2024 at [208(a)].

1181. The ADF refers to its response to recommendation (l) above and notes that subparagraph (1) in [1169] incorporates Mr and Mrs Turner's suggestion that "appeal" processes be considered as part of any review.[1603]

1182. Joanna Turner disagrees with the ADF that an independent review cannot be undertaken prior to issuing a clearance/waiver. She considers that it would be reasonable for either a member of a regional JHC senior mental health team or otherwise the ADF Second Opinion Clinic to review and provide comment on any such decision. This would enable an independent review to be considered and documented, whilst maintaining confidentiality/privacy. She notes that all such documentation for these situations should require sign off by two levels of assessment (i.e., mental health professional carrying out the review and the senior or second opinion clinician reviewing the assessment).[1604]

1183. Counsel Assisting is supportive of the proposed modification proposed by Mr and Mrs Turner[1605] and does not oppose the ADF's alternative recommendation, subject to the consideration of matters raised by GPCAPT Ross and Mr and Mrs Turner in relation to recommendations (l), (m), and (n).[1606]

Consideration

1184. Having considered the submissions made on this issue, I accept the general approach of the Commonwealth and intend to deal with recommendations (l), (m) and (n) together.

Proposed recommendation (n)

1185. Counsel Assisting proposes that the Chief of the Defence Force give consideration to requiring that when an independent review as per (m) above results in a clearance being granted, that:

1. the risks to the individual resulting from the clearance being granted are clearly identified and documented along with detailed reasons why the need to deploy the individual outweighs the risks involved;

2. a detailed plan to mitigate the identified risks to the individual is documented and signed off by the relevant medical and command personnel; and

[1603] Submissions of the Commonwealth dated 7 June 2024 at 17.
[1604] Submissions in reply of Joanna Turner at [1(b)].
[1605] Submissions in reply of Counsel Assisting dated 22 August 2024 at [76.1].
[1606] Submissions in reply of Counsel Assisting dated 22 August 2024 at [246.1].

3. the CO of a soldier who has been granted a medical clearance be designated as personally responsible for the implementation of the mitigation plan as per (n)(2) above (regardless of whether the person ultimately falls under the authority of a different Chain of Command once deployed).[1607]

Submissions

1186. CAPT MH neither supports nor opposes this recommendation.[1608]

1187. CPL TJ accepts this recommendation.[1609]

1188. Dr Sringeri appears to accept this recommendation.[1610]

1189. Dr Hale neither supports nor opposes this recommendation.[1611]

1190. The ADF refers to its response to recommendation (l) above.[1612]

1191. Mr and Mrs Turner propose that the recommendation be modified to include "4. a plan of action to be formulated as part of the mitigation plan should the condition for which the ADF member received a clearance begin to deteriorate."[1613]

1192. GPCAPT Ross considers that this recommendation confuses the medical clearance process with the command waiver process and that an "acceptable alternative" to this recommendation would be that any ADF member with a history of PTSD be dealt with separately from the medical clearance process such that there is no possibility that the member be medically cleared to deploy and would require a command waiver. However, GPCAPT Ross does not support such an alternative because, in his professional opinion, an ADF member with PTSD could be cleared to deploy.[1614]

1193. Counsel Assisting is supportive of the proposed modification to this recommendation made by Mr and Mrs Turner and accepts GPCAPT Ross' comment that recommendation (n)(1) elides the distinction between command waiver and medical clearance processes (and, accordingly, Counsel Assisting does not process for that aspect of the recommendation).[1615] Counsel Assisting does not support GPCAPT

[1607] Submissions of Counsel Assisting dated 2 November 2023 at 167-169.
[1608] Submissions of CAPT MH dated 7 June 2024 at [6], [46].
[1609] Submissions of CPL TJ dated 7 June 2024 at [53].
[1610] Submissions of Dr Sringeri dated 24 April 2024 at [2].
[1611] Submissions of Dr Hale dated 31 May 2024 at [38].
[1612] Submissions of the Commonwealth dated 7 June 2024 at 18.
[1613] Submissions of Mr and Mrs Turner dated 28 January 2024 at [208(b)].
[1614] Submissions of GPCAPT Ross dated 5 June 2024 at [127(b)-(f)].
[1615] Submissions in reply of Counsel Assisting dated 22 August 2024 at [181].

Ross' proposed alternative to recommendation (n), noting that he himself does not support it.[1616]

Consideration

1194. I have considered all the submissions made in relation to proposed recommendations (l),(m) and (n) together and intend to make the following recommendation which in my view appropriately addresses the issues raised:

i. that the Chief of the Defence Force give consideration to reviewing its policy framework with respect to the making of deployment decisions for ADF members who have or have had a diagnosis of PTSD or another similar mental health condition, with a view to developing clear guidelines and procedures about:

a. How such decisions should be made (including whether and how they can be "appealed");

b. The roles and responsibilities of operational personnel, medical personnel and any external health practitioners in the making of such decisions;

c. The information to which operational personnel, medical personnel and any external health practitioners may and may not have access in making such decisions; and

d. In the event that a decision to deploy is made, the development and implementation of risk mitigation strategies (a plan of action should also be formulated as part of the mitigation plan/strategy in the event the condition for which the ADF member received a clearance or waiver begins to deteriorate).

Proposed recommendation (o)

1195. Counsel Assisting proposes that the Chief of the Defence Force give consideration to where an RtAPS or POPS screening reveals PTSD symptoms, that it is promptly notified to the Chain of Command.[1617]

[1616] Submissions in reply of Counsel Assisting dated 22 August 2024 at [179].
[1617] Submissions of Counsel Assisting dated 2 November 2023 at 167-169.

Submissions

1196. Mr and Mrs Turner accept this recommendation.[1618]

1197. Dr Sringeri appears to accept this recommendation.[1619]

1198. Dr Hale neither supports nor opposes this recommendation.[1620]

1199. GPCAPT Ross neither supports nor opposes this recommendation.[1621]

1200. CAPT MH neither supports nor opposes this recommendation.[1622]

1201. CPL TJ accepts this recommendation.[1623]

1202. The ADF does not support a recommendation to this effect, as it believes it does not take account of legal, ethical, and policy restrictions concerning patient privacy and confidentiality and the sharing of ADF member's health information. The ADF notes that a RtAPS or POPS that identifies PTSD symptoms cannot be notified to the member's Chain of Command unless the member consents or the medical/health professional reasonably believes that the disclosure is necessary to lessen or prevent an imminent serious threat to the life, health, or safety of any individual or to public health and safety.[1624]

1203. Joanna Turner agrees with the ADF's position raising concerns about confidentiality and resulting underreporting and she proposes that there be training directed to those administering such screenings to lead to better outcomes.[1625]

1204. Counsel Assisting maintains this recommendation in its present form.[1626]

Consideration

1205. I understand the need to protect the therapeutic relationship and to promote honesty in RtAPS and POPS procedures. Nevertheless, it would be of benefit for the Chain of Command to know when a member is experiencing severe symptoms of PTSD. It appears to me that there could be consideration of developing a system where a simple alert is issued (without detailed personal confidences being revealed) when severe symptoms are disclosed and permission to advise the Chain of Command is not

[1618] Submissions of Mr and Mrs Turner dated 28 January 2024 at [208].
[1619] Submissions of Dr Sringeri dated 24 April 2024 at [2].
[1620] Submissions of Dr Hale dated 31 May 2024 at [38].
[1621] Submissions of GPCAPT Ross dated. 5 June 2024 at [126].
[1622] Submissions of CAPT MH dated 7 June 2024 at [6], [46].
[1623] Submissions of CPL TJ dated 7 June 2024 at [53].
[1624] Submissions of the Commonwealth dated 7 June 2024 at 18.
[1625] Submissions in reply of Joanna Turner at [1(c)].
[1626] Submissions in reply of Counsel Assisting dated 22 August 2024 at [246.2].

forthcoming. Clearly, this would necessitate working through issues of confidentiality and privacy.

1206. I make the recommendation in an amended form and ask that the Chief of the Defence Force give consideration to that where an RtAPS or POPS screening reveals severe PTSD symptoms, and permission to advise the Chain of Command is not forthcoming, that the Chain of Command is promptly notified by issuing a simple alert. Responsibility will then fall to the Chain of Command to seek further information from the member.

Proposed recommendation (p)

1207. Counsel Assisting proposes that the Chief of the Defence Force give consideration to the implementation of training programs for ADF members in command roles in relation to PTSD, including the identification of PTSD symptoms and the appropriate management of soldiers experiencing PTSD.[1627]

Submissions

1208. The ADF supports a recommendation to this effect and repeats the observations made in relation to proposed recommendation (b).[1628]

1209. Mr and Mrs Turner accept this recommendation.[1629]

1210. Dr Sringeri appears to accept this recommendation.[1630]

1211. Dr Hale neither supports nor opposes this recommendation.[1631]

1212. GPCAPT Ross neither supports nor opposes this recommendation.[1632]

1213. CAPT MH neither supports nor opposes this recommendation.[1633]

1214. CPL TJ accepts this recommendation.[1634]

1215. Counsel Assisting notes that no objection is taken by the interested parties to this recommendation and, accordingly, it is maintained in its present form.[1635]

[1627] Submissions of Counsel Assisting dated 2 November 2023 at 167-169.
[1628] Submissions of the Commonwealth dated 7 June 2024 at 18.
[1629] Submissions of Mr and Mrs Turner dated 28 January 2024 at [208].
[1630] Submissions of Dr Sringeri dated 24 April 2024 at [2].
[1631] Submissions of Dr Hale dated 31 May 2024 at [38].
[1632] Submissions of GPCAPT Ross dated. 5 June 2024 at [126].
[1633] Submissions of CAPT MH dated 7 June 2024 at [6], [46].
[1634] Submissions of CPL TJ dated 7 June 2024 at [53].
[1635] Counsel Assisting submissions in reply dated 22 August 2024 at Annexure A.

Consideration

1216. The evidence demonstrated a very clear need for this recommendation and I intend to make it.

Proposed recommendation (q)

1217. Counsel Assisting proposes that a review be conducted of the management of soldiers suffering from mental health conditions in 2CDO in consideration of:

    1. best clinical practice;

    2. longitudinal management of conditions and treatments; and the appointment of a single point of coordination and responsibility for the overall treatment of the individual.[1636]

Submissions

1218. Mr and Mrs Turner accept this recommendation.[1637]

1219. Dr Sringeri appears to accept this recommendation.[1638]

1220. Dr Hale neither supports nor opposes this recommendation.[1639]

1221. GPCAPT Ross neither supports nor opposes this recommendation.[1640]

1222. CAPT MH neither supports nor opposes this recommendation.[1641]

1223. CPL TJ accepts this recommendation.[1642]

1224. The ADF does not support this recommendation in its present form. The ADF considers that the drafting of this recommendation is unclear and it does not understand it, meaning that it would not be able to implement it. Further, to the extent that this proposed recommendation is directed towards a review of the practices of the HPW and/or a review of the coordination of care in complex cases, the ADF does not accept that the evidence in this Inquest provides a sufficient basis for the making of this recommendation.[1643]

[1636] Submissions of Counsel Assisting dated 2 November 2023 at 167-169.
[1637] Submissions of Mr and Mrs Turner dated 28 January 2024 at [208].
[1638] Submissions of Dr Sringeri dated 24 April 2024 at [2].
[1639] Submissions of Dr Hale dated 31 May 2024 at [38].
[1640] Submissions of GPCAPT Ross dated. 5 June 2024 at [126].
[1641] Submissions of CAPT MH dated 7 June 2024 at [6], [46].
[1642] Submissions of CPL TJ dated 7 June 2024 at [53].
[1643] Submissions of the Commonwealth dated 7 June 2024 at 19.

1225. Counsel Assisting maintains that the recommendation is clear in its terms and arises directly from the issues raised regarding the management of CPL Turner and his mental health.[1644]

Consideration

1226. The evidence indicated that members of the 2CDO undertook a considerable combat load, which places them at clear risk of mental health consequences. That fact should be uncontroverted. It is apparent that members suffering mental health conditions deserve best clinical practice and that their management is evidence-based and well-coordinated.

1227. I was surprised that the ADF could not understand the recommendation, perhaps on further reflection its purport will be clear. After listening to the evidence of Mr Cardinaels and others, I was not convinced that at the time CPL Turner was being managed that his condition was handled appropriately and in accordance with best practice. Should the review find that much has changed, little further work will need to be done.

1228. I intend to make the recommendation.

Proposed recommendation (r)

1229. Counsel Assisting proposes that the Chief of the Defence Force give consideration to conducting a review of the role of the padre in relation to the identification, treatment, and management of soldiers with mental health conditions in 2CDO.[1645]

Submissions

1230. Mr and Mrs Turner accept this recommendation.[1646]

1231. Dr Sringeri appears to accept this recommendation.[1647]

1232. Dr Hale neither supports nor opposes this recommendation.[1648]

1233. GPCAPT Ross neither supports nor opposes this recommendation.[1649]

1234. Captain MH neither supports nor opposes this recommendation.[1650]

[1644] Submissions in reply of Counsel Assisting dated 22 August 2024 at [225].
[1645] Submissions of Counsel Assisting dated 2 November 2023 at 167-169.
[1646] Submissions of Mr and Mrs Turner dated 28 January 2024 at [208].
[1647] Submissions of Dr Sringeri dated 24 April 2024 at [2].
[1648] Submissions of Dr Hale dated 31 May 2024 at [38].
[1649] Submissions of GPCAPT Ross dated 5 June 2024 at [126].
[1650] Submissions of CAPT MH dated 7 June 2024 at [6], [46].

1235. CPL TJ accepts this recommendation.[1651]

1236. The ADF does not support a recommendation to this effect and notes that policy documents/guidelines relating to the role of the padre (which exist and which have been updated since 2017) were never requested by those assisting or the subject of a subpoena/order for production. The ADF is of the view that there is no appropriate evidence base to support the need for this recommendation.[1652]

1237. Joanna Turner agrees "that Padres need to have very established boundaries defining and identifying what constitutes pastoral response and what presentations require mental health professional assessment" and that the recommendation should not be limited to 2CDO.[1653]

1238. Counsel Assisting maintains this recommendation in its present form and notes that, if made, it should be confined to 2CDO in light of the scope of the evidence adduced in the Inquest.[1654]

Consideration

1239. I do not accept that I need old and updated policies about the padre to make this recommendation. In my view, it arises clearly from the evidence in this Inquest. I identified a variety of potential issues relating to the padre's role. The boundaries around the padre's involvement were not well-defined. A padre needs an ability to identify the difference between a pastoral care role and a treatment role which requires psychological or social work experience. A number of times during the Inquest a witness would advise the Court that they had "told the padre" about something, but it was rarely clear what obligation the padre had to share or withhold that information.

1240. I understand that the padre's role pre-dates an army with professional mental health services. It is a role that requires review, perhaps throughout the whole Army but given the evidence in this Inquest I make it only with regard to the 2CDO.

Mr and Mrs Turner's proposed recommendations

Proposed recommendation (a)

1241. Regarding the impact of CPL Turner's service in the ADF on his mental health, Mr and Mrs Turner would like to see the ADF formally track the time members deploy by

[1651] Submissions of CPL TJ dated 7 June 2024 at [53].
[1652] Submissions of the Commonwealth dated 7 June 2024 at 19.
[1653] Submissions in reply of Joanna Turner at [1(d)].
[1654] Counsel Assisting submissions in reply dated 22 August 2024 at [246.3].

establishing a system for mapping the history of an ADF members leave entitlements, the leave taken, and lapsing/lapsed leave and to ensure that they are considered in decisions relating to deployments.[1655]

Submissions

1242. The ADF does not oppose a recommendation to this effect.[1656]

1243. Counsel Assisting supports this recommendation, noting that it would complement Counsel Assisting's proposed recommendation (a) and (k).[1657] It is submitted that if those recommendations are accepted, Mr and Mrs Turner's recommendation would not pose a significant additional burden on the ADF. CPL Turner was deployed for a substantial period of time between 2007 and 2016 and the expert evidence emphasised the "inherently potentially traumatic" nature of service, the "accumulative effects of multiple deployments and the cumulative traumas greatly increase the probability of enduring psychological harm", and the impact of "cumulative exposure" to traumatic incidents.[1658]

Consideration

1244. In my view, this is a useful recommendation and I intend to make it.

Proposed recommendation (b)

1245. Mr and Mrs Turner would like to see the ADF study the effects of repeated deployments on a member's home and family life.[1659]

Submissions

1246. The ADF does not oppose a recommendation to this effect.[1660]

1247. Counsel Assisting supports this recommendation on the same bases as above at [1243].[1661]

Consideration

1248. This is a useful recommendation and I intend to make it.

[1655] Submissions of Mr and Mrs Turner dated 28 January 2024 at [37], [209].
[1656] Submissions of the Commonwealth dated 7 June 2024 at 19-20.
[1657] Submissions in reply of Counsel Assisting dated 22 August 2024 at [36].
[1658] Tab 110 at 10; 7/2/2023 T71.1; 8/2/23 T46.19.
[1659] Submissions of Mr and Mrs Turner dated 28 January 2024 at [37] and [209].
[1660] Submissions of the Commonwealth dated 7 June 2024 at 20.
[1661] Counsel Assisting submissions in reply dated 22 August 2024 at [36].

Proposed recommendation (c)

1249. Mr and Mrs Turner contend that education for ADF families and significant others of ADF members regarding PTSD should be made available and there ought to be appropriate services available to assist family members deal with the effects of combat related PTSD. Accordingly, Mr and Mrs Turner propose the establishment of systems to provide:

    1. Education for ADF families and significant others of ADF members in recognising the symptoms of PTSD (including subsyndromal PTSD) and other combat related psychological conditions;
    2. Suitable services to assist ADF family members and significant others of ADF members to deal with the impact of the symptoms of the PTSD and / other combat related psychological conditions; and
    3. Suitable services to ADF family members and significant others of an ADF member who suicide from PTSD and/or other combat related psychological conditions during service.[1662]

Submissions

1250. The ADF is of the view that issues of this kind were being explored by the Royal Commission and that the Royal Commission was the more appropriate forum for consideration of this issue.[1663]

1251. Joanna Turner considers that this issue "could be addressed", however, she notes that the recommendation places undue responsibility on family members and that, in CPL Turner's case, focus regarding education should have been on "command and treating medical professionals" in their recognition of "family dysfunction" and on the relevant ADF member "so they maintain primary responsibility".[1664]

1252. Counsel Assisting does not consider recommendations (c)(1) and (c)(2) to be appropriate given recommendations need to be "in relation to any matter connected with the death" (s 82 of the *Coroners Act*) and the evidence did not suggest CPL Turner's death in any way arose from a lack of recognition of symptoms by his partner or family. Rather, Counsel Assisting posits that the concerns canvassed by this

[1662] Submissions of Mr and Mrs Turner dated 28 January 2024 at [45]-[46] and [209].
[1663] Submissions of the Commonwealth dated 7 June 2024 at 20.
[1664] Submissions of Joanna Turner in reply at [2(a)].

recommendation are more appropriately addressed in Counsel Assisting's proposed recommendations (c) and (d).[1665]

1253. Counsel Assisting does not consider there to be a sufficient evidentiary basis for recommendation (c)(3).[1666]

Consideration

1254. While I have considerable sympathy for ADF families and the significant others of members, I accept Counsel Assisting's submission that matters raised may go beyond scope and may not arise directly from the evidence before me. I decline to make the recommendation and note that the issue was considered by the Royal Commission.

Proposed recommendation (d)

1255. Mr and Mrs Turner suggest that the correlation between incidents of domestic violence and PTSD should be the subject of greater research and analysis (as it is an important part of looking after the family of ADF members suffering from PTSD). In a similar vein, they recommend that the ADF give "greater consideration" to the impact of vicarious trauma on intimate partners and children of ADF members and, in turn, their ability to support the ADF member. They also contend that it would be useful to have a study that investigates the decompensation of members with PTSD on or around the dates of the traumas experienced by the members. [1667]

Submissions

1256. The ADF notes that the interrelationship(s) between PTSD, abuse of alcohol/drugs, and domestic violence/coercive control are complex.[1668]

1257. Joanna Turner emphasises the need to maintain focus on the perpetrator of domestic violence and to ensure such behaviour is not used to excuse the behaviour.[1669]

1258. Counsel Assisting supports the recommendation in relation to the decompensation study, noting the evidence of Dr Hopwood was that this issue was not "researched well".[1670]

[1665] Submissions in reply of Counsel Assisting dated 22 August 2024 at [41].
[1666] Submissions of Counsel Assisting dated 22 August 2024 at [43].
[1667] Submissions of Mr and Mrs Turner dated 28 January 2024 at [45], [48] and [209].
[1668] Submissions of the Commonwealth dated 7 June 2024 at 20.
[1669] Submissions in reply of Joanna Turner at [2(b)].
[1670] Submissions in reply of Counsel Assisting dated 22 August 2024 at [49].

Consideration

1259. Given the differences of emphasis that emerged in the expert conclave in relation to the relationship between PTSD and domestic violence, I accept that it is worthy of study. Accepting a link between domestic violence and PTSD does not excuse violent behaviour or fail to recognise the harm wrought on family members. The breakdown of CPL Turner's family unit due to domestic violence certainly contributed to the mental health decline which ended ultimately in his death, so the connection to my coronial purpose is established. I also accept that it would be useful to have some empirical evidence about the reported decompensation of members which appears to occur around trauma dates.

1260. In my view, both areas are worthy of study. I will make the recommendations.

Proposed recommendation (e)

1261. Mr and Mrs Turner would like to see more stringent guidelines for psychologists undertaking psychological screenings in connection with follow up action. Mr and Mrs Turner propose that the ADF should implement a policy which prioritises the treatment of its members over operational need. A lack of time should not be the default reason a member is not assessed or treated for an occupationally acquired illness or injury. ADF policy should adapt to ensure members returning from combat operations have available both appropriate and timely mental health assessments and ongoing interventions as required.[1671]

Submissions

1262. The ADF relies on its submissions[1672] (summarised above at [567]-[568]) concerning RtAPS and POPS screenings and referrals from such screenings.[1673]

1263. Counsel Assisting refers to the submissions above concerning Issue 3[1674] and emphasises that there were early warning signs, by way of CPL Turner's RtAPS and POPS screenings, and that it does not appear that the ADF had in place any longitudinal method of identifying individuals who were at particular risk of deterioration in their mental health.[1675] Counsel Assisting considers that the gravamen sought to be addressed by Mr and Mrs Turner's recommendations regarding psychological screening are addressed by existing recommendations proposed by Counsel

[1671] Submissions of Mr and Mrs Turner dated 28 January 2024 at [61] and [209].
[1672] Submissions of the Commonwealth dated 7 June 2024 at [101]-[112].
[1673] Submissions of the Commonwealth dated 7 June 2024 at 20.
[1674]Submissions in reply of Counsel Assisting dated 22 August 2024 at [56].
[1675] Submissions in reply of Counsel Assisting dated 22 August 2024 at [56.1]-[56.5].

Assisting, namely recommendations (a), (o), and (q). To the extent that Mr and Mrs Turner's recommendations are not otherwise covered by those proposed by Counsel Assisting, Counsel Assisting is supportive of the recommendations.[1676]

Consideration

1264. The issues raised by Mr and Mrs Turner are worthy of consideration. I accept that the issues are covered by other recommendations I will make.

Proposed recommendation (f)

1265. Mr and Mrs Turner propose that it be mandated that all psychologists conducting the RtAPS and POPS:

i. consider previous psychological screening results to ensure that they have a complete picture when carrying out individual assessments; and

ii. be trained to ensure they understand and appreciate the importance of their role in identifying and responding appropriately to combat trauma; and

iii. undertake the assessment in an environment that allows the member to fully participate in the assessment.[1677]

Submissions

1266. The ADF relies on its submissions[1678] (summarised above at [567]-[568]) concerning RtAPS and POPS screenings and referrals from such screenings.[1679]

1267. Counsel Assisting's position on this recommendation is summarised at [1263] above.[1680]

Consideration

1268. I accept Counsel Assisting's submission that these matters may be covered by recommendations already made. Nevertheless, given the important role psychologists play in undertaking the RtAPS and POPS screenings, I am satisfied that making the recommendation may have some merit.

[1676] Submissions in reply of Counsel Assisting dated 22 August 2024 at [56.4]-[56.5].
[1677] Submissions of Mr and Mrs Turner dated 28 January 2024 at [64], [69]-[71] and [209].
[1678] Submissions of the Commonwealth dated 7 June 2024 at [101]-[112].
[1679] Submissions of the Commonwealth dated 7 June 2024 at 21.
[1680] Submissions in reply of Counsel Assisting dated 22 August 2024 at [56.1].

Proposed recommendation (g)

1269. Mr and Mrs Turner consider that there should be better education regarding subsyndromal PTSD and an independent review should be undertaken of health files and a policy developed to guide future reviews in similar situations.[1681]

Submissions

1270. The ADF supports a recommendation concerning training/education about PTSD and refers to its proposed amendments to Counsel Assisting's proposed recommendations (b) and (p).[1682]

1271. Counsel Assisting supports the proposed amendments contained in the Commonwealth's response to Counsel Assisting's proposed recommendations (b) and (p) in this regard.[1683]

Consideration

1272. The issue raised is an important one and I make the recommendation in the terms suggested.

Proposed recommendation (h)

1273. Mr and Mrs Turner would like the ADF to consider that where ADF members are discharging on medical grounds for combat-acquired PTSD that it should be seen as a red flag for others within the unit and should trigger suitable interventions where necessary.[1684]

Submissions

1274. The ADF does not support a recommendation to this effect on the basis that this issue was not the subject of appropriate evidence in this Inquest.[1685]

1275. Counsel Assisting's position on this recommendation is summarised at [1263] above. Counsel Assisting supports this recommendation.[1686]

[1681] Submissions of Mr and Mrs Turner dated 28 January 2024 at [209].
[1682] Submissions of the Commonwealth dated 7 June 2024 at 21.
[1683] Submissions in reply of Counsel Assisting dated 22 August 2024 at [93.1] and Annexure A.
[1684] Submissions of Mr and Mrs Turner dated 28 January 2024 at [66] and [209].
[1685] Submissions of the Commonwealth dated 7 June 2024 at 20.
[1686] Submissions in reply of Counsel Assisting dated 22 August 2024 at [56.5].

Consideration

1276. I have considered the issue carefully. I accept that discharge of a member on medical grounds for combat-acquired PTSD would be a very significant event in any unit. In my view, Mr and Mrs Turner's recommendation of calling for assessment of others in the unit is a useful suggestion. It does not appear onerous and yet it has the capacity to identify other members who may be at risk. I intend to make the recommendation.

Proposed recommendation (i)

1277. Mr and Mrs Turner contend that in complex cases, clinical subject matter experts should be engaged to guide and support the Chain of Command in IWBs in relation to their responsibilities to ensure effective care for the mental health and well-being of members in their Chain of Command.[1687]

Submissions

1278. The ADF does not support a recommendation to this effect given that the evidence in this Inquest establishes that welfare boards were attended by appropriate medical and health personnel.[1688]

1279. Joanna Turner agrees with the ADF and does not support the recommendation, noting that relevant personnel on the boards are suitably qualified and adding further to the boards would create complexity.[1689]

1280. Counsel Assisting does not support this recommendation on the basis that suitable medical professionals are already attendees.[1690]

Consideration

1281. I have considered the recommendation and am concerned that introducing a new role at the IWB may complicate rather than improve care. I have decided not to make the recommendation in that form.

Proposed recommendation (j)

1282. Mr and Mrs Turner would like the ADF to review their policies and practices in managing complex psychiatric cases, including clarity on where additional support and when referral to alternative service providers can be requested. It is also submitted

[1687] Submissions of Mr and Mrs Turner dated 28 January 2024 at [96] and [209].
[1688] Submissions of the Commonwealth dated 7 June 2024 at 20.
[1689] Submissions in reply of Joanna Turner at [2(c)].
[1690] Submissions in reply of Counsel Assisting dated 22 August 2024 at [65].

that there should be specialised clinical oversight in managing and making decisions regarding the suitability of activities, duties, and clinical intervention for members in CPL Turner's situation.[1691]

Submissions

1283. The ADF does not support a recommendation to this effect, which appears to propose a total review of the entirety of the ADF's policy framework in relation to mental health issues. It considers that the Royal Commission was the appropriate forum for recommendations of this kind.[1692]

1284. Joanna Turner does not support this recommendation on the basis that she does not consider CPL Turner's case should be used to "inform such broad statements".[1693]

1285. Counsel Assisting is supportive of this recommendation. Contrary to the ADF's position, Counsel Assisting considers that if a matter properly arises for recommendation under s 82(1) of the *Coroners Act*, a coroner is entitled to make a recommendation and should not decline to do so based on supposition of what might occur in another forum such as the Royal Commission. Counsel Assisting considers that the recommendation is not as broad as the ADF appears to characterise it (it being focussed on a subset of "complex psychiatric cases" and a consideration of how additional resources and oversight might occur for such cases).[1694]

Consideration

1286. I can readily see the benefit of reviewing policies and practices governing the way complex psychiatric cases are managed. The evidence in this case demonstrates that there are opportunities to provide clarity about when additional or alternative support is available. There was limited or no clinical oversight regarding the suitability of the activities, duties, and clinical intervention provided. As we have seen, care was fragmented.

1287. In my view, the recommendation arises directly out of the evidence I heard and I intend to make it.

[1691] Submissions of Mr and Mrs Turner dated 28 January 2024 at [185] and [209].
[1692] Submissions of the Commonwealth dated 7 June 2024 at 21-22.
[1693] Submissions in reply of Joanna Turner at [2(d)].
[1694] Submissions in reply of Counsel Assisting dated 22 August 2024 at [92].

Proposed recommendation (k)

1288. Mr and Mrs Turner request that the ADF consider how the Chain of Command above the unit level be informed of the complexity of certain challenging cases and what their response will be to ensure adequate resources are made available to the unit for proper care.[1695]

Submissions

1289. The ADF does not support a recommendation to this effect on the basis that this issue was not the subject of appropriate evidence at the Inquest.[1696]

1290. Counsel Assisting supports this recommendation on the same basis as [1285] above.[1697]

Consideration

1291. I accept that this recommendation touches on matters that were not the subject of direct evidence. I decline making the recommendation.

Proposed recommendation (l)

1292. Mr and Mrs Turner propose that the ADF's policy, *Army Standing Instruction (Personnel) Part 8 Chapter 8: Delivery of Support to Wounded, Injured and Ill Members in the Australian Army (ASI(P) Part 8 Chapter 8)* dated November 2021, be amended to include the following:

    1. If the member is physically unable to attend the WB meeting, the policy is to stipulate who is responsible for providing the member with details of the proceeding and the outcome;

    2. A process of referral in circumstances where the WB is not witnessing an expected trajectory of improvement in the member's condition, the Chain of Command can escalate the matter for additional resource support, including additional clinical input for a higher level of care;

    3. Implementing recommendation (d) arising from a Joint After- Action Review conducted by Special Operations Command and Joint Health Command 195 that Director Garrison Operations be included in quarterly Commander Special

[1695] Submissions of Mr and Mrs Turner dated 28 January 2024 at [209].
[1696] Submissions of the Commonwealth dated 7 June 2024 at 22.
[1697] Submissions in reply of Counsel Assisting dated 22 August 2024 at [91]-[92].

Forces Welfare Board to ensure that complex cases have the adequate resources at the unit level to deliver appropriate care; and

4. Coordination of services.[1698]

Submissions

1293. The ADF does not oppose a recommendation to this effect.[1699]

1294. Counsel Assisting supports this recommendation, noting that the amendments broadly relate to ensuring welfare boards have member involvement and resourcing and can escalate issues up the Chain of Command.[1700]

Consideration

1295. This recommendation arises from the evidence. I make the recommendation.

Proposed recommendation (m)

1296. Mr and Mrs Turner contend that the ADF needs to formulate alternative career pathways that transition from combat roles to other ADF roles or roles outside the ADF once a member suffers traumatic injuries such as PTSD. It should not be a situation where an occupationally acquired mental health illness means no further gainful employment.[1701]

Submissions

1297. The ADF considers that Counsel Assisting's proposed recommendation (j), which it does not oppose, sufficiently addresses this matter.[1702]

1298. Counsel Assisting takes the same view as the ADF on this recommendation.[1703]

Consideration

1299. I accept the submissions of Counsel Assisting and the ADF on this matter. The issue is an important one but I am confident it is covered by Counsel Assisting's recommendation (j). I decline to make the recommendation in this form.

[1698] Submissions of Mr and Mrs Turner dated 28 January 2024 at [209].
[1699] Submissions of the Commonwealth dated 7 June 2024 at 22.
[1700] Submissions in reply of Counsel Assisting dated 22 August 2024 at [66].
[1701] Submissions of Mr and Mrs Turner dated 28 January 2024 at [209].
[1702] Submissions of the Commonwealth dated 7 June 2024 at 23.
[1703] Submissions in reply of Counsel Assisting dated 22 August 2024 at [81].

Proposed recommendation (n)

1300. Mr and Mrs Turner would like to see clearer policy around the management of deceased members personal effects. They contend that there should be some greater transparency such that while recognising the need for the ADF to protect sensitive material, possessions should not be removed and left unaccounted regardless of content.[1704]

Submissions

1301. The ADF does not support a recommendation to this effect. The ADF's view is that in light of the ultimate evidence on this issue, it is doubtful that I would have jurisdiction to make a recommendation to this effect under s 82(1) of the *Coroners Act.* In any event, it is noted that the ADF has existing clear policy addressing the management of deceased members' personal effects, including the *Defence Incident Scene Initial Action and Preservation Manual*[1705] and the *Casualty Manual Chapter 6: Management of Effects for Defence Members Declared Deceased, Missing, Incapacitated or Captured* (which replaced the *Defence Casualty and Bereavement Support Manual Chapter 6: Disposal of effects for Defence Members Declared Deceased, Missing, Incapacitated or Captured*)[1706] A Second Edition of the *Defence Incident Scene Initial Action and Preservation Manual* was released in November 2023.[1707]

1302. Counsel Assisting agrees with the position proffered by the Commonwealth, noting that there is an insufficient evidentiary basis for the recommendation.[1708]

Consideration

1303. While I understand Mr and Mrs Turner's concerns, I accept that at the conclusion of evidence I was unable to establish what happened to CPL Turner's missing property. Given that no breach of established policy or wrongdoing was identified, I accept that this recommendation may be beyond scope. I decline to make the recommendation.

Proposed recommendation (o)

1304. Mr and Mrs Turner suggest that appealing an unsuccessful medical clearance or command waiver should be a formalised process that involves clinicians involved in the direct care of a member making clinically informed assessments about an

[1704] Submissions of Mr and Mrs Turner dated 28 January 2024 at [161] and [209].
[1705] Exhibit 59 at 1.
[1706] Exhibit 59 at 19.
[1707] Submissions of the Commonwealth dated 7 June 2024 at 23.
[1708] Submissions in reply of Counsel Assisting dated 22 August 2024 at [89].

individual. The role and responsibilities of a medical officer need to be clearly defined to ensure that a proper and unbiased perspective is provided.[1709]

Submissions

1305. The ADF repeats its response to Counsel Assisting's proposed recommendations (l), (m), and (n).[1710]

1306. Counsel Assisting considers that the recommendation is likely to be unnecessary if Counsel Assisting's recommendations (m) and (n) are modified in the manner suggested by Mr and Mrs Turner.[1711]

Consideration

1307. I agree with Counsel Assisting's submission that the recommendation is adequately addressed by other recommendations I intend to make.

Proposed recommendation (p)

1308. Mr and Mrs Turner suggest that the ADF should clearly delineate the difference between a medical clearance and a command waiver and ensure that all documentation including policies and forms used in the process reflect that delineation.[1712]

Submissions

1309. The ADF repeats its response to Counsel Assisting's proposed recommendations (l),(m), and (n).[1713] On the point of the distinction between command waivers and medical clearances, the ADF observes that "[w]hile the processes are distinct, they are not hermetically sealed. The Chain of Command may have input into the medical clearance process and health practitioners may give medical advice during the command waiver process".[1714]

1310. Counsel Assisting considers that the ADF's submission on this recommendation underscores the need for clarity in this context notwithstanding the conceptual distinction between medical clearances and command waivers. Counsel Assisting supports this recommendation.[1715]

[1709] Submissions of Mr and Mrs Turner dated 28 January 2024 at [173] and [209].
[1710] Submissions of the Commonwealth dated 7 June 2024 at 23.
[1711] Submissions in reply of Counsel Assisting dated 22 August 2024 at [76].
[1712] Submissions of Mr and Mrs Turner dated 28 January 2024 at [178] and [209].
[1713] Submissions of the Commonwealth dated 7 June 2024 at 23.
[1714] Submissions of the Commonwealth dated 7 June 2024 at [300].
[1715] Submissions in reply of Counsel Assisting dated 22 August 2024 at [78].

Consideration

1311. As I have already stated, there was significant confusion during the Inquest about the precise relationship between a command waiver and medical clearance demonstrated by senior officers and medical staff. Every time a clear distinction was drawn, there was further evidence indicating the distinction was not so clear. The Commonwealth's response to this recommendation proposal concerns me and I accept Counsel Assisting's submission that the lack of clarity on the distinction between the two concepts increases rather than reduces the need for the recommendation.

1312. I intend to make the recommendation which, in my view, highlights an important issue which arises directly from the evidence in this matter. If the delineation is already clear, the work involved will not be onerous.

Proposed recommendation (q)

1313. Mr and Mrs Turner suggest that the Australian Government and the ADF "review the decisions that result in a few select ADF units undertaking the main combat" in Afghanistan.[1716]

Submissions

1314. The ADF's view is that this recommendation is beyond the scope of s 82(1) of the *Coroners Act*.[1717]

1315. Counsel Assisting adopts the same view as the ADF in relation to this recommendation.[1718]

Consideration

1316. This proposed recommendation raises a very significant issue, however, I accept it is beyond the scope of s 82 of the *Coroners Act*.

Proposed recommendation (r)

1317. Mr and Mrs Turner suggest that the ADF consider undertaking research regarding the value of a transition period between a member being on operations and returning to a domestic environment and the extent, in terms of time required to make such a transition.[1719]

[1716] Submissions of Mr and Mrs Turner dated 28 January 2024 at [209].
[1717] Submissions of the Commonwealth dated 7 June 2024 at 24.
[1718] Submissions in reply of Counsel Assisting dated 22 August 2024 at [93.2].
[1719] Submissions of Mr and Mrs Turner dated 28 January 2024 at [209].

Submissions

1318. The ADF does not support a recommendation to this effect on the basis that it was not subject to appropriate evidence in the Inquest.[1720]

1319. Counsel Assisting supports this recommendation and considers that this is a relevant ancillary consideration to the consideration of ADF members' schedules of deployments and periods of leave taken and that CPL Turner's transition into the home environment following deployment was a matter which was the subject of evidence in the Inquest.[1721]

Consideration

1320. In my view, the proposed recommendation raises an important issue for research consideration. The evidence reflected the difficulty involved in CPL Turner's transitions home. The ADF would be well served by research that examined this issue.

1321. I am comfortable the proposed recommendation arises from the evidence and I intend to make it.

Proposed recommendation (s)

1322. Mr and Mrs Turner propose that the ADF give consideration as to how they might facilitate members having supervised visits with their children if there are Family Court proceedings in progress and access to their children is problematic, particularly in the context of mental health issues related to service.[1722]

Submissions

1323. The ADF does not support this recommendation on the basis that it is not within the ambit of s 82(1) of the *Coroners Act*.[1723]

1324. Joanna Turner does not support the recommendation and considers that this is a matter for the Family Court.[1724]

1325. Counsel Assisting agrees with the ADF's conclusion on this recommendation and, accordingly, does not support the recommendation.[1725]

[1720] Submissions of the Commonwealth dated 7 June 2024 at 24.
[1721] Submissions of Counsel Assisting dated 2 November 2023 at [62]-[65].
[1722] Submissions of Mr and Mrs Turner dated 28 January 2024 at [209].
[1723] Submissions of the Commonwealth dated 7 June 2024 at 24.
[1724] Submissions in reply of Joanna Turner at [2(e)].
[1725] Submissions in reply of Counsel Assisting dated 22 August 2024 at [93.4].

Consideration

1326. In my view, this recommendation goes beyond my purview. I decline to make it.

Recommendations proposed by Joanna Turner

Proposed recommendation 1

1327. Joanna Turner proposes that external health providers should not assess or comment on the employability or deployability of ADF members. She also notes that "a Command referral PM008 should [have] been requested and a military psychiatrist and/or psychologist complete a comprehensive file review and in person assessment".[1726]

Submissions

1328. The ADF repeats its responses to Counsel Assisting's proposed recommendations (l), (m), and (n) in relation.[1727]

1329. As to the first aspect of the recommendation/submission, Counsel Assisting does not agree that the evidence would support such a recommendation. Rather, as has been emphasised in relation to Dr Sringeri's letter of 13 July 2016, flaws arose in the pre-deployment process from a lack of clarity as to the nature of the opinion being sought from Dr Sringeri, the information on which that opinion was based, how that opinion was expressed and what it conveyed to the reader, and where the responsibility lay for the final determination of fitness to deploy. The fact that Dr Sringeri was an external practitioner did not, in and of itself, contribute to the flawed process.[1728]

1330. As to the second aspect of the recommendation/submission, the substance of it is adopted by Counsel Assisting's recommendations (l), (m), and (n).[1729]

1331. Counsel Assisting does not support a recommendation that external health providers should not be involved in assessments of employability or deployability. Counsel Assisting notes there is no evidentiary basis for this arising from this Inquest. In respect of a pre-deployment assessment, Counsel Assisting does not oppose such a recommendation, but considers the substance of Joanna Turner's proposal is

[1726] Submissions of Joanna Turner dated 17 January 2024 at [1].
[1727] Submissions of the Commonwealth dated 7 June 2024 at 16-18, 24.
[1728] Submissions in reply of Counsel Assisting dated 22 August 2024 at [111].
[1729] Submissions in reply of Counsel Assisting dated 22 August 2024 at [112].

adequately adopted by Counsel Assisting's proposed recommendations (l), (m), and (n).[1730]

Consideration

1332. In my view, while the evidence reveals that there were real flaws in the pre-deployment process and the use and content of the Dr Sringeri letter, it does not allow me to make a blanket finding that external providers should never be involved in deployability decisions. I accept that the other aspects of Joanna Turner's suggestion are adequately covered by recommendations I have already made.

Proposed recommendation 2

1333. Joanna Turner proposes that Special Operations units should only employ of a MAJ or above rank, as this would ensure that the psychologist has both the experience in profession and rank to understand complex cases, which are more likely in high tempo units.[1731]

Submissions

1334. The ADF does not support a recommendation to this effect and notes that, as discussed in its response to Counsel Assisting's proposed recommendations (g), (h) and (i), the ADF is currently facing significant workforce/recruitment challenges, including in relation to medical and health personnel. The ADF is of the view that requiring psychologists to have the rank of Major or above would "greatly exacerbate" those challenges.[1732]

1335. Joanna Turner submits that "workforce issues" ought not outweigh considerations of "[q]uality of care" and that CPL Turner's quality of care declined when under the care of psychologists with the rank of Captain.[1733]

1336. Counsel Assisting does not support this recommendation, noting that mere rank does not (and need not) necessarily correlate to quality of care nor the assertiveness with which it can be provided.[1734]

[1730] Submissions in reply of Counsel Assisting dated 22 August 2024 at [110]-[111].
[1731] Submissions of Joanna Turner dated 17 January 2024 at [2].
[1732] Submissions of the Commonwealth dated 7 June 2024 at 25.
[1733] Submissions in reply of Joanna Turner at [3(a)].
[1734] Submissions in reply of Counsel Assisting dated 22 August 2024 at [114].

Consideration

1337. I understand that the management of a person such as CPL Turner would require considerable skill and authority. However, I am persuaded that mandating a rank would be unlikely to ensure the quality of care required. I decline to make the recommendation.

Proposed recommendation 3

1338. Joanna Turner encourages the ADF to consider education for units, in particular male dominated units, regarding the ethical and moral treatment of women. Joanna Turner submits that greater emphasis ought to have been placed by the ADF on "[p]rotecting the family unit" for a member suffering from ill mental health as the family provides a "secure base of support".[1735]

Submissions

1339. The ADF does not oppose a recommendation to this effect, noting that significant work has already been done (and is ongoing) in relation to family and domestic violence policies and procedures.[1736]

1340. Counsel Assisting does not oppose a recommendation to this effect and notes that Counsel Assisting's proposed recommendation (c) is directly relevant to the concern raised in this recommendation.[1737]

Consideration

1341. In my view, this is an important recommendation that arises directly from the evidence before me. The need for education in this area is revealed by the ADF's treatment of Joanna Turner and the frequent failure to recognise and name the family violence which was occurring. Her concerns were frequently ignored and using euphemisms such as "marital issues" were used to describe what was in fact family violence. The Court also had the opportunity to read personal texts from a number of ADF members. This strengthened my concern about a culture which devalued women.

1342. I intend to make the recommendation, which I note was not opposed by the ADF.

[1735] Submissions of Joanna Turner dated 17 January 2024 at [3].
[1736] Submissions of the Commonwealth dated 7 June 2024 at 25.
[1737] Submissions in reply of Counsel Assisting dated 22 August 2024 at [116]-[117].

Proposed recommendation 4

1343. Noting the duty of care owed by the ADF to her family in relation to the reports made of family violence and dangerous consumption of substances in the family home, Joanna Turner submits that the ADF should be required to follow risk of harm reporting protocols (i.e., reporting to Family and Community Services).[1738] Joanna Turner asserts there was a breach of relevant legal reporting obligations in CPL Turner's case.[1739]

Submissions

1344. The ADF does not support a recommendation to this effect, as it has existing reporting requirements in place for reporting family and domestic violence and other matters. Some of those reporting requirements are outlined in documents included in Exhibit 38 of the ADF's submissions, including *A Commanders and Managers Guide to Responding to Family and Domestic Violence*, which takes into account relevant internal and external reporting requirements, and privacy and confidentiality laws.[1740]

1345. Counsel Assisting does not consider that the sufficiencies of the ADF's existing reporting mechanisms to *external* agencies was sufficiently explored in the evidence so as to ground a finding or recommendation of the kind proposed by Joanna Turner. While no finding is sought that the ADF breached "child protection laws" (as asserted by Joanna Turner), Counsel Assisting refers to the evidence concerning how the ADF responded *internally* to reports of domestic violence, how it monitored and engaged with Joanna Turner following direct reports to the ADF of domestic violence, and how it monitored the external criminal proceedings that related to domestic violence.[1741]

Consideration

1346. While the issue is an important one, I accept Counsel Assisting's submission that the issue of external reporting obligations was not sufficiently explored in the evidence before me and I decline to make the recommendation.

Proposed recommendation 5

1347. Joanna Turner proposes that the ADF administration policies be reviewed and reconsidered, noting the changes made to CPL Turner's will and the removal of herself and her son from his PMKeyS without CPL Turner needing to provide any

[1738] Submissions of Joanna Turner dated 17 January 2024 at [4].
[1739] Submissions in reply of Joanna Turner at [3(b)].
[1740] Submissions of the Commonwealth dated 7 June 2024 at 25.
[1741] Submissions in reply of Counsel Assisting dated 22 August 2024 at [119].

documentation.[1742]Joanna Turner proposes that changes to a member's will and removal of family remembers from PMKeyS should not occur "without command approval" (noting that the changes made to CPL Turner's will and the removal of herself and her son from his PMKeyS were done without CPL Turner needing to provide any documentation).[1743]

Submissions

1348. The ADF does not support such a recommendation on the basis that it was not the subject of appropriate evidence at the Inquest.[1744]

1349. In her reply submissions, Joanna Turner presses the necessity of a review of this process.[1745]

1350. Counsel Assisting does not support this recommendation as it is not considered appropriate (or indeed lawful) for a member of the ADF to be subject to "command approval" prior to changes being made to their will. It is not accepted by Counsel Assisting that a mere change to a serving member's will or amendment to PMKeyS would of itself give rise to particular concern so as to warrant a recommendation of the breadth proposed by Joanna Turner.[1746]

Consideration

1351. I consider this issue, while clearly important to Joanna Turner, as beyond my purview.

Recommendations proposed by GPCAPT Ross

Proposed recommendation 1

1352. GPCAPT Ross proposes that the Joint Health Command investigate whether the ADF should retain or revise its policy that an ADF member who has a history of PTSD, irrespective of whether that person is symptomatic or asymptomatic, is capable of being deployed to a combat or combat-related role.[1747]

Submissions

1353. The ADF supports the intent behind this recommendation but does not support the recommendation in its present form. The ADF considers that the more appropriate

[1742] Submissions of Joanna Turner dated 17 January 2024 at [5].
[1743] Submissions of Joanna Turner dated 17 January 2024 at [5].
[1744] Submissions of the Commonwealth dated 7 June 2024 at 25.
[1745] Submissions in reply of Joanna Turner at [3(e)].
[1746] Submissions in reply of Counsel Assisting dated 22 August 2024 at [120]-[121].
[1747] Submissions of GPCAPT Ross dated 5 June 2024 at [127](g)-(h)].

course would be for this issue to be addressed in the context of any evidence-based review that the ADF decides to conduct pursuant to Counsel Assisting's proposed recommendation (k). This would ensure that any change in ADF policy that might ultimately be considered/made would have a sound basis in existing and emerging psychiatric, psychological, and medical evidence.[1748]

1354. Counsel Assisting does not support this recommendation on the basis that this recommendation would be adequately covered by Counsel Assisting's proposed recommendations (l), (m), and (n) (or the Commonwealth's alternative).[1749]

Consideration

1355. I consider the issue raised by this proposed recommendation is adequately covered by recommendations I have already made. I decline to make it.

Recommendations proposed by CAPT MH

Proposed recommendation 1

1356. CAPT MH suggests that consideration be given to providing specific training to ADF personnel in understanding and dealing with members with PTSD, which should include simulations of realistic situations which may be encountered and methods of decision making as to how to handle situations dealing with mental health issues.[1750]

Submissions

1357. Mr and Mrs Turner support this recommendation.[1751]

1358. The ADF considers that Counsel Assisting's recommendation (b) sufficiently addresses this matter and (as noted above) further indicates that it would not oppose an amendment to (b) to include at the end of the current recommendation the words "which appropriately includes simulations of real-life scenarios and recommendations about methods of decision-making".[1752]

1359. Counsel Assisting supports the intent of CAPT MH's recommendation but considers that it is adequately addressed by Counsel Assisting's recommendation (b) (as modified by the Commonwealth's proposed modification).[1753]

[1748] Submissions in reply of the Commonwealth dated 22 July 2024 at 2.
[1749] Submissions in reply of Counsel Assisting dated 22 August 2024 at [180].
[1750] Submissions of CAPT MH dated 7 June 2024 at [46]-[48].
[1751] Submissions in reply of Mr and Mrs Turner dated 22 July 2024 at [2].
[1752] Submissions in reply of the Commonwealth dated 22 July 2024 at 2.
[1753] Submissions in reply of Counsel Assisting dated 22 August 2024 at [142]-[143].

Consideration

1360. I see great benefit in training that includes simulations of real-life scenarios and recommendations for decision making. I intend to have the Commonwealth's modification added to recommendation (b).

Recommendations proposed by CPL TJ

Proposed recommendations 1, 2, and 3

1361. CPL TJ proposes that a recommendation be made regarding the introduction of an Employee Assistance Program (**EAP**) within the ADF that would facilitate the ability of both ADF members and their families and loves ones to seek on behalf of the member 24 hour medical/psychological support services in times of crises (Recommendation 1). CPL TJ suggests that the EAP be independent of the ADF (but also linked to in order to facilitate access to ADF medical records in order to prevent concerns of issues being "back-briefed" to the Chain of Command (Recommendation 2). CPL TJ also proposes that the EAP be in the form of an iOS/Android application for reasons of accessibility (Recommendation 3).[1754]

Submissions

1362. These recommendations are supported by Mr and Mrs Turner.[1755]

1363. The ADF opposes these recommendations on the grounds that there are already medical/psychological systems in place for ADF members and the public at large and the suggested EAP raises legal, ethical, and policy restrictions concerning patient privacy and confidentiality in relation to the sharing of ADF member's health information. The Commonwealth also submits that the proposed service would be beyond the capacity and remit of Joint Health Command and the ADF more broadly. It is also noted that the benefit for members in the current approach is that it "avoid[s] concerns about fragmentation/coordination of care and to ensure that operational personnel have access to information that they "need to know".[1756]

1364. Counsel Assisting does not support the system as proposed by CPL TJ, particularly as it relates to ADF members on the basis that the proposed "non-ADF system" may have the effect of undermining the longitudinal management and organisational

[1754] Submissions of CPLT TJ dated 7 June 2024 at [54].
[1755] Submissions in reply of Mr and Mrs Turner dated 22 July at [2].
[1756] Submissions in reply of the Commonwealth dated 22 July 2024 at 3-4.

oversight of members' mental health to which many of Counsel Assisting's recommendations are directed.[1757]

Consideration

1365. I accept Counsel Assisting's submissions on this matter. I am concerned that introducing a non-ADF system may have the unwanted effect of undermining the longitudinal management and oversight of a member's mental health. I decline to make the recommendation.

FINDINGS

1366. The findings I make under s 81(1) of the *Coroners Act 2009* (NSW) are:

Identity

The person who died was Ian Turner

Date of death

He died between 14 and 15 July 2017.

Place of death

He died at 206/18 Amelia Street, Waterloo, NSW.

Cause of death

He died of multi-drug toxicity. The antecedent cause was combat-related Post Traumatic Stress Disorder (PTSD).

Manner of death

His death was intentionally self-inflicted in the context of combat-related PTSD.

Recommendations

1367. For the reasons stated above and pursuant to s 82 of the *Coroners Act*, I recommend that the Chief of the Defence Force give consideration to:

1. Introducing a systematic process for mapping the history of an ADF member's deployments, their RtAPS and POPS screens data, and other reported psychiatric

[1757] Submissions in reply of Counsel Assisting dated 22 August 2024 at [150].

diagnoses and treatment, that forms part of a member's health record and including systems to record and action such notifications and to ensure that they are taken into account in decisions relating to deployment.

2. Including a mandatory annual training for all Special Forces members in recognising and destigmatising the symptoms of and managing PTSD, which appropriately includes simulations of real-life scenarios and recommendations about methods of decision-making.

3. Establishing a system by which psychological distress in the home environment can be communicated to an ADF member's unit by family members including systems to record and action such notifications and to ensure that they are taken into account in decisions relating to deployment.

4. Providing opportunities for ADF families to be notified of and involved in treatment programs provided to ADF members for PTSD and other combat-related psychological conditions.

5. Making it a requirement that the impact upon mental health be taken into account in decisions relating to deployment, change of company, or support of members' study plans or transitional plans to non-combat roles within the ADF or employment roles outside the ADF.

6. Implementing a requirement for psychological screening and support to be automatically offered to ADF members who are undergoing disciplinary proceedings.

7. Providing psychological screening and support whilst on deployment to ADF members who have previously been diagnosed with PTSD.

8. Employing enlisted ADF psychiatrists with:

    i. specialist training in military and veterans' psychiatry; and

    ii. security clearances at a level consistent with the clearances of the ADF members who are being treated by them.

9. Ensuring that enlisted psychologists and contracted psychologists have security clearances at a level consistent with the clearances of the ADF members who are being treated by them.

10. Establishing systems and a culture of transition from Special Forces, including providing adequate support for transitions:

    i. to non-combat roles within the ADF; and

    ii. to employment roles outside the ADF.

11. Undertaking an evidence-based review as to whether and how the ADF should limit the number of combat deployments upon which an ADF member can deploy during their career before being required to transition to non-combat roles.

12. Reviewing the ADF policy framework with respect to the making of deployment decisions for ADF members who have or have had a diagnosis of PTSD or another similar mental health condition, with a view to developing clear guidelines and procedures about:

    i. How such decisions should be made (including whether and how they can be “appealed”);

    ii. The roles and responsibilities of operational personnel, medical personnel and any external health practitioners in the making of such decisions;

    iii. The information to which operational personnel, medical personnel and any external health practitioners may and may not have access in making such decisions; and

    iv. In the event that a decision to deploy is made, the development and implementation of risk mitigation strategies (a plan of action should also be formulated as part of the mitigation plan/strategy in the event the condition for which the ADF member received a clearance or waiver begins to deteriorate).

13. Promptly notifying the Chain of Command by issuing a simple alert where an RtAPS or POPS reveals severe PTSD symptoms and permission to advise the Chain of Command is not forthcoming..

14. Implementing training programs for ADF members in command roles in relation to PTSD, including the identification of PTSD symptoms and the appropriate management of soldiers experiencing PTSD.

15. Reviewing the management of soldiers suffering from mental health conditions in 2CDO in consideration of:

    i. best clinical practice;

    ii. longitudinal management of conditions and treatments; and

    iii. the appointment of a single point of coordination and responsibility for the overall treatment of the individual.

16. Reviewing the role of the padre in relation to the identification, treatment, and management of soldiers with mental health conditions in 2CDO.

17. Implementing a system whereby the ADF formally track the time members deploy by establishing a system for mapping the history of an ADF members leave entitlements, the leave taken, and lapsing/lapsed leave and to ensure that they are considered in decisions relating to deployments.

18. Undertaking a study of the effects of repeated deployments on a member's home and family life.

19. Conducting greater research and analysis on the correlation between incidents of domestic violence and PTSD and considering the impact of vicarious trauma on intimate partners and children of ADF members and, in turn, their ability to support the ADF member, which could include undertaking a study that investigates the decompensation of members with PTSD on or around the dates of the traumas experienced by the members.

20. Requiring all ADF psychologists conducting the RtAPS and POPS to:

    i. consider previous psychological screening results to ensure that they have a complete picture when carrying out individual assessments;

    ii. be trained to ensure they understand and appreciate the importance of their role in identifying and responding appropriately to combat trauma; and

    iii. undertake the assessment in an environment that allows the member to fully participate in the assessment.

21. Providing better education regarding subsyndromal PTSD and undertaking an independent review of health files and developing a policy to guide future reviews in similar situations.

22. Implementing a system whereby where ADF members are discharging on medical grounds for combat-acquired PTSD, it should be seen as a red flag for others within the unit and should trigger suitable interventions where necessary.

23. Reviewing ADF policies and practices in managing complex psychiatric cases, including clarity on where additional support and when referral to alternative service providers can be requested and ensuring that there is specialised clinical oversight in managing and making decisions regarding the suitability of activities, duties, and clinical intervention for members in CPL Turner's situation.

24. Amending the ADF's policy, *Army Standing Instruction (Personnel) Part 8 Chapter 8: Delivery of Support to Wounded, Injured and Ill Members in the Australian Army (ASI(P) Part 8 Chapter 8)* dated November 2021, by including the following:

    i. If the member is physically unable to attend the welfare board meeting, the policy is to stipulate who is responsible for providing the member with details of the proceeding and the outcome;

    ii. A process of referral in circumstances where the welfare board is not witnessing an expected trajectory of improvement in the member's condition, the Chain of Command can escalate the matter for additional resource support, including additional clinical input for a higher level of care;

    iii. Implementing recommendation (d) arising from a Joint After-Action Review conducted by Special Operations Command and Joint Health Command 195 that Director Garrison Operations be included in quarterly Commander Special Forces Welfare Board to ensure that complex cases have the adequate resources at the unit level to deliver appropriate care; and

    iv. Coordination of services..

25. Clearly delineating the difference between a medical clearance and a command waiver and ensure that all documentation including policies and forms used in the process reflect that delineation.

26. Undertaking research regarding the value of a transition period between a member being on operations and returning to a domestic environment and the time required to make such a transition.

27. Providing education for units, in particular male dominated units, regarding the ethical and moral treatment of women and placing greater emphasis on "[p]rotecting the family unit" for a member suffering from ill mental health.

CONCLUSION

1368. I am aware the inquest process has been extremely painful for Joanna Turner and her children, for CPL Turner's parents and siblings, for CPL TJ, and for members of the ADF and others who loved and respected CPL Turner. Their commitment to these difficult proceedings was clearly motivated by a desire to shine a light on the systems and procedures which failed him. I know they hope there will be changes to ADF policies and procedures that may protect others from future harm.

1369. CPL Turner was unwell for an extended period. His behaviour must be understood in that context. In my view, a greater institutional understanding of PTSD might have protected not just CPL Turner, but also those around him. I intend to send a copy of these Findings to the Chief of the Defence Force and to the Minister for Defence. The ADF must understand and grapple with the real effects of PTSD at the highest levels of the organisation.

1370. I acknowledge the particular pain those close to CPL Turner experienced when searingly personal details of his and their lives were revealed and discussed in open court. It was a high price to pay. I accept that they endured it in the hope that the Inquest could support change within the ADF. Their ongoing participation in the inquest has protected the integrity of the proceedings and their contribution to the recommendation process has been meaningful and appreciated.

1371. It is necessary to say something about the effect of the quite considerable delays in these proceedings. I am sure it extended the suffering of those involved. It is regrettable and while there were many factors involved, the inadequate resourcing of this Court cannot be ignored. I am sorry that CPL Turner's brother Steven is not present with us today and I offer his family my sincere condolences for their profound loss.

1372. I wish to thank the assisting team for their very great assistance in this matter. Their deep commitment to these proceedings was extraordinary. I thank Kristina Stern SC (now Justice Stern SC) and her able junior counsels Madeleine Ellicott and Naomi Wootton. When Kristina Stern SC was elevated to the bench, a huge task fell to Ms Wootton. I am especially grateful to her. I would also like to thank Edward McGinness for stepping in to assist Ms Wootton at the conclusion of these proceedings. I have

also been assisted by a number of solicitors in the conduct of this inquest. Paul Armstrong's commitment in the preparation and conduct of these proceedings was unparalleled and I specifically thank him. James Prindiville of the CSO has assisted in this final stage with his usual skill and tenacity.

1373. It is important to say that CPL Turner was so much more than an example of PTSD we can learn from. He was clearly a charismatic, intelligent, and much loved man. He was a highly respected soldier who served this country to the best of his ability. He was loyal to his fellow commandos and he expected much from the soldiers he led. His life is not defined by the chaos and pain that resulted from his poorly managed PTSD and related substance use. Inquest proceedings are not about blame or liability. We conduct them to find clarity about what occurred and to consider change where change is needed. As a community we must learn something from CPL Turner's journey from optimistic recruitment to the ADF to his final terrible despair. I trust that the recommendations that have arisen from the evidence in these proceedings will be given careful consideration by the ADF.

1374. Finally, once again I offer my personal condolences to those who loved CPL Turner. I am so sorry for your profound loss.

Magistrate Harriet Grahame
Deputy State Coroner
NSW Coroners Court, Lidcombe
19 December 2024

ANNEXURE A: DRAMATIS PERSONNAE

ADF PERSONNEL (with pseudonyms)		
Pseudonym	**Role**	**Relevant Period for the Inquest**
MAJ AF (also referred to as LTCOL AF)	Officer Commanding, B Coy, 2CDO	2016 - 2017
MAJ AM (also referred to as LTCOL AM)	Senior Regimental Medical Officer at 2 CDO. Was involved with obtaining a medical waiver for CPL Turner to be deployed to Iraq in 2016.	Jan 2014 – Dec 2016
MAJ BJ	Captain in Bravo Coy, 2 CDO. Undertook two overseas deployments and one domestic deployment as Junior Platoon Commander with CPL Turner.	Nov 2013 - 2017
MAJ CM	Executive officer at 2CDO at the time of CPL Turner's death	Jul 2017
LCPL DL	Deployed in CPL Turner's team to Afghanistan and Iraq.	2012 – 2015
WO2 DP	Company Sergeant Major of Bravo Coy, 2 CDO.	2018
WO1 EL	Regimental Sergeant Major of 2 CDO.	Jan 2016 - Jan 2018
BRIG GD	Commander Special Forces at Special Operations Headquarters. Met with Person 1 re concerns about Human Performance Wing.	April 2018
LTCOL GG	2CDO member, Acting CO of 2CDO	2014-2015
COL HM (also referred to as BRIG HM)	Presided over proceedings against CPL Turner for the cock card incident.	Jul 2016
MAJ JP	Platoon commander in Bravo Coy, 2 CDO around 2010-2012 and the XO of SOTG in 2015. Wrote a reference for CPL Turner for his Local Court appearance on 3 April 2014.	2010 - 2015
CPL JW	Team commander within Bravo Coy, 2 CDO from 2008 to 2017. Deployed with CPL Turner to Afghanistan and Iraq.	2008-2017
COL KS	Special operations headquarters chief of staff. Advised BRIG GD in relation to the issues raised by PERSON 1.	April/May 2018
COL L	Commanding Officer SOER.	Jun 2016
LTCOL LS	Special operations headquarters chief legal officer. Advised BRIG GD in relation to the issues raised by PERSON 1.	April/May 2018
COL MF (also referred to as BRIG MF)	Commanding Officer, 2 CDO	2016 - 2017

CAPT MH (also referred to as MAJ MH)	Platoon Commander of R Platoon, B Coy, 2 CDO.	2016 - 2017
WO2 MM	Personnel officer who attended Welfare Board held on 7 July 2017.	Jul 2017
MP (also referred to as Padre MP, Chaplain MP and MAJ MP)	Padre of 2 CDO.	2016 - 2017
SGT NA	Section Commander, B Coy, 2 CDO	2015-2018
LTCOL NJ	Commanding Officer of OP OKRA.	Jun 2016
WO2 NW	CSM of B Coy, 2 CDO. Served provisional AVO on CPL Turner whilst on a course at Singleton.	Apr 2014
PERSON 1	Personnel Officer for 2 CDO. Emailed and subsequently met with BRIG GD re concerns about Human Performance Wing.	Feb 2017 to Sep 2018
LCPL RG	A friend of CPL Turner's	Around 2017
CPL SM	Friend of CPL Turner who collected him from home in November 2013 after he had returned drunk from the memorial service for Cameron Baird.	2013
LTCOL SW	CO of Bravo Coy, 2 CDO. Wrote a reference for CPL Turner which was tendered at his disciplinary hearing into the cock card incident.	2008-2009
CPL TJ (also referred to as SGT TJ)	Deployed to Iraq with CPL Turner in 2016 and commenced a relationship with him.	2016-2017

ADF PERSONNEL (named)		
Name	**Role**	**Relevant Period**
CPL CAMERON BAIRD	Close friend of CPL Turner who died on 22 June 2013, Oruzgan, Afghanistan. Posthumously awarded the VC.	2013
SGT MATTHEW CARDINAELS	Leader of the Human Performance Wing, 2 CDO. Responsible for CPL Turner's rehabilitation and found CPL Turner's body.	2016 - 2017
MAJ SELENA CLANCY (also referred to as SELENA CLANCY)	2CDO welfare officer. Family liaison officer allocated to Joanna Turner.	2014 – Oct 2015

BRIG LANGFORD (also referred to as COL Langford and BRIG IL)	CO, 2 CDO.	2014 - 2015
CAPT ZOE LIPPIS	Legal Officer at AMAB	2016
EDDIE ROBERTSON	Ex-commando who knew CPL Turner well. Responded to a set of questions posed by Mike Turner.	-
PTE DAMIEN THOMLINSON	Friend of CPL Turner who lost both his legs when his vehicle was struck by an IED on 3 April 2009. CPL Turner witnessed the injury and applied first aid.	2009
PTE LUKE WORSLEY	Close friend of CPL Turner who died during a building clearance operation in Afghanistan on 23 November 2007	2007

ADF PERSONNEL (medical)		
Name/Pseudonym	**Role**	**Relevant Period**
ANDREA CANTWELL	Clinical Psychologist at Tobruk Lines Regimental Aid Post (designated health facility for Special Forces personnel stationed at Holsworthy) who treated CPL Turner in March 2017.	Mar 2017
DR BRENDAN HALE	Full time GP with ADF from January 2013 to present. GP at Holsworthy barracks from 2014 – 2017. Provided treatment to CPL Turner following his return from deployment in Iraq from approximately 31 January 2017 to the time of death.	2014 - 2017
CAPT KV (also referred to as MAJ KV)	Unit psychologist at 2 CDO. Took over psychological care of CPL Turner from Andrea Cantwell in March 2017.	2016 and 2017
MAJ LK	Was copied on MAJ AM's submission in support of grant of medical clearance.	Jun 2016
CAPT KH	Psychologist at 2CDO.	2015
CAPT McLEAN	ADF psychologist	2017
DR MM (also referred to as LTCOL MM)	GP at the Tobruk Clinic at Holsworthy.	2014
DR PA	GP at Tobruk Clinic. Supported CPL Turner's application for medical waiver to attend promotion course in August 2014.	2014
DR REPPAS	Unit medical officer.	Jul 2017
GPCAPT ROSS	J07 HQJOC.	Jun 2016

CAPT SG	2 CDO psychologist.	April/May 2014
CAPT SW	Medical officer at 2CDO.	2016 - 2017
DR DUNCAN WALLACE	ADF psychiatrist in 2015; spoke to CAPT KH about CPL Turner/Joanna Turner in September 2015	September 2015

NON-ADF MEDICAL PERSONNEL		
Name	**Role**	**Relevant Period**
DR MALIK	Visiting psychiatric medical officer at St John of God Hospital, Richmond. Treated CPL Turner from 24 April 2017 when he was admitted to the St John of God Hospital	Apr 2017 – Jul 2017
CARMEL POULTER	Rehabilitation consultant engaged by the ADF	2017
DR SRINGERI	Consultant psychiatrist at the Sydney Southwest Private Hospital. Treated CPL Turner for PTSD, alcohol dependence, etc. from April 2014 until April 2017.	Apr 2014 – Apr 2017
DR JESSICA SWAIN	External psychologist engaged by the ADF	2017

FAMILY MEMBERS	
Name/Pseudonym	**Relationship**
Joanna Turner	CPL Turner's wife
XS	CPL Turner's stepson
ET	CPL Turner's daughter
Mike Turner	CPL Turner's father
Pat Turner	CPL Turner's mother
Christine Turner	CPL Turner's sister
Karen Hossain	CPL Turner's sister
Lisa Hammond	CPL Turner's sister
Steven Turner	CPL Turner's brother (now deceased)

OTHER INDIVIDUALS	
Name	**Relationship**
Hannah Steele	Friend of CPL Turner.

ANNEXURE B: DEFINED TERMS / ACRONYMS

LOCATIONS (overseas)	
Term/Acronym	**Meaning**
AMAB	Al Minhad Air Base, military installation in the United Arab Emirates
TQ	At-Taqaddum military airbase in Iraq
BDSC	Baghdad Diplomatic Support Centre

LOCATIONS (in Australia)	
Term/Acronym	**Meaning**
TLHC	Tobruk Lines Health Centre

ADF ORGANISATIONAL TERMS	
ADF	Australian Defence Force
SOCOMD	Special Operations Command
SOTG	Special Operations Task Group
HQJOC	Headquarters Joint Operations Command
2CDO	2nd Commando Regiment
B Coy	Bravo Company, one of four infantry companies making up 2 CDO
C Coy	Charlie Company, one of four infantry companies making up 2 CDO
SOER	Special Operations Engineer Regiment
JHC	Joint Health Command
IGADF	Inspector General Australian Defence Force
ADFIS	Australian Defence Force Investigative Service

ADF RANKS / POSITIONS	
CO	Commanding Officer - Commands a battalion or equivalent and is ranked as a Lieutenant-Colonel.
OC	Officer Commanding - usually a Major who commands a sub-unit of a battalion (or equivalent) such as a Company.
J07 HQJOC	Director Health, Headquarters Joint Operations Command.
RMO	Regimental Medical Officer.
XO	Executive Officer.
NCO	Non-commissioned Officer (e.g. Corporal, Sergeant, Warrant Officer).
RSM	Regimental Sergeant Major (most senior NCO role in a Battalion).
CSM	Company Sergeant major (most senior NCO role in a Company).
BRIG	Brigadier
COL	Colonel
LTCOL	Lieutenant Colonel
MAJ	Major
GPCAPT	Group Captain (RAAF Rank)

CAPT	Captain
LT	Lieutenant
WO1	Warrant Officer 1
WO2	Warrant Officer 2
SGT	Sergeant
CPL	Corporal
LCPL	Lance Corporal
PTE	Private

OTHER TERMINOLOGY	
AAR	After Action Review
COC	Chain of Command
DFDA	*Defence Force Discipline Act 1982*
DVA	Department of Veterans' Affairs
HRT	Hostage Recovery Team – specific to OP OKRA
NTSC	*Notice to Show Cause*
OP SLIPPER	*Operation Slipper* was the ADF contribution to the war in Afghanistan.
OP OKRA	*Operation Okra* was the ADF contribution to the international coalition against the Islamic State in Iraq and Syria
RtAPS	Return to Australia Psychology Screen
POPS	Post-Operational Psychological Screening
ROI	Record of Interview
SSPH	Sydney Southwest Private Hospital

ANNEXURE C: TIMELINE OF CPL TURNER'S MOVEMENTS IN IRAQ IN 2016

1. AMAB to TQ: 30 July 2016
2. In TQ: 30 July 2016 to 15 August 2016
3. TQ to AMAB: 15 August 2016
4. In AMAB: 15 August 2016 to 28 August 2016
5. AMAB to Dubai: 28 August 2016
6. Dubai to AMAB: 29 August 2016
7. AMAB to BDSC: 29 August 2016
8. In BDSC: 29 August 2016 to 4 September 2016
9. BDSC to TQ: 4 September 2016
10. In TQ: 4 September 2016 to 20 October 2016
11. TQ to BDSC: 20 October 2016
12. In BDSC: 20 October 2016 to 9 December 2016
13. BDSC to AMAB: 9 December 2016
14. In AMAB: 9 December 2016 to 14 December 2016
15. AMAB to Australia: 14 December 2016