**FINDINGS, RECOMMENDATIONS and COMMENT of Magistrate Simon Cooper, Coroner, following the holding of an inquest under the *Coroners Act* 1995 into the deaths of:**

**Paul George Hunt, Paul James Reynolds, Simon Graham Darke, and Robert Anthony Cooke**

**Contents**

**Hearing dates** 4
**Representation** 4
**Introduction** 4
**What a coroner does** 6
**Preliminary matters** 7
**Issues at the inquest** 10
**Evidence at the inquest** 10
**Welfare and welfare support** 13
**Constable Paul George Hunt** 16
Background 16
Investigations relating to Constable Hunt's drug use 17
Circumstances of death 28
Detention – Mental Health Act? 35
Events after Constable Hunt left the Bellerive Police Station 37
Forensic, pathology and ballistic evidence 40
Welfare issues 41
**Senior Sergeant Paul James Reynolds** 47
Background 47
The evidence of Senior Sergeant Reynolds' criminal conduct 50
Circumstances of death 56
Forensic, pathology and ballistic evidence 58
The execution of the warrant by Professional Standards 59
**Constable Simon Graham Darke** 59
Background 59
Constable Darke's personal life 60
Was fatigue a factor in Constable Darke's death? 66
Circumstances of death 68
Forensic, pathology and ballistic evidence 68
**Sergeant Robert Anthony Cooke** 70
Background 70
Sergeant Cooke's mental health 72
The Second sergeant's position at Oatlands 77
The management of Sergeant Cooke's workers compensation claim 80
Inspector Burk's management of Sergeant Cooke 81
Suicide attempt in August 84
The last days of Sergeant Cooke's life 86
Sergeant Cooke and Senior Constable Carlisle's relationship 89

The reporting of Sergeant Cooke's death.......... 90
Forensic and pathology evidence.......... 91
**Welfare - procedures and protocol**.......... 92
**Fatigue Management Policy**.......... 98
**Early detection of PTSD**.......... 98
**Formal Findings**.......... 99
**Recommendations**.......... 101
**Comment**.......... 105
**Conclusion**.......... 105

# Record of Investigation into Death (With Inquest)

*Coroners Act* 1995
*Coroners Rules* 2006
*Rule* 11

I, Magistrate Simon Cooper, Coroner, having investigated the deaths of Paul Hunt, Paul Reynolds, Simon Darke, and Robert Cooke with an inquest held at Hobart in Tasmania, make the following findings.

**Hearing dates**

21– 23 November 2022 at Launceston in Tasmania.

24 November – 9 December 2022 at Hobart in Tasmania with final written submissions received on 14 June 2023.

**Representation**

Counsel Assisting the Coroner: C Lee

Counsel for Tasmania Police: M Miller, R Munnings and A Constance

Counsel for Police Association of Tasmania: P Harris and K Child

**Introduction**

1. On 8 July 2016, Paul Hunt died as a result of a self-inflicted gunshot wound at his father's home at Mount Direction, north of Launceston. On 13 September 2018, Paul Reynolds died in his car near Deloraine as a result of a self-inflicted gunshot wound. On 6 February 2019, Simon Darke died at Midway Point as a result of a self-inflicted gunshot wound. Finally, on 13 October 2020 Robert Cooke died at the Royal Hobart Hospital as a result of suicide by hanging.

2. All four men were, at the time of their deaths, members of the Tasmania Police Service. Constable Simon Darke was on duty and took his life with his issued service pistol. Constable Paul Hunt had been suspended from duty a matter of hours before he took his own life. Senior Sergeant Paul Reynolds was the subject of investigation by Tasmania Police Professional Standards at the time of his death. Sergeant Robert Cooke was in receipt of workers compensation in relation to a diagnosis of post-traumatic stress disorder ("PTSD"), which condition was directly attributable to his service as a police officer.

3. Their deaths by suicide, close together, were the first by any serving police officers in Tasmania since 1991. Over the 45 year period from 1971 until June 2016, four members of Tasmania Police (all male officers) died by suicide. In the period of 2016 to 2020 another four police officers (all male, and whose deaths are the subject of this finding) died by suicide.

4. I should make it very clear that there was no evidence to suggest that, aside from each being serving police officers, there was any particular connection between the deaths of Constable Hunt, Senior Sergeant Reynolds, Constable Darke and Sergeant Cooke.

5. The fact of each death was reported in accordance with the requirements of the *Coroners Act* 1995. Initially, the investigation of each death was allocated to different coroners. Ultimately, all matters were assigned to me following Sergeant Cooke's death and a direction made pursuant to section 50(b) of the *Coroners Act* 1995 for all four deaths to be investigated together.

6. As Mr Lee, Counsel Assisting, submitted, correctly in my view:

> *"When investigating the death of a police officer and considering what circumstances may have led to their death, it always needs to be remembered that the life of a police officer is inevitably a very difficult one. They are frequently exposed to dangerous and traumatic events, resulting in a large tally in the life experience of an experienced police officer. One cannot control what events one is required to attend – in a sense, it is very much "luck of the draw" as to what events one is required to attend. And when one attends such events, one cannot "unsee" what one has seen. Over time, this has a cumulative effect on that officer. Somehow, one has to find a way to try and manage it. This is why mental health, welfare support and psychological assistance… formed a large component of the four inquests".*

7. That having been said, the mere fact that each of the men whose deaths were examined were serving police officers is only part of the whole picture. Each had a private life, with family, friends, love, disappointment and everything that life entails. Whilst there is no doubt in my mind that Sergeant Cooke's police service was the direct cause of his death, that is not necessarily the case in relation to each of the other men. However, a common element was the provision of welfare support and assistance by Tasmania Police, and this was a central consideration at the inquest.

**What a coroner does**

8. Before considering the circumstances of each man's death it is necessary to say something about the general role of the coroner. In Tasmania, a coroner has jurisdiction to investigate any death that occurs in Tasmania and appears to "have been unexpected, unnatural or violent or to have resulted directly or indirectly from an accident or injury".[1] Obviously, the death of each man meets this definition.

9. When conducting an inquest, a coroner performs a role very different to other judicial officers. The coroner's role is inquisitorial. An inquest might be best described as a quest for the truth, rather than a contest between parties to either prove or disprove a case. When conducting an inquest, a coroner is required to thoroughly investigate the death and answer the questions (if possible) that section 28(1) of the *Coroners Act* 1995 asks. Those questions include who the deceased was, how they died, the cause of the person's death, and where and when the person died. It is settled law that this process requires a coroner to make various findings, but without apportioning legal or moral blame for the death.[2] The job of the coroner is to make findings of fact about the death from which others may draw conclusions. A coroner may, if she or he thinks fit, make comments about the death or, in appropriate circumstances, recommendations to prevent similar deaths in the future.

10. It is important to recognise that a coroner does not punish or award compensation to anyone. Punishment and/or compensation are for other proceedings, in other courts, if appropriate. Nor does a coroner charge people with crimes or offences arising out of a death that is the subject of investigation. In fact, a coroner must not even include in "any finding or comment [*sic*] any statement that a person is or may be guilty of an offence".[3]

11. As was noted above, one matter that the *Coroners Act* 1995 requires, is a finding (if possible) as to how the death occurred.[4] 'How' has been determined to mean 'by what means and in what circumstances',[5] a phrase which involves the application of the ordinary concepts of legal causation.[6] Any coronial inquest necessarily involves a consideration of the particular circumstances surrounding the particular death so as to discharge the obligation imposed by section 28(1)(b) upon the coroner.

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[1] Section 3, *Coroners Act* 1995.
[2] *R v Tennent; Ex Parte Jager* [2000] TASSC 64.
[3] Section 28 (4) of the *Coroners Act* 1995.
[4] Section 28(1)(b) of the *Coroners Act* 1995.
[5] See *Atkinson v Morrow* [2005] QCA 353.
[6] See *March v E. & M.H. Stramare Pty. Limited and Another [*1990 – 1991] 171 CLR 506.

12. It is also important to recognise that a degree of caution must necessarily attend this aspect of the coroners function. Self-evidently, the analysis involves a consideration of all the circumstances involving the death including decisions that were made at the time that may or may not have impacted upon the ultimate outcome. Coroners enjoy the distinct advantage of knowing exactly what occurred when making that assessment – something others involved with the deceased person at the time do not enjoy.

13. The standard of proof at an inquest is the civil standard. This means that where findings of fact are made, a coroner needs to be satisfied on the balance of probabilities as to the existence of those facts. However, if an inquest reaches a stage where findings being made may reflect adversely upon an individual, it is well-settled that the standard applicable is that expressed in *Briginshaw v Briginshaw*, that is, that the task of deciding whether a serious allegation against anyone is proved should be approached with a good deal of caution.[7]

14. The final matter that should be highlighted is the fact that the coronial process, including an inquest, is subject to the requirement to afford procedural fairness.[8] A coroner must ensure that any person (and the term 'person' means legal person, which includes any legal entity) who might be the subject of an adverse finding or comment is made aware of that possibility and given the opportunity to fully put their side of the story forward for consideration.

**Preliminary matters**

15. In accordance with this requirement, all parties who were identified as having a sufficient interest in the outcome of the inquest into each death were apprised of the fact of the inquest and provided complete disclosure of all documentation relevant to the investigation. I note that the phrase "sufficient interest" is not defined in the *Coroners Act* 1995. So far as I am aware the relevant section in the *Act* (section 52) has not been the subject of curial scrutiny in this jurisdiction. It does seem clear enough that sufficiency of interest is a concept incapable of prescriptive formulation, at least in so far as the category or classes of persons are who might be thought to enjoy sufficient interest. In that regard, it seems well-settled that family membership and the potential for an adverse finding will, generally speaking, amount to sufficient interest to justify representation at an inquest.[9] On the other hand the fact that a person is to be called as a witness will rarely, if ever, be sufficient in and of itself to give rise to a

[7] (1938) 60 CLR 336 (see in particular Dixon J at page 362).
[8] See *Annetts v McCann* (1990) 170 CLR 596 and section 52 of the *Coroners Act* 1995, generally.
[9] See *Annetts v McCann*, *supra*.

sufficiency of interest to warrant the granting of leave to appear and/or be represented at an inquest.[10] Again there is clear authority that where a person has been identified as being someone whose actions may have caused or contributed to the death of the deceased person then that fact will amount to sufficiency of interest in terms of the *Coroners Act* 1995.[11]

16. An application was made by Sergeant Fiona Smith, pursuant to rule 22 of the *Coroners Rules* 2006 to be represented by an Australian Legal Practitioner at the inquest. I might add that at the time the application was made not a single person had been identified as a witness to be called at the inquest, including Sergeant Smith. In any event Sergeant Smith submitted she had sufficient interest in terms of the *Coroners Act* 1995 for leave to be granted on the basis that in the lead up to his death she had provided Constable Hunt with "welfare support". I made it quite clear at a Case Management Conference that I did not consider there was any possibility I would make any adverse finding in relation to her nor any finding that would or could be reasonably viewed as damaging in any way to her reputation, either personally or professionally. Despite that indication, written submissions were received in relation to the application from counsel on behalf of Sergeant Smith. The application was originally made, as I understood it at least, in relation to all four deaths; it was subsequently refined for leave to appear only in relation to the death of Constable Hunt.

17. It was submitted on behalf of Sergeant Smith that in some way a claim she had under the provisions of the *Workers Rehabilitation and Compensation Act* 1998 and/or the possibility of an action at some stage in the future for damages arising out of her employment as a police officer (and specifically her duties as a welfare officer) were relevant matters for me to consider in relation to the question of her appearing at the inquest. I did not consider that those matters could have any bearing on the exercise of my discretion under section 52 (4) of the *Coroners Act* 1995.

18. Further, Sergeant Smith submitted that there was a likelihood of conflicting evidence as between her and then Inspector (now Commander) Joanne Stolp about, in effect, who said what to whom in the lead up to Constable Hunt's death on 8 July 2016. Again, I did not consider that the potential for a finding in relation to which version of events offered by two witnesses, assuming following the hearing of the evidence from both of those witnesses there remained a conflict, could possibly give rise to sufficiency of interest to entitle one witness (rather than the other or, I suppose,

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[10] R *v Coroner for Southern District of Greater London; ex parte Driscoll* (1995) 159 JP 45 at 56.
[11] *Barci v Heffney* [1995] SCVic 4306.

both) to be represented by an Australian Legal Practitioner at an inquest. Her application was accordingly refused.

19. In any event, all other parties identified as having a sufficient interest were also afforded the opportunity to appear at the inquest and be represented by lawyers.

20. As I have mentioned, Constable Darke was on duty when he died. He was wearing his police uniform and accoutrements at the time of his death. He used his police issue Glock service pistol to inflict the fatal wound which caused his death, albeit he took his own life in the backyard of his private residence.

21. Senior Sergeant Reynolds had had a search warrant executed upon him the night before his death by officers of Tasmania Police Professional Standards.

22. Constable Hunt had been served with a notice suspending him from duty hours before his death.

23. Sergeant Cooke was in receipt of payments pursuant to the *Workers Rehabilitation and Compensation Act* 1988 in relation to PTSD, a condition unquestionably caused by his employment.

24. In my view, there was sufficient nexus between the deaths in terms of occupation, gender and date of death to justify all four deaths being examined together. In addition, I consider Constable Darke's death – whilst on duty, in uniform and using his service firearm – to meet the definition of one that resulted from "an injury that occurred at a person's place of work, and [was not] due to natural causes".[12] As such, an inquest was, I consider, mandatory.[13] Even if I am wrong about that, in the exercise of the discretion conferred upon me by section 24 (2) of the *Coroners Act* 1995 in Constable Darke's case and in the case of the other three men I consider that inquests were warranted for the same reasons set out above: occupation, gender, date and circumstances of death.

25. Finally, with only one exception, I considered the witnesses at the inquest to have been cooperative, forthright people who attempted to tell the truth and assist the inquest.

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[12] Section 3 of the *Coroners Act* 1995.
[13] Section 24 (1) (ea) of the *Coroners Act* 1995.

**Issues at the inquest**

26. In advance of the inquest a number of issues, in addition to those mandated by the *Coroners Act* 1995, were identified as being matters to be particularly considered at the hearing. After hearing submissions from all interested parties and Counsel Assisting, Mr Lee, I determined that the matters to be specifically examined included:

    a) The policies and procedures of Tasmania Police in respect to the investigation of any complaints, standing down, suspension and termination of employment of serving police officers, both leading up to and at the time of each death, and now.

    b) The nature of any welfare and fatigue management program operated by or on behalf of Tasmania Police in respect to their police officers, both leading up to and at the time of each death, and now.

    c) Any policies and procedures of Tasmania Police in relation to moving police officers between operational and non-operational roles (and *vice versa*), both leading up to and at the time of Paul Hunt's death and now.

    d) Whether the management of Robert Cooke's workers compensation claim and/or return to work programme had an adverse effect on his mental health.

**Evidence at the inquest**

27. After a number of Case Management Conferences designed to ensure all issues were identified and all evidentiary material made available to all interested parties for hearing, an inquest was held in Launceston and Hobart in November and December 2022. A significant amount of documentary material was tendered and a number of witnesses called to give evidence. The details of the documentary material tendered appear in annexures A, B, C, D and E of this finding. The witnesses called to give evidence and answer questions were:

    a) Mr Matthew (Alan) Hunt;

    b) Sergeant Fiona Smith;

    c) Ms Karen Carey;

    d) Mr James Dilger;

    e) Mr Joshua Smith;

f) Mrs Sharon Reynolds;

g) Detective Sergeant Stephen Herbert;

h) Detective Inspector Mark Wright;

i) Inspector Philippa Burk APM;

j) Mr Patrick Allen;

k) Sergeant Peter Andricopoulos;

l) Inspector John Ward;

m) Senior Sergeant Andrew Bennett;

n) Sergeant Ann Edge;

o) Senior Sergeant Robyn Harper;

p) Commander Joanne Stolp APM;

q) Commander Robert Bonde APM;

r) Detective Sergeant Virgil Rowe;

s) Detective Sergeant Bernard Peters;

t) Inspector Troy Morrisby;

u) Assistant Commissioner Adrian Bodnar APM;

v) Ms Shana Sweeney;

w) Ms Kimberly Freeman;

x) Ms Simone Bertoz;

y) Mr Graham Darke;

z) Sergeant Peter May;

aa) Ms Michelle Cooke;

bb) Dr Leonard Lee;

cc) Constable Shane Tilley;

dd) Mr Malcom Direen;

ee) Constable Gavin Cashion;

ff) Sergeant Adrian Mollon;

gg) Commander Robert Blackwood APM;

hh) Mr Jarrod Cooke;

ii) Mr Liam Cooke;

jj) Ms Jacqui Prichard;

kk) Dr Yvonne Turnier-Shea;

ll) Senior Constable Elizabeth (Jenny) Carlisle;

mm) Inspector Colin Reilly CSC;

nn) Inspector Matthew Richman; and

oo) Commissioner (retired) Darren Hine AO, PSM, APM.

28. A coroner is not bound by the rules of evidence in holding an inquest and may be informed and conduct an inquest in any manner he or she reasonably thinks fit.[14] To be properly received at an inquest, evidence must be capable in some way of assisting the coroner to determine the matters under section 28 (1) or, in appropriate circumstances, to assist in making a comment or recommendation. A coroner has significant latitude in receiving evidence, providing the evidence is something more than *"mere supposition, guess or intuitive hypothesis"*.[15] The question of weight to be given to any evidence tendered at an inquest is a question for the coroner after receiving submissions from interested parties.

29. As the list set out above indicates, many of the witnesses were police officers. Some have retired since the events about which they were called to give evidence; others have been promoted. For the sake of consistency in this finding I have used their rank at the time they gave evidence.

[14] Section 51 of the *Coroners Act* 1995.
[15] See my *Ruling and reasons* in the *Inquest into the deaths of Craig Nigel Gleeson, Alistair Michael Lucas and Michael George Welsh* dated 1 February 2018, and the authorities referred to therein.

30. Following the conclusion of evidence, the inquest was adjourned to enable all counsel to file and serve written submissions. An extension of time was requested by, and granted to, all counsel, given the sheer volume of material that needed to be considered. The last of those submissions was received on 14 June 2023.

31. The circumstances of death of each officer are uncontentious, in the sense that there is no doubt at all that each took his own life, and did so voluntarily, alone and as a result of an intentional act. However, the circumstances surrounding each death are unique to each man, as are their backgrounds and lives, and the impact of their deaths. Before I consider the background and circumstances surrounding the death of each man in chronological order, I think it necessary to say something about the evidence relating to 'welfare' and 'welfare support', since that issue was an important factor in the death of Constable Hunt and to a lesser extent the deaths of Senior Sergeant Reynolds and Sergeant Cooke, but not,, in my view Constable Darke. A considerable amount of detailed evidence was received at the inquest in relation to this issue to which I now turn.

**Welfare and welfare support**

32. A key matter considered at the inquest was the provision of 'welfare' and 'welfare support' by Tasmania Police to its officers. I will deal with the various aspects associated with 'welfare' and 'welfare support' as they arise in the context of each officer's death, but an initial overview is appropriate.

33. I start by observing that despite a significant amount of evidence from those responsible for providing welfare support or supervising the provision of it, there was a surprising lack of precision as to what 'welfare' and 'welfare support' actually are, or mean. There was evidence from Inspector Richman for example as to what it is not – neither advocacy nor counselling. Sergeant May, a Wellbeing Support Officer who provided assistance to Sergeant Cooke also gave evidence as to what the role is not - neither "client advocate… [nor] professional counsellor".[16]

34. I think it is reasonable to conclude that the role involves the relatively simple concept of the provision of support, in the broadest sense of that word. I proceed on that basis.

35. It seemed reasonably clear that the provision of welfare support to members of Tasmania Police consisted of two main limbs: first that of Wellbeing Support Officers

[16] Exhibit C 22 – affidavit Peter Laurie May, sworn 22 June 2021, page 1 of 22.

and second, the Critical Incident Stress Management Program (CISM). In addition, and supporting the provision of welfare and CISM was the Police Psychology Service which by the time of the inquest fell under the Department of Police, Fire and Emergency Management's People and Culture Division.

36. The evidence was that the background, in a broad sense, to welfare and wellbeing support is that in 1973, Tasmania Police appointed as its first Welfare Officer (the role later being re-named Welfare Support Officer and later still as Wellbeing Support Officer).

37. In 1988, the CISM program was introduced. Inspector Matthew Richman gave evidence in relation to CISM. He explained that it comprised of and involved:

> *"Emergency service personnel (frontline responders) "peers" from Ambulance Tasmania, the Tasmania Fire Service and Tasmania Police, together with privately practising psychologists. At the current time there are 64 peers and six psychologists. The program is being expanded to 100 peers and 12 psychologists. One of the psychologists is the Clinical Consultant for the CISM Program. The CISM Program was founded on a strong volunteer ethos, with peers volunteering their time (although time off in lieu is available). Psychologists are paid on an hourly basis, or per training day.*
>
> ….
>
> *The CISM program is focused on providing support to emergency service personnel following involvement in critical (traumatic) incidents*."[17]

38. Inspector Richman went on to explain that the services provided included assessment, on the scene support, what was described as "diffusing" – individual or group, "debriefing" – individual or group, follow up assistance, the provision of advice to partners, families and friends and education information sessions. He said support was provided following critical incidents, which were those involving death or serious injury to a member (including suicide of a member), incidents involving serious threats from firearms in which a member is fired upon or returns fire, other situations in which there is a serious threat to life or safety to a member, situations involving serious injury to, or the death of, a child and any other situation that is assessed as being likely to produce a high level of immediate or delayed emotional reaction.

[17] Exhibit C 25, affidavit Matthew Peter Richman, sworn 7 July 2021 page 9 of 14.

39. I heard evidence that when a critical incident occurs, the supervisor or manager responsible is required to advise the CISM Program and provide the names of all the attending emergency service first responders. Contact is then made by a peer, who assesses whether any follow-up or referral is required. If it is assessed that referral is required then that may be made to a psychologist either for a one-on-one or a group intervention. The evidence was that when particularly impactful incidents occur representatives from the CISM Program will attend on the day of the incident and provide on scene support.

40. Constable Hunt, Senior Sergeant Reynolds, Constable Darke and Sergeant Cooke all necessarily had a number of contacts with the CISM program over the course of their policing careers. There is no evidence to suggest that the program was not effectively delivered nor that it did not provide an appropriate measure of support for each of the officers during difficult times. There is no evidence to support a conclusion that the CISM program (whether poor, indifferent or good) was a factor in any of the deaths subject of this finding. In my view, the program does not require any further consideration in the context of these four deaths.

41. Returning to the history of provision of welfare support services generally, I was assisted by the evidence at the inquest of retired Sergeant of Police, Mr Malcolm Direen.[18] His evidence was that he was the only full-time welfare officer for 15 years between 1996 and his retirement in May 2011. Mr Direen said in his evidence that between 1998 and 2010 he delivered suicide awareness and prevention presentations to members of Tasmania Police throughout the state. He said that when he performed the role of welfare officer he managed about 30 people at any one time. There was evidence that during the 1990s (exactly when was not entirely clear) the numbers of personnel providing welfare support increased as a result of arrangements being made for relief Wellbeing Support Officers to be in place, although those arrangements were to cover leave and weekend periods and the like, as opposed to an actual expansion of the establishment.

42. Mr Direen said that upon his retirement from the role on 6 May 2011 he handed over to his replacement, Sergeant Phil Burton. Mr Direen said he considered the role to be both busy and challenging. He also said that he had received appropriate training in relation areas such as grief and loss and suicide awareness whilst in the role.[19]

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[18] Exhibit G 17, affidavit Malcolm Anthony Direen, sworn 24 November 2022.

[19] *Supra.*

43. Sergeant Smith followed Sergeant Burton in the role. I will return to his time later in this finding. Whilst Sergeant Smith was in the role an additional full time appointment was made.

44. During 2017, expressions of interest called for people seeking to perform the role of relief Wellbeing Support Officer. Several people were appointed and annual training for them was initiated by Sergeant May and the manager of Psychology Services, Ms Julie Spohn.

45. In May 2019, the number of full time Wellbeing Support Officers doubled again to four in total with the appointment of two State Service employees into that role.[20] The evidence was that by the time the inquest was held there were a total of nine Wellbeing Support Officers serving Tasmania Police, with two based in the North West region, two based in the North and five based in Southern Tasmania. I can only guess whether the increase in numbers of Wellbeing Support Officers means that the provision of well-being support services are at an acceptable level. The best that can be said with any confidence is that the workload for individual Wellbeing Support Officers has probably decreased.

**Constable Paul George Hunt**

**Background**

46. Paul George Hunt was born in Launceston, Tasmania on 30 September 1983. He was the son of Matthew and Carrie Hunt. Mrs Hunt died on 12 February 2013, something that evidently affected Constable Hunt greatly.

47. He was educated in the Launceston area and in October 2005 joined Tasmania Police. His time in training at the Police Academy at Rokeby appears to have been unremarkable, as was his initial employment as a police officer. He was initially posted as a general duties uniform Constable in the Northern District in June 2006, initially as a probationary constable before being confirmed as a Constable on 9 July 2006. During his initial posting to the Northern Division he worked variously in Launceston, Scottsdale and George Town.

48. On 3 May 2010 he was transferred at his own request to a general duties position stationed at Currie on King Island.

[20] Exhibit G 5.

49. It appears that he was first formally diagnosed by a medical practitioner as suffering from a depressive disorder in 2008, although there is evidence that he had struggled with mental health issues since his childhood. There was also evidence of a paternal grandfather of Constable Hunt's suffering from mental illness for many years and an uncle committing suicide.

50. In addition, from at least 2008 or 2009, Constable Hunt developed an addiction to over-the-counter and prescription medication. The addiction continued until his death.

51. In December 2011, while posted to King Island, Constable Hunt met his future wife Jessica ('Jess'). The couple were married on 6 December 2014 and were living together at Margate at the time of Constable Hunt's death.

52. It is fair to conclude that Constable Hunt's time on King Island, apart from meeting his future wife, was not entirely happy for him. He attended a number of sudden deaths over and above what might be described as "normal" deaths. In addition to the ordinary vicissitudes of country policing (principally the difficulties associated with living in, and at the same time policing, a very small community), Mrs Jess Hunt outlined issues he experienced with social isolation and difficulties with a "friendship" group which no doubt caused him some distress.

53. A review of Constable Hunt's Tasmania Police personnel records[21] indicate that his engagement with Welfare Support (until later in his service) was fairly limited. His involvement with CISM only involved notifications in 2006, 2011 and 2014. The evidence does not support a conclusion that there was anything in particular about Constable Hunt's policing activities which were out of the ordinary.

**Investigations relating to Constable Hunt's drug use**

54. The evidence at the inquest was that on 18 September 2014, as a result of routine investigations, Southern Drug Investigation Services of Tasmania Police first became aware that Constable Hunt had been identified as purchasing significant amounts of pseudoephedrine regularly throughout the state since at least January 2013. In this regard, there was also evidence at the inquest from Mrs Jess Hunt that Constable Hunt had been regularly taking Panadeine Forte for back pain and diazepam for anxiety since at least 2011.[22]

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[21] Exhibit H 53.

[22] Exhibit H 14, affidavit Jessica Lee Hunt, sworn 28 July 2016, page 1, paragraphs 3 – 5.

55. As a result of that information, Senior Sergeant Troy Hodge, who was performing the role of Acting Inspector at Southern Drug Investigation Services met on 18 September 2014 with then Inspector Mark Beech-James. Inspector Beech-Jones was at the time Constable Hunt's Divisional Inspector. Welfare Officer Sergeant Burton and an investigator from Southern Drug Investigation Services, Detective Sergeant Cosentino also attended the meeting. As a result of meeting a decision was made to speak to Constable Hunt immediately.

56. Accordingly a meeting was held with Constable Hunt later the same day to discuss his usage of medications, in particular pseudoephedrine. Constable Hunt acknowledged a "high usage of pseudoephedrine based medications"[23], but attributed that use to sinus (and not back) pain for which he was self-medicating, using both pseudoephedrine and codeine-based medicines.

57. Those present at the meeting seem to have concluded that the pseudoephedrine purchasing was a "welfare issue" and not associated with any criminal activity. Constable Hunt was stood down for the rest of his shift but there, for the time at least, the matter rested. The evidence is that following the meeting, Constable Hunt saw his GP Dr Gregor, who provided a non-pseudoephedrine based nasal spray to assist with relief from his reported severe sinus pain.

58. On 9 October 2014, Senior Sergeant Hodge submitted a report to Commander Robert Bonde of Professional Standards in relation to Constable Hunt's purchasing and use of pseudoephedrine. The matter had become more acute light of the fact that by that date it had been identified that, notwithstanding the discussions with Constable Hunt on 18 September 2014, he had continued to purchase further amounts of pseudoephedrine. He had been identified by that date as one of the top four purchasers of pseudoephedrine and codeine based medicines in the whole of Tasmania for the month of September. Again, the matter appears to have been dealt with as what was described as a health and welfare matter, rather than a disciplinary or criminal offence. It is difficult to criticise that decision at that time, although arguably even though Constable Hunt had committed no criminal offence his behaviour might have been considered to be straying into the disciplinary area.

59. The immediate response of Tasmania Police was to develop what was described as a management plan. The plan initially involved Constable Hunt's duties being reassigned the following day by placing him within a team within the Road and Public Order

[23] Exhibit H 17, affidavit Robert James Bonde, sworn 30 August 2016, paragraph 19.

Services Branch. The practical effect of that reassignment was that there was an increased level of supervision. Again, it is difficult to criticise the approach of Tasmania Police at this point in time given the state of knowledge of Constable Hunt's behaviour.

60. Second, and in accordance with the "welfare issue" approach, on 16 October 2014 the Commissioner of Police, by letter, directed pursuant to section 29 (3) of the *Police Service Act* 2003 that Constable Hunt undergo a medical examination to determine whether or not his extensive use of pseudoephedrine and codeine based products may have a detrimental effect on his ability to effectively and efficiently perform his duties as a sworn police officer. Again, this approach appears to me to have been sound.

61. In addition, Inspector John Ward (who had by then taken over responsibility from Inspector Beech-Jones), tasked Sergeant Peter Andricopolus to continually monitor Constable Hunt's overall demeanour and well-being, essentially to ensure his safety within the workplace.[24] As part of this approach Sergeant Andricopolus appointed a mentor for Constable Hunt.

62. Accordingly, and as a result of the direction, 24 November 2014 Constable Hunt was examined by a doctor, Dr Ruttenberg. I observe Dr Ruttenberg was not, apparently, a practitioner with any particular specialisation in relation to addiction medicine, but rather a consultant occupational physician. Dr Ruttenberg provided a report to Tasmania Police stated 8 December 2014.[25] In that report he noted that a review of pharmacy records showed what he considered to be "excessive purchasing and (assuming for self-use) use of opiates and pseudoephedrine products… [which were] totally unnecessary from a medical and therapeutic perspective given the absence of medical and/or specialist consultation and diagnoses indicating any need for such".[26]

63. In his report to Tasmania Police, Dr Ruttenberg expressed the opinion that Constable Hunt was fit to perform the role of an operational police officer.[27] He made a number of recommendations in that report including probable referral to a drug and alcohol service for assistance in decreasing and ultimately stopping Constable Hunt's consumption of codeine and pseudoephedrine based products.

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[24] Exhibit H 30, affidavit John Ward, sworn 18 August 2016, page 2 of 8.
[25] Exhibit H 37, affidavit Joanne Louise Stolp, sworn 16 August 2016, annexure A.
[26] Exhibit H 30, *op. cit,*, page 5 of 8.
[27] *Supra*, page 7 of 8.

64. After the medical examination, Constable Hunt met with personnel from Staff Support Services to discuss the contents of the report. As a consequence of that meeting (or at least following it) various strategies were developed to endeavour to assist Constable Hunt to reduce his use of medication. In summary, I am satisfied that all of the recommendations flowing from Dr Ruttenberg's report were implemented by Tasmania Police, specifically by Inspector Ward.

65. In addition, on 13 February 2015, Constable Hunt assured Inspector Ward that he was no longer using pseudoephedrine products. Inspector Ward said he had no reason to "doubt the veracity of Constable Hunt's comments as his health, demeanour and interaction had improved considerably, and [Inspector Ward] had observed the Constable to be exhibiting behaviours associated with an employee who appeared content and competent with in the work place".[28]

66. Unfortunately, however, none of the strategies were successful because, on 13 March 2015, Constable Hunt committed the offence of driving whilst under the influence of drugs. Following the commission of the offence, and after his apprehension, he was admitted as an inpatient at St Helen's Private Hospital for psychiatric care.

67. The circumstances of the driving which led to Constable Hunt being charged with an offence under the *Road Safety (Alcohol and Drugs) Act* 1970 were as follows. On 11 March 2015 he took some drugs in his shed at home. His wife went to Melbourne the next day (12 March 2015). The following day (13 March 2015) Constable Hunt consumed a mixture of drugs (apparently including diazepam) and alcoholic pear cider before attempting to drive from his home in Margate to collect his wife from the airport. He was apprehended in Macquarie Street in the Central Business District area of Hobart after members of the public had contacted Police to report concerns about the matter of his driving in the Margate and Kingston areas.

68. Constable Hunt was charged on complaint 2268/15 with one count of driving under the influence of drugs, contrary to section 4 of the *Road Safety (Alcohol and Drugs) Act* 1970. He was admitted to police bail, which bail required him to appear in the Hobart Magistrates Court on Monday 23 March 2015. His bail was subject to a condition that he not be found behind the driving controls of a motor vehicle.

69. Following Constable Hunt's admission to bail he was taken into protective custody, admitted to St Helen's Private Hospital and made the subject of a Mental Health

[28] *Supra*, page 3 of 8.

Treatment Order due to threats of self-harm by, significantly, threatening to shoot himself.

70. On 16 March 2015, Constable Hunt's civilian firearms licence was suspended pursuant to Section 29 of the *Firearms Act* 1996 on the basis that the Commissioner of Police considered he was not a fit and proper person to hold the licence (and thus firearms). Accordingly, Constable Hunt surrendered his firearms.

71. Constable Hunt did not appear in accordance with the terms of his bail on 23 March 2015 (because he was in hospital), and so his prohibition from being found behind the driving controls of a motor vehicle lapsed (although it does not appear to have been treated as such). He did not appear in court until 29 June 2015. The complaint was adjourned without plea on that date, and again on 4 August and again on 7 September.

72. Backtracking slightly, the next date of significance was 14 May 2015 when his treating psychiatrist Dr Weidman "cleared" Constable Hunt to return to work. He returned the following day. However, by 7 June 2015 it was apparent that Constable Hunt was continuing to experience continued problems in relation to drug use. On that day Senior Sergeant Robyn Harper (a supervisor) considered that he was under the influence of some type of drug at work and sent him home.

73. At about this time Constable Hunt's father described his son as threatening (or at the very least implying) suicide. Mr Hunt took the threat so seriously that he changed the combination lock on his gun safe to prevent his son from having access to it.[29]

74. Next, on 22 July 2015, Constable Hunt was interviewed by officers of Professional Standards in relation to this driving matter. I note the evidence is that on the occasion of that interview he had a support person, the then President of Police Association of Tasmania, Constable Pat Allen, present.[30] Mr Allen has since retired from Tasmania Police.

75. In August 2015, Constable Hunt attempted to have his firearm license reinstated but his request (or application) was refused. However, Constable Hunt's drug use, and abuse, continued unabated. On 19 August 2015, he attempted to purchase codeine from a chemist in Hobart, but was refused. The following day he did so again but this time using a false name. On 31 August 2015, his Divisional Inspector, Inspector Ward

[29] Exhibit H 15, affidavit Matthew Alan (Alan) Hunt, sworn 22 July 2016.
[30] Exhibit H 24A, affidavit Patrick James Allen, sworn 22 July 2021.

became aware that Constable Hunt had arrived unfit for work and had been stood down by Commander Glenn Frame. Constable Hunt was taken home and again his circumstances were assessed as being a welfare issue, notwithstanding his attempt to purchase drugs using a false name.

76. Thereafter Constable Hunt remained off work until 25 September 2015, having received a medical certificate from Dr Weidman. On 30 September 2015, he sent a suicide message to his wife. Following that message Constable Hunt was picked up by his welfare officer (Sergeant Fiona Smith) and taken to St Helen's Hospital. Unfortunately no beds were available but he was admitted as voluntary patient for mental health treatment the following day.[31] He remained as an inpatient at St Helen's Hospital for several days. He appears to have remained off work from the start of October 2015 until about 12 November 2015. During some of that period he was an inpatient receiving treatment, but notably absented himself (perhaps absconded may be the better word) from the hospital on 5 October 2015 and returned home.

77. On 9 October 2015, Constable Hunt appeared in the Hobart Magistrates Court where he pled guilty to complaint number 2268/15, the charge of driving whilst under the influence of drugs on 13 March 2015. He was convicted, fined $700 and ordered to pay costs and a victims of crime levy, as well as being disqualified from driving for 12 months. Curiously, the operation of the period of disqualification was postponed until 12 December 2015 to apparently enable an application to be made for a restricted license. I say, curiously, having regard to the effect of section 19 (1A) of the *Road Safety (Alcohol and Drugs) Act* 1970, which operates as a complete bar to the granting of an order authorising a restricted license following conviction for an offence contrary to section 4 of the same Act which Constable Hunt had of course been convicted. Nothing perhaps turns on that fact in the overall context of his death other than it may have been another matter left, broadly speaking, at least so far as Constable Hunt was concerned, unresolved.

78. Next, on 5 November 2015, Constable Hunt's sister, Ms Louise Greatrix, found her brother at home in bed in what she described as a "bad way"[32]. She had gone to his home as a result of being concerned about the tenor of a text message she had received from him.[33]

[31] Exhibit H 38, affidavit Fiona Michelle Smith, sworn 4 October 2016, page 3 of 8.
[32] Exhibit H 16, affidavit of Louise Greatrix, sworn 13 September 2016, page 7 of 11.
[33] *Supra*, page 6 of 11.

79. On 13 November 2015, Constable Hunt was interviewed again by Professional Standards in relation to the pharmacy issue, specifically his purchasing significant quantities of codeine. His wife and a representative of the Police Association of Tasmania, again Constable Pat Allen, were both present to support him during the interview. Following that interview, Constable Hunt drove to Launceston. A member of the public reported him to be driving erratically. He was not apprehended by police as such, but spoken to by telephone at that time (whilst driving) by now retired Inspector David Plumpton.

80. Professional Standards decided to treat this driving matter (which had been reported) separately to his other matters. The allegation of erratic driving (for want of a better expression) on the Midlands Highway was investigated by Professional Standards and it was ultimately concluded that the matter was not substantiated. The evidence was that that determination was not made until May 2016.

81. In January 2016, Constable Hunt again sought to return to operational status. In response to that request Commander Frame advised that his non-operational status remained, a decision which appears to have been made by Deputy Commissioner Scott Tilyard. Constable Hunt's wife said he regarded this decision as a 'huge setback'.[34] That is as may be, but Constable Hunt was at the time disqualified by court order from holding or obtaining a driver's licence. He was, as a matter of law, precluded from being granted a restricted driver's licence. Furthermore, his firearms licence had been revoked. He was not able, in my assessment, to perform the duties required of an operational police officer. In addition, at that time, he was still being investigated in relation to his purchasing of pseudoephedrine products and his erratic driving on the Midlands Highway. The decision not to return him to operational duties appears to me to have been completely reasonable in all of the circumstances. In fact, I do not consider any other decision would have been appropriate in the circumstances as they then existed.

82. On 3 February 2016, Constable Hunt failed to attend for work, without explanation. His supervisor, Sergeant (then Senior Constable) Ann Edge called him repeatedly during that morning, without success. Eventually, Constable Hunt messaged her at about 12.15 pm, apologising for failing to attend and indicating he would be there the following day.

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[34] Exhibit H 14, *op. cit.*, page 6 of 10. I do note that the evidence of Inspector Ward about Constable Hunt's reaction to the decision was different. He said that Constable Hunt 'was appreciative of his assistance, and appeared to accept the outcome' - see Exhibit H 30, *op. cit.*, page 7 of 8.

83. On 11 March 2016, the Professional Standards report in relation to the allegations of erratic driving by Constable Hunt on the Midlands Highway in November the previous year was finalised and provided to Commander Bonde. Before finalising the matter, Commander Bonde decided to seek in effect Constable Hunt's explanation about the allegation.

84. Accordingly, on 23 May 2016, Constable Hunt was served by Inspector Ward with a direction from Commander Bonde requiring him to submit a report (or explanation) in relation to his alleged poor or erratic driving on the Midlands Highway in November 2015. Inspector Ward said at the same time he provided advice to Constable Hunt in relation to legal support, recommending that he contact the Police Association of Tasmania. Inspector Ward described his interaction with Constable Hunt on that occasion as "*business like*". Inspector Ward did say that he was contacted later the same day by since retired Inspector Glenn Lathey who indicated that another officer present considered that Inspector Ward had upset Constable Hunt in the exchange. Neither Mr Lathey nor the other officer involved gave evidence at the inquest. Whether Inspector Ward upset Constable Hunt or not seems unimportant to me – the direction to Constable Hunt had been given by the Officer in Charge of Professional Standards. It had to be delivered to Constable Hunt by someone and Inspector Ward was that someone.

85. In any event, Inspector Ward's evidence about the matter was that he contacted Constable Hunt the following day to offer an apology but that Constable Hunt told him he had not been upset by their interaction. If there is to be any criticism of the circumstances surrounding the provision of the direction to Constable Hunt it is the fact that it took nearly six months for Professional Standards to act on the allegation, the second of its type concerning Constable Hunt in less than nine months.

86. In summary, my assessment of the evidence in relation to this incident is that Inspector Ward acted both professionally and appropriately. I have no hesitation in accepting his evidence in relation to the events of 23 May 2016, or indeed generally. His evidence at the inquest was delivered in a clear and forthright manner. In contrast, there is no reliable evidence that Constable Hunt was in fact upset by their interaction. Even if he was, there is insufficient temporal connection with his death, in my view, to make the matter forensically significant. And even if I am wrong as to all that, I do not see that Inspector Ward had any reasonable alternative.

87. During the period between March and July 2016, Constable Hunt continued to perform non-operational duties within Tasmania Police within Serious Organised

Crime and Road and Public Order Services at Bellerive Police Station, largely without incident. There was evidence that he had unexplained absences from work in early June. Colleagues reported seeing unusual behaviour on his seeing him picking at a wound on his hand that had been stitched. However, broadly speaking, his behaviour did not seem to attract any adverse attention, particularly from senior officers. In the same month discussions were had with Constable Hunt involving Acting Inspector Andrew Bennett and Senior Sergeant Robyn Harper to discuss future work plans for him. Sergeant Smith and Sergeant Edge both gave evidence at the inquest that in June 2016 Constable Hunt appeared to be happy and in effect more settled.

88. By the end of June 2016 Professional Standards had concluded its assessment of Constable Hunt's driving matter on 13 March 2015 for which he had been charged and convicted the previous year. Unsurprisingly, Professional Standards considered the matter to be sustained. The disciplinary outcome for Constable Hunt (of which he was made aware) was that he would be transferred to Hobart, placed on non-operational duties for a period of two years and receive a $924 wholly suspended fine. This outcome cannot have been a surprise to Constable Hunt.

89. On 1 July 2016 the evidence is that Constable Hunt went to a pharmacy in Risdon Vale where he presented a false driver's licence number and showed his police warrant card in an attempt to obtain codeine based medication (Panefen Plus). He was refused the medication he sought and police were contacted, which triggered another Professional Standards investigation.

90. Finally, on 7 July 2016, the day before his death, Constable Hunt returned again to the same pharmacy in Risdon Vale and again attempted to purchase further codeine-based medication. He was recognised by staff and again refused. He then took a taxi to a pharmacy in Lindisfarne and obtained codeine-based medication again using his police badge as a method of identification.

91. Thus, in summary, by the day of his death, Constable Hunt had been apprehended, charged and convicted for driving under the influence of drugs, investigated for another alleged incident of driving under the influence of drugs (or at the very least erratic driving, in which drugs were suspected to have played a part), sent home from work at least twice for apparently being under the influence of drugs, made several threats of suicide to those close to him (and to members of Tasmania Police) and been identified on several occasions as being one of the largest purchasers of pseudoephedrine in the State of Tasmania. He had been disqualified from holding a driver's licence by a magistrate and his firearms licence had been cancelled by the

Commissioner of Police. Constable Hunt had had several periods of unexplained absence from work and been treated as an inpatient in a psychiatric ward for mental illness and drug addiction. He had been detected purchasing pseudoephedrine (or at least attempting to) using false identification and also his police badge. Finally, he had taken extensive sick leave (a total of 138 days on 18 separate occasions between 1 July 2014 and 8 July 2016).[35] Nonetheless, he remained a serving, sworn member of Tasmania Police.

92. After several years of treating Constable Hunt's conduct as a "welfare issue", Professional Standards determined it was now necessary to act and to act quickly. They had compelling evidence that Constable Hunt had engaged in criminal activity and serious disciplinary misconduct on 1 and 7 July 2016, (apparently during his lunch break from work at Bellerive Police Station on both occasions). That conduct occurred against a lengthy history of continued misuse and abuse of over-the-counter drugs, absences from work and driving under the influence of drugs. Commander Bonde gave evidence that during the afternoon of 7 July 2016 he briefed the Deputy Commissioner of Police, apprised the Inspector of Staff Support Services (then Inspector Stolp) and the Police Psychologist of what was intended and also sought their advice as to whether there was any reason not to proceed. He was given no indication that he should not proceed to administer the stand down notice.

93. Commander Bonde said that when deciding to act as he did he also had regard to recent discussions he had had about Constable Hunt with other senior officers, including the Acting Commander of Southern District Command and the Acting Commander of Human Resources Command.[36]

94. I also note Assistant Commissioner Adrian Bodnar's evidence that he was aware of it being a long-standing practice (from as early as 2004 he said in his oral evidence at the inquest) [37] that Professional Standards would seek advice from an officer's treating doctor or other health professional before seeking to interview the officer. I observe that there is no evidence that was done in relation to Constable Hunt.

95. Also particularly relevant was the evidence at the inquest of Commander Blackwood, who is now the Officer in Charge of Professional Standards. His evidence touched upon the relationship between Professional Standards and Welfare Support. He explained how the practice now is to, generally speaking, suspend any investigation in

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[35] Exhibit H 17, *op. cit.*, paragraph 14.
[36] *Supra*, paragraphs 66-67.
[37] Transcript.

relation to a code of conduct matter until a medical clearance is received. The situation is understandably different, however, when it involves criminal matters being investigated by Professional Standards. In those circumstances different considerations, including public interest, any potential victims and in some cases the existence of statutes of limitations all mean that the investigation of an officer for an alleged criminal matter is dealt with in the same manner as for an ordinary member of the public. In my view this is precisely how it should be.

96. I observe that Commander Stolp's evidence on this point at the inquest was that the conversation with Commander Bonde about Constable Hunt did not occur until the following morning (i.e. 8 July 2016). I do not accept that was the case, for reasons I shall set out shortly. I also note that Commander Stolp's evidence about Constable Hunt included that she was unaware of:

- Constable Hunt being investigated in relation to the Midlands Highway erratic driving allegations in November 2015;
- Constable Hunt not attending work (without explanation) on 3 February 2016;
- Constable Hunt not attending work (without explanation) on 2 June 2016; and
- Constable Hunt being seen at work attempting to bandage his own hand on several occasions on 7 June 2016.

97. In short, she seemed largely unaware of many issues that may have impacted upon Constable Hunt's welfare. Nor is there any evidence she took any steps to inform herself or find out about any such issues. Given Commander Stolp was actually responsible for police welfare generally, and Constable Hunt's welfare in particular, and was asked expressly for advice as to anything which would preclude Professional Standards proceeding as intended, I consider that this lack of knowledge was both surprising and potentially very dangerous. Without that information to hand it is difficult to see how any rational answer could have been given to the question of whether there was any reason not to proceed with the stand down notice, from a welfare perspective.

98. Part of the reason why Commander Stolp, in her role as Inspector of Staff Support Services may have been so poorly informed about any issues associated with Constable Hunt is that the evidence suggests file management systems within the office during her tenure were very poor. Commander Stolp said in her evidence that she did not have access to Constable Hunt's welfare file because it was a "confidential

file between him and Sergeant Smith".[38] It is difficult to see why the Inspector in charge of welfare considered she could not look at the file of an officer receiving welfare support. And assuming that was in fact the case, given she was unable to read the file it is equally difficult to understand why Commander Stolp did not refer Commander Bonde's enquiry (which was directed to ascertaining whether there was any reason from a welfare perspective not to proceed with the stand down notice), to Sergeant Smith, who, if Commander Stolp's evidence is correct, was the only person who would, or could, have had that knowledge.

99. Commander Stolp said in her evidence by way of explanation about what might be called a "confidentiality issue" that *"a lot of those workers would not have sought welfare support if they thought those matters that they discussed with the welfare officer would be privy to officers beyond [sic] them"*.[39] She said that this belief was based on anecdotal as opposed to empirical or verifiable evidence. I found her evidence in this regard to be unconvincing, and I do not accept that she did not have access to Constable Hunt's welfare file.

100. Further, I reject her evidence about her discussions with Commander Bonde occurring only on 8 July 2016. I am satisfied Commander Stolp was warned on 7 July 2016 by Commander Bonde of Professional Standards' intention to search, seek to interview and serve Constable Hunt with a stand down notice the following day. I am satisfied that following that advice Commander Stolp did nothing to put in place any plan for welfare support for Constable Hunt. As a result when Constable Hunt was served with his stand down notice the following day, no welfare support was available to him.

101. In the event, as I hope I have made clear, by late afternoon on 7 July 2016 a decision had been made that it was necessary to interview Constable Hunt, search his locker and work area and serve him with a stand down notice. Professional Standards personnel were briefed accordingly the following morning.

**Circumstances of death**

102. On the day of his death, 8 July 2016, Constable Hunt was working in a non-operational role at the Bellerive Police Station.

103. The evidence was that he left his home for work to catch a bus at 7.00 am from Margate. His wife said that he seemed "*fine*" when he left for work – which is

[38] Transcript.

[39] *Supra*.

generally consistent with evidence from other witnesses as to his demeanour and mood in the lead up to his death.

104. Meanwhile, preparations were being made at Professional Standards to deal with Constable Hunt. Commander Bonde briefed Detective Senior Sergeant Troy Morrisby, Detective Sergeant Virgil Rowe and Detective Sergeant Bernard Peters, all then members of Professional Standards and each an experienced detective. The officers were all broadly aware of the allegations in relation to Constable Hunt and had viewed CCTV videos of his movements on 1 July and 7 July the previous day to confirm his visits on pharmacies. Another officer – Detective Inspector Glen Ball was present (why is not entirely clear). So was Acting Inspector Bennett, who was the Officer in Charge of Road and Public Order Services ("RPOS") at Bellerive and as such Constable Hunt's superior.

105. Detective Senior Sergeant Morrisby and Detective Sergeants Rowe and Peters were provided with an overview by Commander Bonde of the issues the subject of the investigation, instructed that Constable Hunt was to be interviewed under caution, his mobile phone seized and examined for evidence and that he was to be served with the stand down notice (a notice pursuant to Section 38 of the *Police Service Act* 2003). They were provided with the notice.

106. All officers said they were clear as to what was to occur and what they are expected to do. Specifically, in relation to the mobile phone, Commander Bonde directed Detective Senior Sergeant Morrisby and Detective Sergeants Rowe and Peters that if Constable Hunt refused to provide them with access to his mobile phone it was "to be taken possession of for later examination".[40]

107. At about the same time, Constable Hunt had a coffee with his welfare officer Sergeant Smith at nearby Eastlands Shopping Centre. Sergeant Smith had been providing welfare support to Constable Hunt since April 2015, when Constable Hunt contacted her whilst undergoing treatment as an inpatient at St Helens Private Hospital for depression. Sergeant Smith and Constable Hunt knew each other well since Constable Hunt was best friends with Sergeant Smith's brother-in-law.[41]

108. Sergeant Smith said in her evidence at the inquest that Constable Hunt appeared to be in good spirits that morning. Both Constable Hunt and Sergeant Smith where unaware of the unfolding events. That they unaware was perfectly understandable.

[40] *Supra,* paragraph 68.
[41] Exhibit H 38, affidavit, *op. cit*., page 1 of 8.

The integrity of any Professional Standards investigation (indeed any investigation) obviously relies upon confidentiality being observed. The efficacy of any search depends upon the subject of the search being unaware that it is to be conducted. Several experienced police officers who gave evidence at the inquest said searches always rely upon the element of surprise. A search conducted by appointment, or with advance warning, obviously enables a suspect (police officer or member of the public), should they be so inclined, to hide or destroy evidence the subject of the search.

109. After their coffee together finished, Constable Hunt went back to work and Sergeant Smith went back to her office in Hobart. She said in her evidence:

> *"I later returned to work after another appointment and had a conversation with [then] Inspector Stolp who told me confidentially that she had a phone call from Commander Robert Bonde who advised her that Professional Standards were going to see [Constable Hunt] at Bellerive Station and suspend him. I told [then] Inspector Stolp that I'd wished I'd known that earlier as I would have delayed catching up with [Constable Hunt] until after his meeting with Professional Standards. I advised [then] Inspector Stolp that I needed to be there for [Constable Hunt] whilst he was dealing with Professional Standards as I knew him well and was concerned, he'd be extremely upset, and he'd need someone with him and to also give him a ride home. [Then] Inspector Stolp advised that she didn't know the details or what time it was going to occur, but I would be advised accordingly should I be required to provide support to [Constable Hunt]. I told [then] Inspector Stolp a couple of times throughout our conversation that I needed to be there to support [Constable Hunt]. I was quite angry about this, as being the welfare officer and having spent so much time over the years supporting [Constable Hunt] and his family, I thought this was part of my core duties – to be there to support clients [sic] in a time of need."*[42]

110. In contrast to Sergeant Smith's detailed evidence about her discussion with Commander Stolp, Commander Stolp made no reference in her affidavit as to a conversation with Sergeant Smith at all. Nor is there any reference to it in her running sheet, nor is there any reference in the running sheet to the conversation she had with Commander Bonde. When she was questioned about this at the inquest Commander Stolp said she had only started her running sheet after Constable Hunt left the station on 8 July 2016. Further, she said in her evidence that she was unable to locate her notebook from that time and claimed it was the only notebook in 27 years

[42] Exhibit H 38, affidavit Fiona Michelle Smith, sworn 4 October 2016, page 6 of 8.

of policing which she had been unable to locate. I find that explanation unconvincing do and her saying in evidence that she had not lost the relevant note book, but rather she '*just hadn't located it*'.[43]

111. I prefer Sergeant Smith and Commander Bonde's account of what occurred. I have already indicated earlier in this finding that I am satisfied that Commander Bonde warned Commander Stolp of what was going to occur with Constable Hunt the day before, but that Commander Stolp did nothing about that information, and in particular did not pass it on to Constable Hunt's Welfare Officer, Sergeant Smith, until about 12.35 pm on 8 July 2016. In real terms, by then it was too late because the effect of Commander Stolp failing to pass information on to Sergeant Smith was that Constable Hunt was without any welfare support when and after he was served with the stand down notice. In fact, by that time he did not have a mobile telephone either, was unable to be contacted by anyone at all in a practical sense and was within a few minutes of leaving the Police Station and any potential support altogether.

112. Senior Sergeant Harper, who was supervising Constable Hunt and working at Bellerive Police Station on 8 July 2016 gave evidence that she was aware that Constable Hunt was due to be visited (to use a neutral expression) by officers of Professional Standards that day. She had become aware because another officer, Senior Constable (now Sergeant) Edge, a close friend and colleague, had been contacted by Professional Standards the previous day (7 July 2016) to determine whether Constable Hunt was due to be working the following day. Senior Constable Edge and Senior Sergeant Harper were both aware of the fact that Constable Hunt had matters pending with Professional Standards. They concluded, correctly, that Constable Hunt would be interviewed on 8 July 2016.

113. Acting Inspector Bennett and Senior Sergeant Harper had a discussion after Acting Inspector Bennett returned from the meeting at Professional Standards. The subject of the discussion was the imminent visit by officers of Professional Standards to deal with Constable Hunt. Acting Inspector Bennett made arrangements for the police station to be clear of staff, to afford Constable Hunt a measure of dignity in his dealings with Professional Standards. He told Senior Sergeant Harper that he intended to do that. Senior Sergeant Harper indicated to Acting Inspector Bennett that she would remain at the station while Professional Standards dealt with Constable Hunt because she considered that Constable Hunt may require support or assistance.

[43] Transcript.

114. Returning to the chronology of events, Detective Senior Sergeant Morrisby, and Detective Sergeants Rowe and Peters arrived at Bellerive Police Station at around 11.50 am. Video evidence[44] which commences at 11.56 am (with Detective Sergeant Peters operating the video camera), shows Detective Senior Sergeant Morrisby put the allegation to Constable Hunt that he had purchased codeine-based medication using false particulars on 1 July 2016 (although there was no mention of the events of the previous day, 7 July 2016, which had in fact, as best as I was able to determine, actually prompted Professional Standards to act when it did). Constable Hunt was told that his conduct may amount to a breach of the Police Code of Conduct or be a criminal offence or both. Detective Senior Sergeant Morrisby then cautioned Constable Hunt and advised him that there would be a search of his desk, locker and drawers. Acting Inspector Bennett then formally directed Constable Hunt to make available his desk and locker to be searched.

115. Constable Hunt's desk, work area and two lockers were then searched. Nothing of interest seems to have been recovered. In fact, his second locker was completely empty. During the search, Constable Hunt identified his bag and jacket and volunteered to the officers from Professional Standards that they had his permission to search both, if they wanted to. All this was recorded on video. At the conclusion of the search at 12.19 pm the officers from Professional Standards, Acting Inspector Bennett and Constable Hunt returned to an office and the video was turned off.

116. In the video footage Constable Hunt can be seen taking off his lanyard containing his police ID and placing it on the desk at which he was working without any prompting or request. He did the same thing with his police badge.

117. Detective Senior Sergeant Morrisby is also recorded on the video telling Constable Hunt that Welfare and the Police Association of Tasmania needed to be notified and an office had been made available to Constable Hunt for when they (Welfare and the Police Association) called him. Detective Senior Sergeant Morrisby asked if he wanted Welfare or the Police Association of Tasmania to be notified and he said "no".

118. During that part of the interview captured on video, there is no mention made of Constable Hunt's mobile telephone at all.

119. At the end of the search, Detective Senior Sergeant Morrisby arranged for Acting Inspector Bennett to serve the stand down notice on Constable Hunt. This was not

[44] See Exhibit H 45, generally.

recorded on video either. Before it was formally served, Detective Senior Sergeant Morrisby's evidence was that he told Constable Hunt that he would be served with a notice and given the matter was unlikely to be resolved in seven days, he could expect service of suspension notice within the next week.[45] He said in his evidence that Constable Hunt nodded and indicated he understood.

120. Unfortunately, other important parts of Professional Standards visit were not captured on video either. Neither the taking of Constable Hunt's mobile telephone nor the actual serving upon him of the stand down notice was recorded on video. In addition, the video camera was turned off when Constable Hunt was offered the opportunity of a video interview, having been apprised of his "Members Rights", namely the right to have an independent person present, the right to seek advice from a member of the Police Association, the right to seek legal advice and the right to record any interview himself by means of audio recording.

121. The evidence of Detective Senior Sergeant Morrisby at the inquest was that Constable Hunt did not elect to take up any of his "Members Rights" that had been explained to him but did indicate he did not wish to participate in a video interview or answer any questions. That he did not take up either of those options is evident from other evidence of what occurred at Bellerive Police Station.

122. Detective Senior Sergeant's Morrisby's evidence in relation to what occurred next was:

> "*I asked Constable Hunt if he had a phone on him, and he indicated he did. I stated that I wanted to view some records on his phone, in particular the notes section for evidentiary purposes and he stated I could not. I then indicated that if required I could seize the phone, but would prefer not to. Constable Hunt asked if I had the power to seize it and* ***I indicated that advice from legal services supported that we did****. He then placed the phone down in front of me and said words the effect of "take it". I asked for the passcode so we could inspect it and he refused to offer it. Detective Sergeant Peters stated that by not giving the pass code he was unnecessarily delaying having the phone returned to him and he said "keep the fucking phone, I'll go and buy another one*".[46] [emphasis added].

123. The reference in the above passage of Detective Senior Sergeant Morrisby's evidence to 'legal services' was a reference to Tasmania Police Legal Services. The legality of

[45] Exhibit H 19, affidavit Troy Graham Morrisby, sworn 30 August 2016, page 5 of 8.
[46] Exhibit H 19, affidavit Troy Graham Morrisby, sworn 30 August 2016, page 5 of 8.

the seizing of Constable Hunt's phone was the subject of scrutiny at the inquest. So far as the legality of removing the phone from Constable Hunt's possession was concerned I accept that Detective Senior Sergeant Morrisby believed he had the power to seize the mobile phone. However, I do not consider he, in fact, had that power. During the inquest Mr Miller made a submission on the issue. In an unusual development, Mr Miller said that he had given the legal advice referred to above, told me that solicitor-client privilege was waived, that he recalled the legal advice was given "at the last minute" and was most likely given verbally to Commander Bonde. He said the advice he gave was that Professional Standards could ask Constable Hunt to produce his phone but if it was not provided to them voluntarily a warrant was needed. Mr Miller expressly conceded that police did not have the power to take Constable Hunt's phone when they did.

124. In my view Mr Miller is correct. Detective Senior Sergeant Morrisby was wrong to have told Constable Hunt that he was lawfully empowered to remove the mobile phone from Constable Hunt's possession, whether he consented or not. That having been said I do not consider that Detective Senior Sergeant Morrisby acted in bad faith as such. Rather he appears to have misunderstood the advice given verbally to Professional Standards by Mr Miller (and not directly to him I note).

125. The practical outcome of the officers from Professional Standards proceeding on a wrong legal basis and requiring Constable Hunt to hand over his mobile telephone against his wishes was that Constable Hunt was, from that moment forward, unable to be contacted by anyone concerned for his welfare.

126. At 12.43 pm the video recording recommenced, because the officers from Professional Standards had become aware that Constable Hunt had a second locker in another part of the Police Station. It is evident from the video footage that Constable Hunt was unaware of the fact that he had another locker. He did not have a key to it and did not seem to know where it was. What is also clear from the video is that by now his phone had been removed from him. The result of that removal was highlighted by Constable Hunt saying in answer to Detective Senior Sergeant Morrisby asking for a telephone number upon which Constable Hunt could be contacted by welfare or the Police Association that he "*doesn't have a phone*".[47]

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[47] *Supra.*

127. During the second video recording, someone (probably Acting Inspector Bennett) can be heard saying to Constable Hunt that he is free to leave if he wishes. The duration of the second video recording is four minutes.

128. In his evidence, Acting Inspector Bennett said that after the completion of the formal process by Professional Standards he asked Constable Hunt to wait in his office while he contacted Sergeant Smith and Constable Pat Allen by phone. However, Constable Hunt refused to wait, indicating that he did not wish to speak to either Sergeant Smith or Constable Allen. Acting Inspector Bennett said that he then offered Constable Hunt a lift home or to go somewhere away from the station for a drink, but that Constable Hunt also refused both offers. Acting Inspector Bennett described Constable Hunt as being obviously very angry, and considered that the anger was perhaps directed at him. He described in his evidence at the inquest the pair nearly having a fight at the door of the Police Station, as he tried to steer Constable Hunt towards a car. He was unsuccessful in his attempts to help Constable Hunt.

129. In any event, Constable Hunt left the Police Station, yelling out the passcode to his mobile telephone to Acting Inspector Andrew Bennett as he did so, which as I said he had earlier apparently refused to provide off-camera. Again, I observe it would have been helpful for his refusal or otherwise to provide the passcode to have been captured on camera.

130. As he left the station it is, to my mind, difficult to imagine that Constable Hunt was anything other than completely aware that his long course of conduct which had culminated in his being served with a stand down notice was likely to lead to his dismissal from Tasmania Police. I consider that this level of awareness is clearly demonstrated by Acting Inspector Bennett's evidence that he heard Constable Hunt say words to the effect "I'm fucked now" as he walked away from him following his refusal to accept a lift either home or to a pub.

### Detention – Mental Health Act?

131. An issue which was explored during the hearing of evidence at the inquest was whether or not Constable Hunt could or should have been taken into some form of protective custody. I do not accept Sergeant Smith's evidence that, had she been present, she could or would have taken Constable Hunt into custody, exercising the powers conferred by section 17 of the *Mental Health Act* 2013. I should explain why I do not accept her evidence in this regard.

132. Section 17 of the *Mental Health Act* 2013 relevantly provides:

*"17. Power to take person into protective custody*

*(1) An MHO or police officer may take a person into protective custody if the MHO or police officer reasonably believes that –*

*(a) the person has a mental illness; and*

*(b) the person should be examined to see if he or she needs to be assessed against the assessment criteria or the treatment criteria; and*

*(c) the person's safety or the safety of other persons is likely to be at risk if the person is not taken into protective custody.*"

133. 'Mental illness' in the *Mental Health Act* 2013 means a serious impairment of thought (which may include delusions) or serious impairment of mood, volition, perception or cognition.[48]

134. 'Assessment criteria' in the same Act means:

*"(a) the person has, or appears to have, a mental illness that requires or is likely to require treatment for –*

*(i) the person's health or safety; or*

*(ii) the safety of other persons; and*

*(b) the person cannot be properly assessed with regard to the mental illness or the making of a treatment order except under the authority of the assessment order; and*

*(c) the person does not have decision-making capacity".*[49]

135. And finally, the meaning of 'treatment criteria' in the same Act is:

*"The treatment criteria in relation to a person are –*

*(a) the person has a mental illness; and*

*(b) without treatment, the mental illness will, or is likely to, seriously harm –*

*(i) the person's health or safety; or*

*(ii) the safety of other persons; and*

[48] See section 4.
[49] See section 25.

*(c) the treatment will be appropriate and effective in terms of the outcomes referred to in section 6(1) ; and*

*(d) the treatment cannot be adequately given except under a treatment order; and*

*(e) the person does not have decision-making capacity".*

136. In my view there is no evidence that would support a conclusion that as at the time of being stood down Constable Hunt had a mental illness, lacked decision making capacity or required any treatment for his own safety or the safety of any other person. To my mind, Sergeant Smith's assertion that she would or could have exercised the power contained in section 17 of the *Mental Health Act* 2013 (and implicit in that assertion is a criticism of the failure of any of the police officers who were actually present to have done so) is the result of the clarity afforded by hindsight, with the knowledge of what subsequently happened.

137. It is my very clear view that Constable Hunt's appearance on video, and the unequivocal evidence of Detective Senior Sergeant Morrisby, Acting Inspector Bennett, Senior Sergeant Harper, Detective Sergeant Rowe and Detective Sergeant Peters (all of whose evidence about the point I accept) is all consistent only with a conclusion that there were no grounds whatsoever to have exercised any power to take Constable Hunt into protective custody, whether under the *Mental Health Act* 2013 or on any other basis.

138. As I have already said, efforts were made in particular by Acting Inspector Bennett to assist Constable Hunt but he rejected those efforts - as he was perfectly entitled to do so. In short, Constable Hunt was completely free to leave Bellerive Police Station when he did, and he did so. He made plain that he did not wish to speak to anyone from the Police Association of Tasmania or to Sergeant Smith, as was also his right. It is quite clear on the evidence that he had decision making capacity. Obviously he was upset, angry and distressed but that does not mean he lacked capacity to make informed decisions. As I have already said, I do not consider his being detained or taken into custody under the *Mental Health Act* 2013 would have been lawful.

**Events after Constable Hunt left the Bellerive Police Station**

139. As I have said, at about 12.35 pm then Inspector Stolp telephoned Sergeant Smith and told her that Constable Hunt had been suspended. I have already mentioned that conversation. Suffice it to say, I am quite satisfied it was the first time then Inspector Stolp acted on the advice from Commander Bonde she had received the previous day.

After that conversation, Sergeant Smith telephoned Acting Inspector Bennett. A discussion occurred between Acting Inspector Bennett, Constable Allen and Sergeant Smith. Following that discussion, and probably as a direct result of it, a search for Constable Hunt was commenced because of the obvious and genuine concerns that were held about his welfare.

140. Aside from Sergeant Smith and Acting Inspector Bennett, then Inspector Stolp, Senior Sergeant Harper and then Senior Constable Edge were also involved in the efforts to locate Constable Hunt. Obviously, attempts to locate Constable Hunt were made extremely difficult by the fact that his mobile telephone had been unlawfully taken from him. Not only did it mean he was unable to be rung and spoken to by anyone but it also meant that police were unable to use location tracking capabilities to determine his whereabouts.

141. Police Radio Dispatch Services (RDS) made contact with taxi companies operating in Hobart in an attempt to locate Constable Hunt. Unfortunately, but completely understandably, information was sought in relation to taxis taking passengers from the area around Eastlands to Margate, and not to Launceston. Accordingly, those enquiries did not elicit any information that assisted in locating the whereabouts of Constable Hunt.

142. Enquiries later established that Constable Hunt had withdrawn a sum of $600.00 in cash from the joint bank account he shared with his wife (although the fact of the withdrawal was not, and could not have been, known until after Constable Hunt's death to any of the officers involved in the search for him). He used this money to pay for taxis to Launceston and then beyond. The evidence of Mr Adrian Madim was that Constable Hunt got into his taxi at Eastlands around 1.00 pm and asked to be taken to Launceston.[50] His father's property was at Mount Direction, a rural locality north of Launceston. Constable Hunt knew the property was vacant as his father was in New Zealand on holidays. He also knew a number of firearms were secured at that address. The taxi driver, Mr Madim, described the journey as quiet, with little conversation, Constable Hunt, appearing pre-occupied. It was during this journey that his wife sent him a message on Facebook asking him to come home. He of course had no means of reading the message because he did not have a mobile phone (or any other device). Mr Madim dropped him off at the Brisbane St Mall, Launceston.

[50] Exhibit H 13, affidavit of Adrian George Madim, sworn 9 July 2016.

143. Another taxi driver, Mr Deutsch Kadima's evidence is that at about 3.25pm a male person (who can only have been Constable Hunt) got into his taxi in Charles Street, was then momentarily dropped off at a bottle shop in Invermay to purchase a bottle of whiskey and four cans of an unknown product, before continuing on to a property on Old Bangor Tram Road, Mount Direction.[51] Mr Kadima dropped off his passenger at 3.57 pm.[52]

144. The evidence from Constable Hunt's father is that his son must have accessed the house using a spare key located near the front door.

145. Ms Jess Hunt's evidence is that around 4.50 pm that afternoon her husband responded to her Facebook message from 2.10 pm in terms which were, in effect, a final goodbye.[53] The computer in the family home at Mt Direction appears to have been used by Constable Hunt to send that message.

146. Ms Robyn Wheeler (a friend of the Hunt family who had known Constable Hunt since he was a boy) received a call from her son in which he told her that Constable Hunt's wife had contacted him very concerned for her husband's welfare. He told his mother she should head around to the Hunt family property immediately. Ms Wheeler did so, taking with her Ms Jayne Donnelly (a family member). Both women lived nearby.

147. Sergeant Smith gave evidence that she sent Constable Hunt a Facebook message at 5.02 pm which was not read.

148. Mr Hunt explained in his evidence[54] how his firearms were stored. It was consistent with the evidence from attending police officers (particularly Sergeant Andrew Hanson) in terms of how the firearms were likely to have been accessed. In short, the evidence is that a small digital locked key safe (in which the keys to the gun safe were secured) was been removed from a wall inside the kitchen pantry. A hammer and pinch bar were located next to the spot from where it had been removed. I am satisfied that Constable Hunt removed the key safe using the hammer and pinch bar. He then took the key safe to an external shed on the property, which he opened using a spare key kept hidden nearby. Once inside the shed, it is apparent that Constable Hunt used an electric angle grinder to cut a hole in the rear of the small lock safe in order to access keys inside it.

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[51] Exhibit H 12, affidavit Deutsch Tshibasu Kadima, sworn 8 July 2016.
[52] *Supra*, page 1 of 2.
[53] Exhibit H 14, *op. cit.*, page 8 of 10.
[54] Exhibit H 15, affidavit Matthew Alan Hunt, sworn 22 July 2016.

149. Constable Hunt was aware that the keys to the gun safe were in the digital safe. His father's evidence was that until around 12 months before his death, his son also knew the combination to the digital safe but that he, Mr Hunt, had changed the combination following a discussion with his son, in which Constable Hunt had articulated suicidal thoughts.[55]

150. I find that having obtained the key to the gun safe, Constable Hunt returned to the pantry, opened the gun safe and removed a Kirici brand 'under and over' double barrel 12 gauge shotgun belonging to his father. The gun safe was of an approved type and secured and locked as required. I find, on the evidence, that Constable Hunt returned to the shed and using the same angle grinder he had used earlier to cut into the key safe and removed around 425 mm of the barrel.

151. Ms Wheeler and Ms Donnelly arrived at the property, but sadly were too late. By the time of their arrival, but only a very short time before, Constable Hunt had placed the barrel of the shortened shotgun against his forehead and pulled the trigger. He was dead as a result of a self-inflicted shotgun wound. The shotgun, a bottle of bourbon whiskey and a hand written note, in its terms a suicide or farewell letter, were located at the scene. Constable Hunt's father later confirmed that the handwriting was that of his son.[56]

152. I am quite satisfied on the evidence at the inquest that the firearm Constable Hunt used to end his own life was properly, lawfully and safely stored.

**Forensic, pathology and ballistic evidence**

153. Constable Hunt's body was identified at the scene by his colleague Sergeant Hanson.[57] His body was then taken by mortuary ambulance to the Royal Hobart Hospital and admitted to the mortuary.

154. At the mortuary, highly experienced forensic pathologist Dr Donald Ritchey performed an autopsy. Dr Ritchey found clear evidence of a contact range of fire shotgun wound of the central upper forehead. Several round shot pellets and a 2 cm white plastic wad were recovered from inside Constable Hunt's skull. Dr Ritchey provided a report (which was tendered at the inquest) in which he expressed the opinion that the cause of Constable Hunt's death was a shotgun wound of the head.[58] I accept Dr Ritchey's opinion as to the cause of Constable Hunt's death.

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[55] *Supra*, page 3 of 4, and see earlier in this finding at paragraph 73.
[56] *Supra,* page 3 of 4.
[57] Exhibit H 25, affidavit Andrew Wayne Hanson sworn 5 August 2016.
[58] Exhibit H 4, affidavit of Donald MacGillivray Ritchey, sworn 23 November 2016.

155. Later, at the laboratory of Forensic Science Service Tasmania an analysis of samples taken from Constable Hunt's body was undertaken. Alcohol (0.24 g per 100 mL of blood), codeine (within the reported fatal range), propoxyphene (within the reported toxic/fatal range), paroxetine (within the reported toxic range), paracetamol (within the reported toxic range) and ibuprofen (in a greater than therapeutic level) were all found to have been present within those samples.[59] It is reasonable to conclude that prior to inflicting the wound which caused his death, Constable Hunt took a considerable number and mixture of drugs and consumed a significant quantity of alcohol.

156. The shortened shotgun, cut-off portion of barrel and fired cartridge case recovered at the scene, as well as the lead pellets and plastic wadding recovered at autopsy were subsequently examined and, in the case of the shot gun, tested by Constable Simon Taylor of the Tasmania Police Ballistics Section. I am satisfied that Constable Taylor is an expert in the field of ballistics and qualified to express the opinions expressed in his affidavit tendered at the inquest.[60] In that affidavit, Constable Taylor in summary said that the shot gun was in working order, had a trigger pressure normal for a weapon of its type, was fitted with an efficient safety catch and was not prone to accidental discharge. He further expressed the opinion that the cut-off portion of barrel was previously attached to the shot gun, the fired cartridge case had been discharged from the shot gun and the wad and pellets recovered at autopsy were of a type found in 12 gauge shot gun cartridges of Winchester manufacture.

157. I accept Constable Taylor's opinion. The forensic, pathology and ballistic evidence together with all of the other evidence surrounding the circumstances of his death, satisfies me to the requisite degree that Constable Hunt died of a self-inflicted gunshot wound to the head.

**Welfare issues**

158. The provision of welfare support services was a central issue in relation to Constable Hunt's death. I have already dealt with what I perceived to be some of the fundamental issues associated with the provision of welfare support services at the time of Constable Hunt's death including the fact that the Inspector in charge of Welfare Support Services had no knowledge of a number of issues associated with him, had no access to his file, put in place no plan for welfare support but had given

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[59] See Exhibit H 5 generally.

[60] Exhibit H 9, affidavit of Simon Andrew Taylor, sworn 26 July 2016.

advice to the Commander Bonde that there was no reason, from a welfare perspective, not to proceed with the service of the stand down notice.

159. In February 2015 Commander Stolp took over as Inspector of Staff Support Services (as it was then known and under which welfare "sat") from Inspector Glenn Woolley. [61] Her tenure in the role concluded in 2017. She was the Inspector with responsibility for welfare at the time of Constable Hunt's death.

160. When she commenced in the role the only Wellbeing Support Officer for the state was Sergeant Smith who had commenced in the role on 14 September 2015.[62] Sergeant Smith had performed the role of relief Wellbeing Support Officer for approximately four years on a temporary basis she said covering weekends and for short periods during the absence (presumably on leave) of Sergeant Burton.[63] During Commander Stolp's tenure the number of Wellbeing Support Officers increased from 1 to 2, with Sergeant May commencing in July 2016.[64]

161. The evidence of Commander Stolp was that during the time Sergeant Smith performed the role of Wellbeing Support Officer there was no position description for that role. In addition, Commander Stolp said there were no specific time frames at which Wellbeing Support Officers were required to attend a psychologist for review and she herself was unaware as to whether Sergeant Smith had taken regular psychological checks (or indeed any checks).[65] Her evidence at the inquest to the effect that the police psychologist did not tell her (Commander Stolp) that Sergeant Smith had not attended any reviews or appointments was, I thought, a somewhat unsatisfactory approach to a serious issue.

162. The role of Sergeant Smith in relation to Constable Hunt needs to be examined carefully. Before I do so, I should make it clear that it is quite apparent to me that she was both passionate and enthusiastic about her role as a Wellbeing Support Officer. In addition, I should also make it very clear that I do not consider that anything she did or failed to do was in anyway a cause of his death or even remotely causally related to Constable Hunt's death. I do not think anything she did, or might be thought to have failed to do (and I do not consider that there was anything she in fact failed to do), could have prevented Constable Hunt's suicide. Nor can I identify any act or omission in the performance of the duty which might be criticised.

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[61] Commander Stolp was promoted after her time as Inspector of Staff Support Services.
[62] Exhibit H 38, affidavit Fiona Michelle Smith, sworn 4 October 2016, page 1 of 8.
[63] Exhibit D 51, affidavit, Fiona Michelle Smith, sworn 19 July 2022, page 1 of 25.
[64] Transcript, evidence of Commander Stolp.
[65] *Supra.*

163. However, I do think that if she had been in a position to provide support to Constable Hunt in the immediate aftermath of the service of the stand down notice upon him then possibly the outcome may have been different. That she was not in a position to provide that support is in no way her fault.

164. Having said all that, I do think the evidence disclosed Sergeant Smith's obvious lack of training and supervision. Again, the lack of training and supervision are not the fault of Sergeant Smith. But they are indicative of some fundamental problems that attended the provision of Welfare Support by Tasmania Police during the service of Constable Hunt, and potentially the other officers the subject of this finding. Thus it is necessary to consider her involvement with police welfare generally and in relation to Constable Hunt in particular.

165. On 14 September 2015 Sergeant Smith commenced the role of Wellbeing Support Coordinator having previously undertaken relief work as a Wellbeing Support Officer for four years. She was at the time an experienced police officer. In her evidence Sergeant Smith said could not recall any specific training she received nor could she (or anyone for that matter) explain the exact selection criteria for the role or indeed what it actually involved, beyond the provision of 'welfare services'. She said she had received promises of ongoing training which never eventuated, aside from what was described as a Mental Health First Aid course she did towards the end of her time in the role of Wellbeing Support Coordinator.[66] I accept her evidence. I consider that it is a matter of genuine concern that anyone would be appointed to perform any role without any training, let alone the crucial role of providing welfare support to police officers struggling with mental health and other issues. Aside from obvious issues with the efficacy of any welfare support provided by someone without any training whatsoever, serious issues arise in relation to the welfare of the Wellbeing Support Officer themselves.

166. Sergeant Smith's June 2018 performance review describes her as *"an extremely hard working officer"* who has achieved *"significant outcomes for clients"*. However, it also refers to her finding it hard to "*switch off*" and that she would "*need to ensure a clear understanding of finding that delicate balance between supporting clients, whilst being mindful of a Departmental position"*.

167. As a result of that review voluntary secondment was suggested for her own welfare.[67]

[66] Exhibit H 58, pp1-2, par 3-6.
[67] Exhibit G 18.

168. In Sergeant Smith's annual performance review the following year it was noted that she was then approaching the end of her fourth year of tenure and that a fifth year would not be supported. The evidence was that role of any Wellbeing Support Officer was temporally limited to a maximum period of five years. The performance review makes reference to two additional Wellbeing Support Officers being appointed to ease workload pressures. The report does however note that she had *"performed the role exceptionally well in difficult circumstances and offered high levels of support to families affected by loss and officers affected by stress"*.[68]

169. Sergeant Smith gave extensive evidence at the inquest. It is not necessary to recount all the contents of her affidavits and oral evidence in relation to her workload and activities. Nor is there any purpose served in dealing with the significant amounts of material in her affidavits about her feelings of being "targeted" by Tasmania Police or her perception of there being attempts to "silence her".[69] Having reviewed her evidence carefully it is sufficient to say I think that she does appear to have had a relatively heavy workload while she was only fulltime Wellbeing Support Officer for the State until Sergeant Peter May commenced in 2016.[70] It is also evident, as I have alluded to, that she lacked any appropriate training, guidance, support or management and suffered as a consequence.

170. Sergeant Smith's evidence was that she was so overworked that she continually asked for assistance and expressed the need for more welfare officers.[71] It was not disputed that while working in Hobart she would return home to Ulverstone on a weekend by bus as she was too tired to drive a car. It was also not disputed that for approximately six weeks Sergeant Smith was actually sleeping in her office during the week, when her accommodation had come to an end in Hobart. That these things occurred – a welfare officer becoming so fatigued that she could not drive home and sleeping in her office – is a matter of real concern. It bespeaks a complete failure to supervise, a failure to set appropriate parameters and an apparent lack of knowledge or understanding by those charged with supervising her as to the toll the job was evidently taking on Sergeant Smith.

171. After Constable Hunt's death, Sergeant Smith continued to be involved in his case, providing support to his family.

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[68] Exhibit G 19.
[69] Exhibit D 51, op. cit., page 18 of 25 for example.
[70] Exhibit C 22, affidavit Peter Laurie May, sworn 22 June 2021.
[71] Exhibit H 58, p13, 50.

172. Sergeant Smith gave evidence that on 27 May 2019 she was told by Inspector Morrisby[72] not to have any further contact with the Hunt family. Specifically, her evidence was that Inspector Morrisby telephoned her and told her that he had had a call from the Commissioner's Office and was asked to give her a formal direction prohibiting her from having any contact with the Hunt family.[73] It was very apparent to me that Sergeant Smith was deeply aggrieved by Inspector Morrisby's direction and seems to have taken it as a personal insult and affront. She requested that the formal direction be put in writing, and in fact received it.[74]

173. In his examination in chief, Inspector Morrisby could not recall who provided that information from the Commissioner's Office. He referred to there needing to be clear personal and professional boundaries, and said that he considered Sergeant Smith had become invested personally and had made some inappropriate comments about management. However, in his evidence Inspector Morrisby was unable to recall the details of those matters. Nonetheless it is difficult to disagree with Inspector Morrisby's assessment of the need for Sergeant Smith to have in place clear personal and professional boundaries - something that should have been implemented some years earlier.

174. Commander Stolp was asked about her understanding of Sergeant Smith's working relationship with Constable Hunt. Given the issues I have already identified surrounding Sergeant Smith's supervision, I think it is necessary to set out Commander Stolp's evidence in some detail. I have already expressed my reservations about aspects of Commander Stolp's evidence at the inquest. In relation to Sergeant Smith, she relevantly said the following in answer to questions from Mr Lee:[75]

> *"MR LEE: [Resuming] how would you describe or are you – are you able to describe um Sergeant Fiona Smith's relationship um with Mr Hunt in the months leading to his death, the professional relationship?..... Ah as I understood it at that time it was a professional relationship as a – as a welfare officer.*
>
> *Would you say it was a a good, bad or indifferent relationship?..... It was a good relationship. She was a conduit between Constable Hunt and the department.*

[72] The same officer who interviewed, searched and serve the stand down notice on Constable Hunt on the day of his death. He was subsequently promoted.
[73] Exhibit R 36, page 17, paragraph 73.
[74] Exhibit D 51, *op cit*, page 17 of 25.
[75] Transcript page 23 line 26 to 25 line 9.

*Do you know um whether or not um Constable Hunt listened to what um to Sergeant Smith?..... I don't know.*

*Would you consider that um Sergeant Smith was an effective welfare officer for Mr Hunt?..... At at the time yes. In hindsight I wasn't aware of the magnitude of the close relationship between Sergeant Smith and Constable Hunt and his family. Had I been, I probably would have changed things. When you say you you weren't aware of the magnitude – ….. Yep.*

*– that's suggestive that there was a problem in your mind with the nature of the relationship, correct?..... Yes but that – I didn't know until after his death. I would suggest it was a conflict.*

*Alright. So why do you think it was a conflict?..... Sergeant Smith was very close to Constable Hunt and his family to the point where I would call her a family friend. That became obvious after his death and leading into the funeral. Um the nature of a welfare officer needs to have a degree of impartiality and I feel like she had gone beyond that and for her own welfare um should have had a break from it. There's nothing to stop her being friends with the family but not as the welfare officer.*

*So what's the problem with it though? Why is it an issue in your mind?..... A welfare officer is not an advocate for a – for a person. They are a a connection between the department and the person. They're there to look out for their welfare and to provide connection to services. When you get too close to a family and a friendship I feel like you you wouldn't be able to see the wood for the trees. I'm not suggesting he would have to go without welfare support I just think somebody more independent may have been appropriate.*

*Do you have any um basis for saying that Sergeant Smith for example was unable to see the wood from the trees? Is there any examples that you could give us to indicate that is a a valid basis?..... No.*

*HIS HONOUR: Did you know um that Sergeant Smith ah took affidavits from Jess Hunt and Louise Greatrex, the latter being Paul Hunt's sister –*

*WITNESS: Yes.*

*HIS HONOUR: – as part of the Coronial investigation?*

*WITNESS: Yes.*

*HIS HONOUR: Um do you have any thoughts about that?*

*WITNESS: In hindsight it was inappropriate. She was too close to it. The family requested it um but I would – I would change it if I had an opportunity to do so.*

*HIS HONOUR: But you didn't change it at the time.*

*WITNESS: No."*

175. After careful consideration, I have concluded that Commander Stolp's supervision of Sergeant Smith was poor. She was quite aware at the time that Sergeant Smith was performing a dual role of collecting evidence and providing welfare support, but did nothing about that. Commander Stolp said in the passage of her evidence (set out above) that with hindsight she recognised that to be wrong and she would change it now. Respectfully, I consider it should have been obvious at the time that not only was Sergeant Smith far too close to some family members but that objectively, by any measure, it was inappropriate for her to perform the dual role of providing welfare support and collecting evidence.

176. There was a clear blurring of the boundaries by Sergeant Smith. She should not have been placed in a position where she was permitted to take affidavits from witnesses as part of an investigation while at the same time as attempting to provide welfare support to those witnesses. The fact that she was permitted to do so is yet more evidence, to my mind, of the wholly inadequate management and structure of the Tasmania Police Welfare Support service during the time of the deaths of the four officers. It is not, I emphasise, a criticism of Sergeant Smith. That inadequacy was a factor in Constable Hunt's death because the outcome was that he did not have access to the welfare support he needed after he was served the stand down notice.

**Senior Sergeant Paul James Reynolds**

**Background**

177. Senior Sergeant Reynolds died by his own hand on 13 September 2018.

178. At the time of his death he was a Senior Sergeant in Tasmania Police, having joined the organisation in 1980, and was the Officer in Charge of Western District Prosecution based in Devonport. He was married and a father to two adult children.

179. Senior Sergeant Reynolds had served for 31 years in Tasmania Police in a variety of postings and positions throughout the whole state, including in the role of a Coroner's Associate within the Coronial Division of this Court. At one stage he had

been promoted to the rank of Inspector but later reverted to the rank of Senior Sergeant at his own request.

180. Mr Lee, Counsel Assisting submitted, correctly in my view, that the evidence makes it very clear the fact that Senior Sergeant Reynolds led a "double life". He enjoyed a measure of popularity and respect in his role as a police officer and his involvement in Australian Rules Football, both at a senior and junior level. At the same time some terrible allegations about his conduct began to emerge in the weeks leading up to his death. I will deal with the nature and extent of those allegations shortly in this finding, as I am satisfied that conduct, much of it apparently seriously criminal in nature, formed a significant part of the circumstances of his death.

181. On 3 September 2018, Senior Sergeant Reynolds took three weeks of recreational leave. The day before his death, Senior Sergeant Reynolds had been at an AFL Tasmania meeting in Hobart. He returned to Launceston that afternoon and had a celebratory dinner with his wife for their wedding anniversary. The couple returned home to their police house in Meander Valley Road, Westbury, at about 8.30 pm. Shortly after arriving home, Senior Sergeant Reynolds went to bed.[76]

182. Not long after Senior Sergeant Reynolds went to bed, Detective Inspector Mark Wright and Detective Sergeants Stephen Herbert, Bernard Peters and John Toohey officers from Tasmania Police's Professional Standards arrived to conduct a search of his property and to take possession of his mobile telephone and any other electronic or photographic devices or images. Senior Sergeant Reynolds was handed a search warrant which had been obtained at around 8.00 pm that evening.[77] It referred to, in part, evidence that was sought in respect to a number of allegations which had been made, namely:

a) That he had sent images of his penis from his mobile phone to boys under the age of 17 years.

b) That sexual or indecent images had been sent by boys under the age of 17 years to him.

c) That he was procuring (that is, grooming) boys under the age of 17 years to have unlawful sexual intercourse with another person or to engage in an unlawful sexual act.

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[76] Exhibit R 7, affidavit, Sharon Helen Reynolds, sworn 4 October 2018, page 2 of 10.
[77] Exhibit R 18, affidavit Mark Gordon Wright, sworn 30 September 2019, paragraph 25 and following. A copy of the actual warrant issued pursuant to the *Search Warrants Act* 1997 was exhibit R 18 A.

183. These matters of course had the potential to give rise to a number of crimes under the *Criminal Code* and the *Classification (Publications, Films and Computer Games) Enforcement Act* 1995.

184. As with the case of Constable Hunt on 8 July 2016 at Bellerive Police Station the officers from Professional Standards filmed part, but not all, of the search and their interactions with Senior Sergeant Reynolds. As with Constable Hunt's case I consider that all of the interactions with Senior Sergeant Reynolds should have been filmed. There is no compelling reason why they should not have been.

185. Senior Sergeant Reynolds was told by the officers from Professional Standards that the search related to his involvement with some children who I will refer to as Child A, Child B, Child C, Child D and Child E. Senior Sergeant Reynolds denied any wrongdoing.

186. During the search Senior Sergeant Reynolds commented "this is career destroying" and "what a way to end a 40 year career".[78] His mobile telephone, laptop, tablets and a USB were all seized by police. His wife's evidence is that after police left the property, he told her that they [the investigators from Professional Standards] would not find anything on any of his electronic devices seized during the search that was evidence of any type of wrongdoing.[79] Senior Sergeant Reynolds was simply lying. Investigators in fact found a significant amount of material obviously indicative of predatory criminal sexual behaviour towards a number of children on his mobile telephone. Senior Sergeant Reynolds must have known that incriminating material was present on his mobile telephone.

187. Mrs Reynolds also said that, after the officers from Professional Standards had completed the search and left, Senior Sergeant Reynolds said "he felt hollow and that he had no reason to live".[80]

188. Like Constable Hunt two years earlier, Senior Sergeant Reynolds was not provided with a replacement mobile telephone by officers from Professional Standards. There was no reason why he could not have been provided with a mobile telephone to replace the one taken from him (completely lawfully on this occasion) by Professional Standards. The fact that he was not provided with a replacement mobile telephone meant he was difficult, but not impossible, to contact by Wellbeing Support in the

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[78] Exhibit R 7, *op cit*, page 7 of 10.
[79] *Supra*.
[80] *Supra*.

aftermath of the search. Senior Sergeant Reynolds still had access to a land line. Nonetheless, as was the case with Constable Hunt, the failure to provide Senior Sergeant Reynolds with a replacement mobile telephone was, in my view, wrong and contrary to existing guidelines.

189. I note that the evidence from Inspector David Gill at the inquest was that between 2017 and 2021 a total of only 11 search warrants were executed on premises owned or occupied by police officers subject to criminal investigations. Five of those were executed in 2020, three relating to the same officer. Even if it is assumed that the execution of each warrant involved the seizing of a police officer's private mobile telephone, the numbers are not large and there is no practical impediment that I can see to the provision of a replacement mobile telephone.

**The evidence of Senior Sergeant Reynolds' criminal conduct**

190. Returning to the investigation in relation to Senior Sergeant Reynolds by Professional Standards, it is necessary to deal with that evidence in a little detail because to my mind it is directly relevant to the circumstances surrounding Senior Sergeant Reynolds death. The evidence at the inquest was that the Professional Standards investigation commenced as a result of another officer lodging a complaint in "Blue Teams" (a confidential conduct reporting mechanism utilised by Tasmania Police) on 6 September 2018. The officer reported that Senior Sergeant Reynolds was widely reputed in the Deloraine area to be a paedophile. A number of children were identified in that report, as well as adults, who were said to have information relevant the allegation. Following the receipt of that report, interviews were quickly arranged by Professional Standards with several children. The first of the interviews in fact commenced on the very day of the search of Senior Sergeant Reynolds' residence.

191. In summary, the results of those interviews were as follows. Child E told police that she observed a Snapchat photo of a penis sent by Senior Sergeant Reynolds on the phone of Child B. She described the penis as exposed through the zip of work-type trousers. She told investigators that Child C also commented at the same time that he had received the same image.

192. Child A was interviewed and told police he received a number of inappropriate messages from Senior Sergeant Reynolds (which images he had deleted) along with a pornographic video. He said he received about five "dick pics", which were all taken from above looking down at the penis and feet. Police were shown a number of messages of a sexual nature on Child A's phone sent by Senior Sergeant Reynolds to

Child A. Child A also disclosed sending multiple indecent images and videos to Senior Sergeant Reynolds, at Senior Sergeant Reynolds' request, by Snapchat.

193. Detective Inspector Wright gave evidence that Mr Terry Roles was also interviewed by police. Mr Roles was a key holder, trainer and committee member at the Deloraine Football Club. His evidence is that Senior Sergeant Reynolds was not a member of the club and should never have had access to any of the club buildings or facilities. I note at the time Senior Sergeant Reynolds had recently been President of the Northern Tasmanian Football Association and Chairman of the Tasmanian Football Council, and was as I said heavily involved with AFL Tasmania at both senior and junior levels. In any event, Mr Roles' evidence was that he had seen Senior Sergeant Reynolds' car parked around the Deloraine Football Club in recent times and seen him massaging a male adult on the rub down table. I have no doubt Mr Roles was a witness of the truth, who doubtless found himself in a difficult position given the fact that he knew Senior Sergeant Reynolds was a senior and long serving police officer, as well as a significant figure in AFL Tasmania. His cooperation with the investigation was exemplary. In my view, he acted completely correctly at all times.

194. The following day, 13 September 2018, Child D was interviewed by police. In the interview he told police he had heard rumours of Senior Sergeant Reynolds being a paedophile. He said he received head and shoulder pictures on his telephone from Senior Sergeant Reynolds for 36 days in a row and had been told by Senior Sergeant Reynolds that he (Reynolds) loved him (Child D) on about 10 occasions. He would also receive messages from Senior Sergeant Reynolds sitting on the toilet. He also described being "dick-tapped" (which I took to mean having his penis touched) by Senior Sergeant Reynolds, smacked on the bottom and being told by Senior Sergeant Reynolds that he had a "nice arse". Child D also told investigators that he was aware of Child C receiving rub downs from Senior Sergeant Reynolds at the Deloraine Football Club, and Child B and C taking naked ice baths in front of Senior Sergeant Reynolds. Finally, Child D said he sent two pictures of himself to Senior Sergeant Reynolds as he was about to get in the shower. He also said that he believed Child B and Child C may have sent so called 'dick pics' to Senior Sergeant Reynolds at Reynolds' request and recalled on one occasion how Senior Sergeant Reynolds referred to Child B as having an "anaconda for a dick".

195. Child B was interviewed by police and disclosed he had received three pictures of a penis and kiss 'emojis' from Senior Sergeant Reynolds.

196. Child C was interviewed by police and told investigators that he had received pictures from Senior Sergeant Reynolds of him (Reynolds) sitting on a toilet. He said he received two 'dick pics' and also mentioned three occasions when he was asked by Senior Sergeant Reynolds to send him pictures of his (Child C's) own penis. He also said that Senior Sergeant Reynolds had touched his (Child C's) penis. He said that it was his belief that Child B (and it was evident that the children all knew each other) had sent a picture of himself in the bath to Senior Sergeant Reynolds.

197. Detective Inspector Wright's evidence was that as a minimum, there was clear evidence to support allegations that Senior Sergeant Reynolds had solicited and/or procured child exploitation material from youths under the age of 17 years, namely images depicting them naked and/or exposing their penises. In his evidence Detective Inspector Wright said in all likelihood, the matter would have been referred to the DPP for an opinion as to charges[81]. The evidence tendered at the inquest leaves no room to doubt that Detective Inspector Wright's categorisation of the nature and extent of the evidentiary material is completely correct, as is his view that the material would have been sent to the Office of the Director of Public Prosecutions for an opinion about appropriate criminal charges. I have no doubt that Senior Sergeant Reynolds, given his length of service and experience with Tasmania Police, would have understood all of this perfectly. He knew exactly what was on his mobile telephone and what it was evidence of.

198. The second issue is in relation to Senior Sergeant Reynolds' mother's financial affairs. There was considerable evidence at the inquest to lead to a conclusion that Senior Sergeant Reynolds had been acting dishonestly in relation to his mother's finances. The background was that in November 2012, Senior Sergeant Reynolds and his wife obtained a Power of Attorney[82] over his mother's financial affairs in which they were jointly and severally appointed. The evidence from Senior Sergeant Reynolds' sister, Ms Karen Carey, is that he rejected her request to be a joint attorney.

199. Senior Sergeant Reynolds' father died the following year and his mother, then suffering from dementia, moved to a nursing home in Smithton. In August 2014 his mother's house was sold for $171,988.37. As at 21 October 2014, the closing balance of his mother's bank account was $165,457.36.

200. Evidence of the remaining balances and depletion of his mother's bank account were as follows:

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[81] *Supra,* paragraph 53.
[82] Exhibit R 28.

a) 21 April 2014 - balance $165,457.36;

b) 21 April 2015 – balance $116,374.77;

c) 21 October 2015 – balance $79, 564.14;

d) 21 April 2016 – balance $4,460.36; and

e) 11 September 2018 – balance $31.68.

201. Thus in a little over four years over $150,000 of his mother's money was dissipated. What that money was spent on remains unclear, although it is clear that it was not spent by, or for the benefit of, Mrs Reynolds senior. There was evidence at the inquest of a large number of sizeable cash withdrawals, many of which were from ATMs at the Launceston Country Club Casino. In addition, funds were spent on car detailing and chainsaws, shopping in Adelaide at Strandbags and in Darwin at Just Jeans and Portmans in Darwin. There was evidence of money being spent on several occasions in Melbourne on purchases at Tiffany & Co, Allana Hill, Joanne Mercer and the General Pants Company, as well as on a $370 dinner at a restaurant – Chin Chin – and a scenic helicopter flight over the Twelve Apostles on the Great Ocean Road.[83]

202. There was no evidence that Senior Sergeant Reynolds' mother had ever taken a helicopter flight in her life and certainly not in recent years over the 12 Apostles in Victoria or anywhere, nor that she owned a chainsaw or a car or had visited Adelaide or Darwin or dined at Chin Chin restaurant in Melbourne. In fact the evidence was that at all material times Senior Sergeant Reynolds' mother was suffering from dementia and living in a nursing home where she received much needed, constant care. Senior Sergeant Reynolds' widow, who it might be thought may have been able to cast light on the issue, was in fact unable to provide any assistance to the court about the expenditure and in particular the various amounts of money apparently spent on women's clothing and handbags.

203. There was clear and un-contradicted evidence from Ms Carey that the funds missing from her mother's account were not spent for her mother's benefit. I accept that evidence. It accords with an examination of the relevant bank statements.[84]

204. Mr James Dilger, a financial adviser and director of Hillross Tasmanian Wealth Management gave evidence about this issue at the inquest.[85] Hillross Tasmania held an

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[83] See Exhibit R 24 generally.
[84] *Supra*.
[85] Exhibit R 17, affidavit James Robert Dilger, sworn 20 May 2022, generally.

investment account in respect to Senior Sergeant Reynolds mother's money and assisted in managed her financial savings. He said that he knew Senior Sergeant Reynolds in a professional capacity only and gave him no advice personally or assistance in relation to the management of his own funds.

205. In February 2016 Mr Dilger's evidence was that Senior Sergeant Reynolds told him that his mother escaped the nursing home in a delivery van and crashed into three parked cars causing approximately $56,000 of damage. Senior Sergeant Reynolds told Mr Dilger that as a result he needed access to funds from his mother's account to pay for the damage caused by his mother's "escape" from her residential aged care facility and misuse of a delivery van. The story was completely untrue. The incident Senior Sergeant Reynolds described did not occur. There was clear and unequivocal evidence at the inquest from Mr Ian Adams, the manager of Mrs Reynolds senior's residential aged care facility to the effect that not only was there no record of such an incident occurring (and there would have been if it had occurred) but he did not consider that Mrs Reynolds senior would have had the capacity to have acted as suggested.[86]

206. Ms Carey said in evidence that at some point after her brother's death, his widow contacted her advising of 'discrepancies' in the bank account and advising that only $20,000 was left. The evidence at the inquest in relation to the transactions relating to Mrs Reynolds senior's bank account was that following Senior Sergeant Reynolds' death the funds in that account began to accumulate in a positive way again.

207. Nonetheless it may be the case that Senior Sergeant Reynolds apparent stealing from his mother was not a direct or proximate factor in his death. The fact of his misuse of his mother's funds did not come to light until after his death. Certainly Professional Standards were unaware of it and therefore made no mention of the issue when they executed the warrant (which was of course concerned with child sex offences). However, it seems to me that Senior Sergeant Reynolds must have been aware that he had been stealing money from his mother and that was something that was likely to become known to investigators, if not immediately, then at some time in the future.

208. The third issue is in relation to messages retrieved from Senior Sergeant Reynolds' mobile telephone from August and September 2018 where he asks an acquaintance (allegedly a methylamphetamine user with criminal associates) for money. I will refer to this person as X. There is evidence of a message on 4 September 2018 in which Senior Sergeant Reynolds tells X he requires $50,000 urgently. On 10 September,

[86] Exhibit R 37, affidavit, Ian Adams, sworn 5 October 2022.

Senior Sergeant Reynolds makes a further request of X for money, saying in a text message that he needs "*a lot of coin and quick*". The evidence at the inquest did not enable me to reach a conclusion why Senior Sergeant Reynolds needed $50,000 in the days leading up to his death. Concerningly, and probably relevantly, in the SMS exchange X requests particular '*information*' from Senior Sergeant Reynolds. Despite this, there was no evidence of any information in fact being provided by Senior Sergeant Reynolds or money received by him. X was subsequently interviewed by officers from Professional Standards. X denied receiving the requested information from Senior Sergeant Reynolds, however he did say Senior Sergeant Reynolds gave him the "*heads up*" about "*things*" from time to time.

209. Unlike the theft of funds from his elderly mother, Professional Standards were aware of the allegations in relation to X when they executed the warrant.[87] However, no mention of X was made to Senior Sergeant Reynolds. Nonetheless, I have no doubt that Senior Sergeant Reynolds must have been aware that his conduct in relation to X, even if not able to be categorised as actually criminal, would almost certainly amount to a code of conduct breach. He must have been aware of the likely consequences for him in a personal and professional sense of his dealings with X.

210. The fourth issue involves an historical allegation of child sexual abuse in which Senior Sergeant Reynolds was said to have been one of a number of victims of a paedophile teacher working at a school in the north of Tasmania. Another victim had come forward and made the initiating complaint. In the weeks leading up to his death, Senior Sergeant Reynolds supplied a draft statement to the investigating officer setting out what had occurred to him at school in the late 1970s. Even if true, there is no evidence this matter caused or contributed to Senior Sergeant Reynolds' death.

211. The fifth issue is that Senior Sergeant Reynolds was noted to have suffered from depression since around 2008. It was formally diagnosed in 2012 by Mr Peter Nelson, a Clinical Psychologist. There was evidence at the inquest that the condition manifested after Senior Sergeant Reynolds' involvement in the mass fatalities at Port Arthur and 1996 and possibly worsened after the Beaconsfield mine collapse in 2006, both events Senior Sergeant Reynolds in which was involved. However, the evidence does not suggest Senior Sergeant Reynolds mental health played a significant role in his death.

[87] X was interviewed on 8 September 2019.

212. Finally, I note that there was evidence that Senior Sergeant Reynolds had reverted from the rank of inspector, at his own request, as he apparently did not enjoy the responsibility associated with being an Inspector and "*wanted to be one of the troops*". While that may have been true to some extent, the other side to it is that his personnel file shows he was formally reprimanded in January 2012 for poor work performance in that role .[88] He reverted to the lower rank of Senior Sergeant shortly after that formal reprimand, as I say apparently at his own request. Whether the demotion or loss of status caused or contributed to Senior Sergeant Reynolds' death seems to me unlikely given the passage of time between his reversion in rank and his death. It merely illustrates that Senior Sergeant Reynolds may have had some difficulty with performing at the level required of an Inspector of Police.

**Circumstances of death**

213. On the morning of the day of his death, Mrs Reynolds said that her husband looked "*terrible and gutted"*.[89] She said he promised her that he would be there in the evening when she returned from work. At around 8.30 am Professional Standards advised Tasmania Police Welfare Support that contact should be made with Senior Sergeant Reynolds and his wife. The evidence was that Sergeant Smith spoke to Mrs Reynolds near midday and obtained an account of what occurred the evening before.[90]

214. The evidence is that shortly after 2.00 pm on 13 September 2018, Senior Sergeant Reynolds visited the property of Mr Joshua Smith. Senior Sergeant Reynolds had coached Mr Smith in Australian Rules Football and was a family friend. He asked Mr Smith if he could borrow a rifle, explaining he needed it to euthanise a dog for a mate who did not want to go to the expense of spending $700 on a vet. Mr Smith lent him a firearm (I suspect reasonably believing there was nothing untoward at all about lending a firearm to a police officer). The firearm was a .17 calibre rifle. Senior Sergeant Reynolds said he would return it that evening.[91] Mr Smith said in his evidence at the inquest that he thought nothing of the request from Senior Sergeant Reynolds saying, "that if you cannot trust a police officer then can you trust?"[92] Mr Smith's evidence is that he had never lent him a firearm before. He also said that it did not appear to him that Senior Sergeant Reynolds had been drinking alcohol. Senior Sergeant Reynolds left at Mr Smith's property at 3.00 pm. What happened over the

[88] Exhibit R 34.
[89] Exhibit R 7, *op. cit*., page 8 of 10.
[90] *Supra.*
[91] Exhibit R 21, recorded video interview, Transcript.
[92] Transcript.

next few hours is unclear, but unimportant in the context of the investigation. As events transpired, Mr Smith is the last known person to have seen Senior Sergeant Reynolds alive, or have communicated with him.

215. Mrs Reynolds returned home from work at 5.30 pm. She said that the lights in the home were not turned on and that Senior Sergeant Reynolds was not there. She started phoning various people but could not find anyone that had seen him that day. Mrs Reynolds evidence was that judging by the logs on the fire it had not been stoked since about 12.30 pm.[93] That seems to be broadly consistent with the known evidence of Senior Sergeant Reynolds visit to Mr Smith at about 2.00 pm.

216. Mr Mark Griffiths swore an affidavit which was tendered at the inquest. In it he said that owned a property on Avenue Road, Parkham. He had asked a neighbour if he could go across onto his property to obtain a chain. Receiving permission, he did so at some point after 7.00 pm but precisely when is unclear (and in the context of the investigation, unimportant). Behind a shed on the property he discovered a male person, with blood on his hand and face, and a firearm "slumped over his right shoulder" seated in a white ute. The engine of the ute was still running. The male was non-responsive and Mr Griffiths assumed, correctly, he was dead. The deceased male was subsequently identified as Senior Sergeant Reynolds. Mr Griffiths phoned police.[94]

217. At about 8.00 pm Senior Constable Simon Triffitt received a call from RDS of a possible suicide at Parkham. Senior Constable Triffitt and Constable Moir attended Mr Griffith's property and spoke to him before driving across the road to the other property where the ute had been found. Their evidence is that upon arrival the ute's engine was still running and a male person was in the driver's seat. A vacuum cleaner hose was attached to the vehicle's exhaust pipe and ran into the cabin, through the passenger window. Given the vehicle was locked, a window had to be smashed to gain access. Once police obtained access to the inside of the vehicle Senior Sergeant Reynolds was found clearly deceased.

218. Constable Brett Tyson from Tasmania Police Forensic Services attended the scene. In his evidence he said that he did not identify any suspicious circumstances. Inspector Philippa Burk gave evidence in similar terms. I am quite satisfied that there were in fact no suspicious circumstances associated with the scene of Senior Sergeant Reynolds' death.

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[93] R 7, *op. cit.*
[94] See Exhibit R 9, affidavit of Mark Griffiths, sworn 13 September 2018, generally.

219. Constable Taylor's ballistic report indicates the weapon used by Senior Sergeant Reynolds to inflict the fatal wound upon himself was an A.17HMR (Horndady Magnum Rimfire) calibre CZ bolt action repeating rifle. The serial number matched the serial number of Mr Smith's firearm.

**Forensic, pathology and ballistic evidence**

220. Senior Sergeant Reynolds' body was identified at the scene by his colleague Constable Brett Tyson.[95] The scene was forensically examined and photographed (including Senior Sergeant Reynolds' body *in situ*). A brief suicide note in Senior Sergeant Reynolds handwriting was located in the car. In addition, medication and a bottle of Chivas Regal blended Scotch whisky was also in the car.

221. After all appropriate forensic procedures were carried out at the scene, Senior Sergeant Reynolds' body was taken by mortuary ambulance to the Royal Hobart Hospital and admitted to the hospital's mortuary.

222. On 14 September 2018 highly experienced forensic pathologist Dr Christopher Lawrence conducted an autopsy upon Senior Sergeant Reynolds' body. The autopsy confirmed the presence of a contact range gunshot wound of the mouth but no other traumatic injuries. Senior Sergeant Reynolds body was quite pink in colour, consistent with carbon monoxide intoxication. Bullet fragments were recovered from the brain. Dr Lawrence provided a report in which he expressed the opinion that the gunshot wound would have been rapidly fatal and was therefore the principal cause of death. I accept Dr Lawrence's opinion.

223. Samples taken at autopsy by Dr Lawrence were subsequently analysed at the laboratory of Forensic Science Service Tasmania. Carbon monoxide was detected in those samples at 70% saturation level, within the reported fatal range.[96] In other words, had he not shot himself in the head with a rifle, it is reasonable to conclude that Senior Sergeant Reynolds would have died of carbon monoxide poisoning. Other findings were of no particular significance, apart from the fact that despite the bottle of Scotch whisky being found in the vehicle with Senior Sergeant Reynolds' body, toxicological analysis of samples detected no alcohol in his body at the time of his death.

224. The circumstances in which Senior Sergeant Reynolds' body was found, the ballistic forensic and forensic pathology evidence all satisfy me to the requisite legal standard

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[95] Exhibit R 3, affidavit of Brett Gerald Tyson, sworn 24 May 2022.
[96] Exhibit R 6, affidavit of Neil McLachlan-Troup Forensic Scientist, sworn 19 October 2018.

that the actions which led to his death were undertaken by him voluntarily, alone and with the express intention of ending his own life.

**The execution of the warrant by Professional Standards**

225. Only two issues arise from the circumstances of Senior Sergeant Reynolds death. Both relate to the execution of the warrant upon him by officers from Professional Standards the night before his death.

226. First, in my view all of the interactions between those officers, Senior Sergeant Reynolds and Mrs Reynolds should have been recorded on a video camera. In my view, the explanations offered as to why that did not occur were unconvincing.

227. Second, there was a failure by Professional Standards to comply with a policy that had been implemented in the aftermath of Constable Hunt's death relating to the provision of a replacement mobile phone when one is removed from a police officer the subject of an investigation.

228. However, I do not consider that either of these deficiencies I have identified played any significant role in Senior Sergeant Reynolds' death. I do not consider that the evidence supports a conclusion that his service with Tasmania Police contributed to his death either. I do not consider that his engagement or otherwise with Professional Standards or Welfare Support Services caused or contributed to the happening of Senior Sergeant Reynolds' death. I find that the allegations of criminal conduct in relation to children which had emerged and were being investigated, together with the probability that his inappropriate dealings with his mother's assets would be uncovered and potentially his dealings with X, were the most likely factors in Senior Sergeant Reynolds death.

**Constable Simon Graham Darke**

**Background**

229. Constable Simon Graham Darke was born on 10 March 1973 in Victoria, the son of Janice and Graham Darke. His family moved to Hobart in 1975 and Constable Darke was raised and educated locally. After leaving school, he completed an apprenticeship as a signwriter[97] before joining Tasmania Police in 2008. He was evidently a quiet and unassuming man, who was popular and well respected within the police force. He was regarded favourably by his superiors and well-liked by his colleagues, amongst whom he had several close friends.

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[97] Exhibit D 8, affidavit of Graham Reginald Darke, sworn 21 February 2019.

230. Constable Darke appeared to keep himself fit and was a keen cyclist. His Inspector thought he had the potential to move into the Criminal Investigation Branch and encouraged him to apply for vacancies in that branch.[98] Constable Darke did not have a history of any real significance with Professional Standards. While he did have some unauthorised vehicle pursuits in late 2017 and early 2018, they can be by no measure considered to be career-defining and the evidence is that he handled the criticism well, according to his supervisors. I do not consider that any complaints about his conduct or investigations by Professional Standards (which in real terms were minor) played any role in Constable Darke's death.

231. Constable Darke had minimal involvement with Police Wellbeing Support Officers and the Welfare Support area generally. I do not consider welfare support, good bad or indifferent, was a factor in Constable Darke's death.

232. The evidence makes it clear that no one had any inkling that Constable Darke intended to take his own life. His suicide came as a terrible shock to his family, friends and colleagues.

233. It is necessary, in the context of the inquest, to understand Constable Darke's death, and to deal with his somewhat complicated relationship history in some detail.

**Constable Darke's personal life**

234. Constable Darke met his wife Angela in 1992 while he was still working as a sign writer. They married in March 1997 and had daughter Cleo together in 2003.[99]

235. The couple separated in 2004, possibly because Constable Darke had an affair. The separation seems to have been difficult, with the evidence being that for a considerable time Constable Darke did not, or possibly could not, see his daughter. There was at least one incident – a dispute of some kind – following the separation from his wife in 2004 which necessitated the involvement of police (and Constable Darke's parents).

236. Shortly after separating from Angela, Constable Darke commenced seeing Ms Shanna Sweeney. Ms Sweeney and Constable Darke were in a relationship for around seven years, during which time Constable Darke joined Tasmania Police. They lived together as a couple at homes in Berridale, Austins Ferry and Geilston Bay.

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[98] Exhibit D 20, affidavit Inspector John George Ward, sworn 12 June 2019.
[99] Exhibit D 12, affidavit Angela Josephine Drake, sworn 19 February 2019.

237. Ms Sweeney said in her evidence at the inquest that she had contacted Tasmania Police in or about July 2011 after, she said, Constable Darke threatened to shoot himself with his police issue Glock pistol and also made some comments about suicide by jumping from a tall building or the Tasman Bridge. Ms Sweeney said in her evidence that their separation was "messy".[100] Again, as with his separation from his wife Angela, the attendance of police was necessary on at least one occasion during the breakup.

238. In fact, other evidence in the form of Tasmania Police records suggests that Ms Sweeney's allegation about Constable Darke was not made formally until 2014. Ms Sweeney was asked about this apparent discrepancy when she gave evidence at the inquest. She said that she had actually raised the issue with two police officers in 2011. It seems that she at least discussed it with one officer in 2011 but did not make an actual formal complaint until 2014. When she did, it was treated seriously. Ms Sweeney's allegation in 2014 led to a formal investigation being carried out. The investigation involved, *inter alia*, Constable Darke being spoken to. He denied threatening suicide. One of the officers to whom Ms Sweeney said she spoke in 2011 was also spoken to and denied that any such conversation had occurred. The other officer concerned recalled Ms Sweeney telling him of Constable Darke's alleged threats, but went on to say that Ms Sweeney did not appear to take the threats seriously, that they had occurred (she said) once only and in the heat of the moment.[101] It is difficult to see what more could have been done in the circumstances. In any event when the report from Ms Sweeney was investigated in 2014, it was found by Professional Standards to be unsubstantiated. I should add that Ms Sweeney's evidence was that Constable Darke had not disclosed, she said, his suicidal ideation to anyone within Tasmania Police.

239. Returning to Constable Darke relationship history, he and Ms Sweeney's relationship ended in 2011, although by then he had commenced seeing Ms Kimberly Freeman. The separation from Ms Sweeney was also not without difficulty. There was evidence that Constable Darke made an application for a family violence order against her on 19 March 2013.

240. Ms Sweeney also said in her evidence that she believed Constable Darke suffered from depression. While I accept that that belief was genuinely held, I note she was not qualified to express that opinion and that there is no evidence of him being diagnosed

[100] See Exhibit D 17, affidavit of Shanna Mary Sweeney, sworn 20 May 2022, generally.
[101] Exhibit D 28, affidavit of Troy Graham Morrisby, sworn 16 September 2019.

by a healthcare professional with depression, anxiety or any other mental illness, nor receiving treatment of any type for any mental ill-health at any time in his life.

241. Even if there was some truth to Constable Darke's threats of self-harm or suicide as reported by Ms Sweeney, I observe that they were made eight or so years prior to his death. There is no evidence of him having any suicidal ideation or making threats, whether by using his service pistol or jumping from height, between the making of threats as reported by Ms Sweeney and his actual death.

242. Constable Darke commenced seeing Ms Freeman in about October 2010 whilst he was still in a relationship with Ms Sweeney. In December 2010, Ms Freeman moved into the home at Geilston Bay recently vacated by Ms Sweeney. Constable Darke appears to have rekindled his relationship with Ms Sweeney early in 2011 (having asked Ms Freeman to move out so that he could do so, shortly after she moved in), before recommitting to the relationship with Ms Freeman a few months later. Together Constable Darke and Ms Freeman had two daughters and became engaged to be married in December 2014.

243. Eventually, in about October 2015 the couple moved into their property at Midway Point, the same property where Constable Darke ultimately took his own life.

244. The couple separated about eight weeks prior to his death in acrimonious circumstances.

245. On 8 December 2018, Ms Freeman assaulted Constable Darke after leaving the Customs House Hotel, significantly intoxicated, following a work Christmas function. The assault involved her pushing, grabbing and scratching him. Constable Darke managed to get Ms Freeman into his vehicle (he was sober – having come to pick her up from the function) and went straight to the Hobart Police Station. Evidence was tendered at the inquest from Sergeant Danny Jackson and Constable Jessica Lyndon in relation to his attendance at the station and also of them speaking with Ms Freeman (who was waiting outside in the car at the time). The upshot of the incident was that Ms Freeman was charged with assault over that matter and a Police Family Violence Order (PFVO) was made by a Sergeant of police, protecting Constable Darke.

246. The evidence of the two attending officers is that Constable Darke was terribly upset about what had occurred.[102] Although he and Ms Freeman went home together (something expressly permitted under the terms of the PFVO) I consider that

[102] Exhibits D 19 and D 18, affidavits of Jessica Lyndon and Danny Jackson respectively.

Constable Darke must have known that his relationship with the mother of two of his children was effectively over after an assault charge have been laid and PFVO having been issued against Ms Freeman.

247. On 12 December 2018 (four days later), Constable Darke attended the Sorell Police Station. He made a complaint to an officer on duty there that Ms Freeman had again assaulted him. He said that she had slapped him to the forehead with an open hand. A video recording on his phone was viewed by the police officer but reportedly did not show any the assault occurring. The matter was essentially 'left' there because Constable Darke indicated that he did not wish to make a formal complaint to police.

248. The evidence is that during the month of December 2018, Inspector Ward spoke to Constable Darke about his relationship difficulties. Inspector Ward said he thought it was difficult for Constable Darke to "open up". Also during this period Sergeant May in his role as a Wellbeing Support Officer contacted and spoke to Constable Darke on two occasions, suggesting relationship counselling for him and Holyoake counselling for Ms Freeman (there was certainly evidence that would support a conclusion she may have had an alcohol problem, and Holyoake provides assistance in that area). Constable Darke declined, as was his right, both psychological and/or welfare support. I consider that the interaction between Welfare Support Services and Constable Darke was appropriate. In addition, there was evidence that arrangements were made for Constable Darke to have extra leave, should he require it. I note that the evidence of Inspector Ward was that in his contact with Constable Darke during this time he did not observe any signs or suggestions, apart from the obvious upset caused by any relationship ending, that Constable Darke was suffering any mental health issues.

249. In any event Ms Freeman moved out of the family home with the couple's two daughters on 11 January 2019. Constable Darke took personal leave from 10-13 January while that occurred.

250. The next relevant event was Ms Freeman's appearance in court on 21 January 2019 and pleading guilty to assaulting Constable Darke on 8 December 2018. The matter was adjourned for sentence and ultimately Ms Freeman was eventually sentenced on 18 March 2019 (after Constable Darke's death) when she received a $400 fine.

251. Following Ms Freeman moving out of the Midway Point home, Constable Darke initiated contact with a woman he had known in the past, Ms Simone Bertoz. He had a coffee with her on 22 January, while still saying to Ms Freeman (by SMS) on

24 January that she could 'stop this rubbish of having to share their girls'. I think the reasonable inference from that SMS exchange was that Constable Darke did not want that relationship to be over, or at least was ambivalent about that. Against that, an SMS message on 28 January to Ms Freeman speaks of him wanting "court orders" (presumably to finalise access and property matters between them) to be done that week.

252. The evidence seems to suggest that the couple had reached some agreement in principle that would see Constable Darke keeping the home, Ms Freeman receiving $10,000 and forgoing child support payments. In respect to the matters concerning children, there is reference to flexible arrangements around work but no mention of overnight time.

253. Constable Darke's last scheduled work week was 31 January 2019 to 7 February 2019. Sergeant Edge, his supervisor that week, gave evidence that she had asked him if he was willing to work as the night Breath Analysis Operator (BAS operator) out of the Bellerive Station to cover a colleague's period of leave during that week. During that discussion, she said that Constable Darke told her that he needed to pay Ms Freeman a sum of money as a property settlement which money needed to come from his superannuation entitlements.[103]

254. None of the evidence of any of his colleagues at the inquest in relation to his health and well-being in the lead up to his death suggests that he was especially fatigued or complained of being overworked. For example, Constable Aaron Woolen said in his affidavit[104] that Constable Darke spoke about his separation and said the main stress was the degree of separation from his children, although he understood it to be a positive step. Constable Woolen said that Constable Darke indicated that he wished to move on from the relationship and was positive about the woman he had commenced seeing. Constable Woolen said that at no stage did Constable Darke speak about feeling depressed and seemed to be his normal self.

255. In his affidavit tendered at the inquest,[105] Constable Ian Provan said he was aware of Constable Darke's issues with relationships but said his death was a complete shock to him. Constable Provan described Constable Darke as a devoted father who maintained as much contact with his children as "*their mothers' and the courts would allow*". He said he was a dedicated and conscientious police officer. He said he thought

[103] Exhibit D 16, affidavit Anne Marle Edge, sworn 16 May 2022.
[104] Exhibit D 53, affidavit Aaron Macon Woolen, sworn 6 February 2019.
[105] Exhibit D 54, affidavit Ian David Provan , sworn 18 November 2022.

Constable Darke had just "*run out of fight*" with what he understood to be the ongoing conflict with Ms Freeman and the "*on-going scars from the failure of his previous relationships*".

256. Constable Samuel Tilley's evidence in his affidavit[106] is that Constable Darke was embarrassed that his private life had entered his work life. He also referred to him as being keen to work some overtime in order to alleviate some of the financial hardship from his separation. Constable Tilley thought the financial hardship and prospects of another custody battle weighed heavily on his mind. He described Constable Darke as "*a relaxed and level headed police officer… [who] seemed to manage the stresses of everyday policing well*".

257. Constable Gareth Auker, a police officer significantly junior to Constable Darke, worked with him in the week of his death. In his affidavit[107] he described Constable Darke as being "*friendly, approachable and willing to explain processes*". Constable Arthur Alforte also spoke to him that week. He said while Constable Darke was tired from night shift he gave no indication that he was "*down in the dumps*".[108] Similarly, Sergeant Steven Keiselis worked with Constable Darke earlier in the week and did not notice anything out of the ordinary about him either. In summary, no one saw anything especially unusual at Constable Darke and there is no evidence of him experiencing any particular fatigue or workload issues.

258. The evidence of Constable Darke's movements and contacts in the final week of his life is unremarkable. He spent time with Ms Bertoz and interacted normally with colleagues. His father considered his son appeared to be his "*usual quiet self*" on the Sunday before he died, when he dropped his children off for a few hours while he helped a mate move house.[109] In short, nothing about his behaviour in the lead up to his death gave anyone, colleagues friends or family any indication that anything was wrong or that he had any plans for self-harm or suicide.

259. His SMS messages are equally anodyne. They include discussions between Constable Darke and Ms Freeman about school clothes and after-school pickups, and with Ms Bertoz about watching the Super Bowl together.

[106] Exhibit D 55, affidavit Samuel John Tilley, sworn 18 November 2022.
[107] Exhibit D 25, affidavit Gareth Auker, sworn 1 July 2020.
[108] Exhibit D 22, affidavit Arthur Alforte, sworn 6 February 2019, page 2 of 2.
[109] Exhibit D 8, affidavit Graham Reginald Darke, sworn 21 February 2019, page 3 of 3.

260. On 5 February 2019, he had dinner with Ms Bertoz and the pair discussed the possibility of going to a cricket match later in the week. Ms Bertoz described Constable Darke as appearing totally normal, happy and in good spirits when they parted.[110] During the evening (before he went to work) he called his children to wish them good night. Ms Freeman's evidence is that he sounded good during the telephone call and was positive about taking the children to the Hobart Cup.[111]

261. However, and to my mind it is likely to have been of some significance, it appears according to the SMS messages forming part of the exhibits, subsequent to that call, Ms Freeman and Constable Darke argued by SMS about her going to the Hobart Cup too (but separately of him).

262. I have mentioned already that there was evidence at the inquest that Constable Darke had experienced difficulties on occasions having access to his daughter from his earlier marriage. In saying this, I make no finding as to whether that was in fact true and, if it was, where, if any, any fault lay for that difficulty. I highlight the matter because it is evident to me that the potential for a repetition of that difficulty so far as access to his daughters with Ms Freeman may well have been something that was exercising Constable Darke's mind at the time of, and in the lead up to his death.

263. It is also worth noting that two officers particularly close to Constable Darke, Constable Frank Aboud[112] and Constable Provan both expressed the opinion that the impact of his separation from Ms Freeman and the prospect of family law litigation were likely to have been a significant factors weighing on Constable Darke's mind at the time of his death.

**Was fatigue a factor in Constable Darke's death?**

264. Constable Darke worked in the Huon region during the extensive bushfires there in the early part of 2019. Although it is evident from his records he did some overtime, there is no evidence that the hours he worked were unusual, especially onerous or in any way linked to his death. Having regard to the records tendered at the inquest, it is evident that he worked a total 31 hours overtime between 1 December 2018 and 29 January 2019. He also had periods of leave during that time. He did work a significant period of overtime – 19 hours - between 27 and 29 January 2019 at those bushfires,

[110] Exhibit D 14, affidavit Simone Louise Bertoz, sworn 8 February 2019, page 3 of 4.
[111] Exhibit D 13, affidavit Kimberly Anne Freeman, sworn 9 February 2019, page 8 of 8.
[112] Exhibit D 53, affidavit Francis Cedric Aboud, sworn 18 November 2022, generally.

but otherwise there was nothing particularly remarkable about the overtime or shifts he worked.[113]

265. In regards to Constable Darke's shifts during the lead up to his death, the objective evidence[114] is:

- He was on leave from 7 December 2018 to 27 December 2018;
- He was on personal leave from 10-13 January 2019; and
- He worked 19 hours of overtime on 27-29 January 2019 at the Huon bushfires.

266. Constable Darke's time off in lieu (or 'TOIL') records reveal a total of 15 hours accrued. Neither those records nor his records of overtime generally suggests to me anything out of the ordinary.

267. In fact, I do not consider that the evidence at the inquest suggests that in any way Constable Darke's service as a police officer was a factor in his death. In saying this, I do not overlook the fact that he was working effectively alone as the night BAS operator out of the Bellerive Station at about the time of his death - something quite rightly highlighted by his father in his evidence.[115] However, whilst police officers working alone (or "one up" as it was described in evidence by several witnesses) is less than desirable, the evidence does not support a conclusion that Constable Darke's rostering arrangements caused or contributed to his death.

268. However, as I have made clear, Constable Darke had some difficulties in his personal life, particularly his relationships with women, with some of those relationships appearing to be problematic. At the time of his death, he had just separated from his partner in unpleasant circumstances and was in the process of negotiating parenting arrangements for his two youngest children and a property settlement. In particular the negotiations associated with parenting arrangements needs to be viewed in the context of previous difficulties associated in spending time with his eldest daughter.

269. It is not unfair to say that while his policing career was sound, Constable Darke's personal life at the time of his death was complicated and likely the cause of significant stress for him.

[113] See exhibit D 50 generally.
[114] See exhibit D 45, Iapro Holdings, generally.
[115] Exhibit D 8A, affidavit Graham Reginald Darke, sworn 16 November 2022, page 4 of 4.

**Circumstances of death**

270. Constable Darke arrived for work at the Bellerive Police Station at 10.32 pm on 5 February 2019. He was rostered as the BAS operator for the Southern Police District. His shift was due to commence at 11.00 pm. The evidence was that a BAS Operator works alone, but is available when not occupied with performing duties associated with breath analysis of people taken into custody under the *Road Safety (Alcohol and Drugs) Act* 1970, to assist other officers as and when required with what might be termed 'ordinary' policing duties.

271. I note that Constable Jamie Harris had a brief conversation with Constable Darke shortly after his arrival at work and did not notice anything different about his demeanour.[116]

272. As part of standard shift procedure, Constable Darke signed out a police issue firearm, a 9mm Glock pistol. He then drove to his home, which he must have known was unoccupied at the time. The evidence was that his police vehicle left the Bellerive Police Station at 12.16 am on 6 February 2019.

273. At 1.14 am, Constables Teagan Walkley and Harris were tasked by RDS to attend Constable Darke's home because RDS had been unable to contact him and his vehicle was showing on GPS tracking as being at that address. They arrived seven minutes later and found Constable Darke lying dead in the back yard of his home. He had an obvious a gunshot wound to his head. His police issue Glock 9 mm pistol was in his hand. Constable Darke's police accoutrements and personal belonging did not appear to be in anyway disturbed. Two handwritten suicide notes were found by police inside his home.[117]

274. Despite the attendance of ambulance paramedics Constable Darke was obviously dead and nothing could be done to resuscitate him.

**Forensic, pathology and ballistic evidence**

275. Constable Darke's body was formally identified at the scene by Inspector Grant Twining, who had known him for 11 or more years.[118] Following forensic examination and photography, it was removed and taken by mortuary ambulance to the Royal Hobart Hospital and admitted to the hospital's mortuary.

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[116] Exhibit D 9, affidavit Jamie Scott Harris, sworn 7 February 2019, page 1 of 3.
[117] Exhibit D 34.
[118] Exhibit D 4, affidavit of Inspector Grant Twining, sworn, 8 February 2019.

276. On 7 February 2019, Dr Donald Ritchey performed an autopsy upon Constable Darke's body. Dr Ritchey provided a report, which was tendered at the inquest,[119] in which he expressed the opinion that the cause of Constable Darke's death was a gunshot wound of the head. Dr Ritchey found clear evidence that, as in the cases of Constable Hunt and Senior Sergeant Reynolds, the fatal gunshot wound was a contact one.

277. I accept Dr Ritchey's opinion. I consider that he is well qualified to express the opinion that he did.

278. Toxicological analysis of samples taken at autopsy were subsequently examined at the laboratory of Forensic Science Service Tasmania. The result of that analysis was negative for both alcohol and drugs.[120] I am satisfied that neither alcohol nor drugs played any part in Constable Darke's death.

279. Now retired Constable Stephen Denholm, at the time of Tasmania Police Ballistics Section, attended the scene of Constable Darke's death shortly after his body was found. Mr Denholm also attended the autopsy and carried out a ballistic examination of the pistol and cartridge case found at the scene. He provided a detailed report which was tendered at the inquest.[121] I am satisfied that Mr Denholm is qualified to express the opinions that he did in that report. He said that the pistol was in proper working order, was fitted with three efficiently operating safety mechanisms and not prone to accidental discharge. He said that it was his opinion that the fired 9 mm cartridge case recovered at the scene had been discharged from the pistol. I accept Mr Denholm's opinion.

280. I find on the evidence that Constable Darke's death was the result of a voluntary and intentional act on his part to end his own life.

281. Viewing the evidence as a whole in relation to Constable Darke's background, his evident difficulties with relationships and the circumstances of his death, I am quite satisfied that, although he was on duty and used his police issued service firearm to take his own life, there is no other connection between his service as a police officer and his death. There is no evidence that supports a conclusion that he was suffering from any particular work-related fatigue or any work-related mental health issues. There is no evidence that Constable Darke was ever formally diagnosed with any form

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[119] Exhibit D 5, affidavit of Donald MacGillivray Ritchey, sworn 18 March 2019.
[120] Exhibit D 6, affidavit of Craig Gardener, Forensic Scientist, sworn 5 March 2019.
[121] Exhibit D 37, affidavit Stephen Scott Denholm, sworn 27 March 2019.

of mental illness and thus received no treatment in that regard. It may be that he was suffering from underlying undiagnosed depression and anxiety, but in saying that at best that is nothing more than mere speculation on my part.

282. As I have said, Constable Darke had no significant involvement with Police Welfare, CISM or Professional Standards. There is no evidence that his death was in any way related to his service as a police officer (apart from in the manner that I have already described, that is to say the use of his service pistol whilst on duty). In contrast, he was experiencing another difficult relationship breakup which had involved him being assaulted by his ex-partner and mother of his two young children. He had reason to be concerned about ongoing access to his children. The stress created by that situation seems to me to be the most likely explanation for Constable Darke's decision to end his own life.

283. In conclusion, I do not consider that anything could realistically have been done by Tasmania Police to have prevented Constable Darke's death.

**Sergeant Robert Anthony Cooke**

**Background**

284. The last death in time considered at the inquest was that of Sergeant Robert Cooke. Sergeant Cooke was born in Tasmania on 9 November 1970 and joined Tasmania Police in 1990. He was the father of two sons, Jarred and Liam, who he had whilst married to fellow police officer, Sonya Cooke. He separated from Sonya in about May 2016.

285. Upon his graduation from the Tasmania Police Academy in July 1990 Sergeant (then Constable) Cooke was first stationed at Hobart Uniform. He remained there until November 1993, but spent time performing secondments at RDS and the Southern Drug Bureau.

286. In 1993, Sergeant Cooke transferred to Glenorchy Uniform and then, in 1995, to Bellerive Uniform where he remained for the next six years. A posting followed to Eastern Traffic Services before his promotion in May 2003 to Sergeant and a return to Glenorchy Uniform. In April 2005, Sergeant Cooke returned to RDS.

287. He went back to Eastern Traffic Services in May of the following year, now as the Officer in Charge. Next, Sergeant Cooke was posted to the Eastern Public Order Response Team (again as Officer in Charge) between 2009 and 2010. In August 2010, Sergeant Cooke was transferred to Operations Support as the District Administration

Sergeant where he remained for two years before returning again to RDS in November 2012.

288. In July 2015, Sergeant Cooke was appointed to the position of Officer in Charge, Oatlands Station. That was his final posting within Tasmania Police.

289. At the time of his death, he was still a Sergeant in Tasmania Police, although by then very ill with PTSD, unable to work and in receipt of benefits under the *Workers Rehabilitation and Compensation Act* 1988. All witnesses who gave evidence at the inquest about him spoke glowingly of Sergeant Cooke as a man, police officer, father and friend. Even allowing for the all too human, and very common, tendency to exaggerate the personal qualities of a person after death, it is evident he was universally liked, respected and admired by his colleagues. For example, Senior Sergeant Bennett, who knew Sergeant Cooke very well, was asked questions about Sergeant Cooke by Mr Harris, Counsel for the Police Association of Tasmania. Senior Sergeant Bennett described Sergeant Cooke as appearing stoic, being looked up to and revered by many serving police officers. He said Sergeant Cooke was the leader that everyone else wanted to be.[122]

290. Several attested to the fact that policing was his life, that he was an outstanding leader and mentor and that he loved being a police officer. His death was a very great shock to many police officers and to many people who knew him.

291. Sergeant Cooke had a profound interest in the well-being and welfare of his colleagues and the organisation in general. He was involved with the Police Association of Tasmania for many years, a demonstration of his strong commitment to both policing and his colleagues.

292. Sergeant Cooke's service with Tasmania Police spanned 30 years. He attended numerous critical incidents. Those critical incidents led Sergeant Cooke to develop severe, chronic PTSD. His condition dominated the last years of his life and brought his career to a conclusion. Counsel Assisting, Mr Lee, submitted, correctly in my view, that Sergeant Cooke's death was related to the cumulative effect of those exposures, rather than a single identifiable discrete event.

[122] Transcript.

**Sergeant Cooke's mental health**

293. Sergeant Cooke's mental health was central to a consideration of the circumstances of his death. The evidence was that his involvement with CISM is recorded as going back to the early years of his service as a police officer.

294. His first recorded interaction was following his attending a fatal motor vehicle accident at Tunbridge in the Midlands of Tasmania on a date unknown but sometime in 1995. Thereafter records tendered at the inquest[123] show he had regular contact with CISM, the last recorded contact being in September 2016, relating to a fatal motor vehicle accident at Interlaken. As is the case with the other officers whose deaths were the subject of the inquest, there is no evidence which would support a conclusion that Sergeant Cooke's interactions with CISM had any causal connection with his death.

295. Sergeant Cooke's posting to Oatlands was followed by the end of his marriage to Sonya, which coincided with his commencing relationship with another colleague Senior Constable Elizabeth (Jen) Carlisle. It is evident that the separation from Sonya was difficult for all concerned. Constable David Rowlands, someone who was very close to Sergeant Cooke, described the separation as "*bitter*"[124] and said that Sergeant Cooke did not see his sons for a considerable period of time, something which caused him considerable grief. I do note that his relationship with his sons appeared to have improved significantly by the time of his death. His son Jarred described his father as being "*racked with guilt*" in the aftermath of the separation.[125] Following the separation, Sergeant Cooke was referred to counselling and undertook approximately six sessions.

296. Those sessions were organised by the Manager of Psychology Services, People and Culture, Business Executive Services, Department of Police, Fire and Emergency Management[126] and were with Mr Murray Kirkwood at the Psychologyworks practice in Hobart. The clinical notes[127] of those consultations in October and November 2017 make clear the focus of the consultations was Sergeant Cooke's marriage breakdown. The issue of PTSD is mentioned, but Sergeant Cooke appears to have denied any symptoms consistent with that condition. In fact it is plain, in my view, on the

[123] See in particular the most helpful summary appearing at annexure RC2 of the affidavit of Matthew Peter Richman, sworn 16 November 2022, exhibit G 14.
[124] Exhibit C 28, affidavit David James Rowlands, sworn 19 July 2021, page 2 of 4.
[125] Exhibit C 9, affidavit Jarred Robert Cooke, sworn 21 October 2020, page 2 of 3.
[126] Exhibit C 45, records, Psychologyworks, page 8 of 85.
[127] *Supra.*

evidence, that by that time Sergeant Cooke had a severe case of PTSD, probably stretching back to an incident in 1994.

297. It is evident that his mental health continued to be problematic. There was evidence at the inquest that Sergeant Cooke was tired, frustrated and suffering difficulties coping with the workload at Oatlands, an obviously busy rural police station which, in addition to a challenging workload, covered a significant geographical area. Nonetheless, the evidence was that Sergeant Cooke loved working at the Oatlands Police station and had developed a strong attachment to the area and its people.

298. There was evidence at the inquest from Senior Sergeant Bennett that losing a staff member at Oatlands in 2017 had a negative impact on calls outs (meaning the frequency of attending call outs increased – which is an obvious result of any reduction in any staff anywhere). Senior Sergeant Bennett described Sergeant Cooke appearing tired and frustrated around this time.

299. In March 2018, Sergeant Cooke and Senior Constable Carlisle purchased a home together at Enfield Lane, Campania. It was at that property that Sergeant Cooke performed the actions which led to his death.

300. In April 2018, he was referred for further counselling. By August 2018, he had been elected the Vice President of the Police Association of Tasmania, a role which evidently kept him busy and created additional stress.

301. Senior Constable Carlisle said she witnessed a significant decline in Sergeant Cooke's mental health from about September 2018 onwards. She described a number of incidents that were playing on Sergeant Cooke's mind which caused him sleeplessness and lead to (when he did manage sleep) nightmares. Her evidence was, in effect, that him being on call constantly kept him in a state of heightened alertness and caused those nightmares. She said he described his nightmares as focused, vivid and involved every "deceased person that he had ever been exposed to work [coming] back to life and [killing] him in a vividly violent way".[128] Sergeant Cooke appears to have become forgetful, agitated, angry and demonstrated physical symptoms of his distress.

302. In January 2019, significant bushfires occurred in the Central Highlands region of Tasmania, within the geographical remit of the Oatlands Police Station. It is clear that Sergeant Cooke was under substantial pressure during this time working long shifts with little down time and remaining on-call when not actually on duty. By March 2019,

[128] Exhibit C 8, affidavit of Elizabeth Jenny Carlisle, sworn 1 December 1 2021, paragraph 26.

after the fires ended it was clear to many who knew Sergeant Cooke that he was far from well. He was seen to be both tearful and angry. Several people present at a Police Association Tasmania meeting (including then Commissioner Darren Hine) were so concerned about him that checks were made after the meeting on his welfare.[129] Sergeant Cooke confided in then Constable Pat Allen about the nightmares he was experiencing. Around that time there was evidence was that Sergeant Cooke attended the death of an elderly person and became angry (evidently unusual behaviour on his part).

303. I find that the role required of Sergeant Cooke during the bushfires in the Central Highlands of Tasmania between January and March 2019, and in particular the hours he was required to work during those fires, whilst not the cause of his PTSD, were clearly the "final straw" as far as his ability to continue to cope with both that condition and the position of Sergeant at Oatlands.

304. Those fires were widespread and long-running. Significant emergency services resources – Tasmanian Fire Service, State Emergency Service and Tasmania Police personnel were committed to managing that emergency. The area most affected by those bushfires was within the area for which Sergeant Cooke was responsible. As noted already the evidence was that Sergeant Cooke worked long shifts for an extended period during these bushfires. However, the impact upon him of the bushfires, and the work he was required to do, was the subject of conflicting evidence. On the one hand his close friend Constable Rowlands who worked with him at Oatlands during the relevant time said that they both worked long hours, sometimes 10 to 12 hour days (plus travel to and from Miena in the Highlands). But Constable Rowlands said that it was his perception that Sergeant Cooke was "*fine and his [usual] jovial self*".[130]

305. In contrast, Senior Constable Carlisle described Sergeant Cooke as working 16 hour continuous shifts for 4 weeks and being "*exhausted and barely functioning towards the end of the third week of the emergency response to the fires*".[131] In the same vein, Senior Sergeant Bennett described Sergeant Cooke as being required to work 60 hour weeks.[132] In addition, Sergeant Cooke's sister, Michelle, said in her evidence that her brother was "*too fatigued*" following the fires.[133] Similar evidence was received from

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[129] Exhibit C 56, affidavit Darren Leigh Hine, sworn 10 October 2022 page 1 of 2.
[130] Exhibit C 28, *op. cit.*, page 2 of 4.
[131] Exhibit C 8, *op. cit.*, paragraph 40.
[132] Exhibit C 52, affidavit Andrew Leslie Bennett, sworn 20 April 2021, paragraph 12.
[133] Exhibit C 11, affidavit of Michelle Anne Cook, sworn 18 June 2021, page 4 of 21.

Sergeant May, Sergeant Cooke's Wellbeing Support Officer Sergeant May said that he became aware on 22 March 2019 that Sergeant Cooke had "fallen over" possibly with fatigue after his duties at the Central Highlands bushfires.[134]

306. I am satisfied that Sergeant Cooke was required to work very long hours during the bushfire crisis in the Central Highlands. The hours that he worked are relevant in two ways. First, as I have said, it appears to have been the "final straw" for him in the sense that he went off work immediately following those fires (which suggests that the impact upon him was significant). Second, the issue of how Tasmania Police managed the issue of fatigue is, in my view, directly raised by Sergeant Cooke's work at the fires and thus a proper matter for consideration at the inquest.

307. There were obvious problems, to my mind, with fatigue management by Tasmania Police at this time, if for no other reason than the service did not even have a fatigue management policy. I will return to this issue later in these findings.

308. After his work on those bushfires had concluded, Sergeant Cooke submitted an application for workers compensation which application was accepted, being supported by a medical certificate issued by his general practitioner Dr Mark Nelson of the Lindisfarne Clinic for a period of total incapacity until 8 May 2019. The medical certificate indicated he was presenting symptoms of anxiety and PTSD and suggested treatment was necessary, including psychological therapy.

309. Tasmania Police (or at least its insurer) accepted and processed Sergeant Cooke's claim for workers compensation appropriately. Tasmania Police's People and Culture Branch organised psychological support for Sergeant Cooke before the claim had even been made and accepted and he began to see Ms Jacqueline Prichard.

310. Her evidence was that she first saw Sergeant Cooke on 3 April 2019. At that time Ms Prichard described seeing him present with PTSD with delayed expression relating to multiple traumatic incidents across his whole policing career. She considered that his PTSD had been present for at least four months. In fact to my mind there can be little doubt that Sergeant Cooke had suffered from the condition for considerably longer than four months. Ms Prichard continued to see Sergeant Cooke regularly. By June 2019, she had seen him five times. Her treatment of Sergeant Cooke included cognitive behavioural therapy, exposure therapy (which involved a visit to the site of a motor vehicle accident at Mary's Hope Road in 1994) and the development of self-care and suicide prevention plans. Ms Prichard was concerned about Sergeant Cooke's

[134] Exhibit C 22, *op. cit.*, page 2 of 22.

consumption of alcohol and considered he was unlikely ever to return to work as a police officer.

311. During this time Sergeant Cooke also continued to see his general practitioner and was treated with antidepressant medication.

312. On 31 May 2019, Sergeant Cooke saw Dr Leonard Lee, Consultant Psychiatrist, at the request of his workers compensation insurer. Following that consultation, Dr Lee authored a medical report which was sent to the insurance company and ultimately tendered at the inquest.[135] In that report he confirmed the diagnosis of PTSD. Dr Lee expressed the opinion that he did not believe that there were any other factors besides Sergeant Cooke's work which could have contributed to that condition. Dr Lee endorsed Sergeant Cooke's then extant Treatment Management Plan involving assistance from a psychologist and referral to a psychiatrist. Dr Lee thought (wrongly as it turned out) this would improve his symptoms.

313. Dr Lee made specific mention of the fact that Sergeant Cooke reported that he felt he had never recovered from a fatal car crash 25 years ago on Mary's Hope Road, Rosetta, around 1994 which involved a three-year-old child. Sergeant Cooke described a scene which involved a nurse and the child being engulfed in flames, the nurse was screaming and subsequently dying. Dr Lee expressed the opinion that intense feelings of helplessness and cumulative exposure to traumatic situations, together with overwork and sleep deprivation, were the factors which caused Sergeant Cooke's condition. Dr Lee's opinion was that Sergeant Cooke could participate in a gradual return to work and that his prognosis was "reasonable", although he would require review in three – six months.[136] Like Ms Prichard, Dr Lee noted Sergeant Cooke's excessive alcohol consumption.

314. Sergeant Cooke's principal treating psychiatrist Dr Yvonne Turnier-Shea gave detailed evidence at the inquest.[137] Dr Turnier-Shea had, at the time of giving her evidence, over 26 years working in the field of psychiatry in both the public and private sectors; 18 of those years as a consultant psychiatrist. She had extensive experience in the treatment of PTSD generally and police officers suffering from PTSD in particular. She said she was in regular contact with the specialised PTSD unit first responders at the Alfred Hospital in Melbourne. Dr Turnier-Shea said:

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[135] Exhibit C 47, report Dr Leonard Lee, Consultant Psychiatrist 14 June 2019.
[136] *Supra,* generally.
[137] See exhibit C 46A affidavit of Dr Yvonne Turnier-Shea, sworn 6 December 2022 and medical records – exhibit C 46, generally.

> *"PTSD is categorised as an anxiety disorder as per DSM 5 and often hard to treat. In my experience, prognosis for any person diagnosed with severe PTSD is typically guarded. [Sergeant] Cook fulfilled all criteria for DSM 5 diagnosis of PTSD and given the severity of the symptoms and a failed return to work program, I was uncertain at the beginning of treatment whether the prognosis was going to be good. In general, dealing with PTSD patients, the literature shows that there is a high incidence of secondary problems such as substance abuse disorders, depression, personality changes and interpersonal problems. In regards to [Sergeant] Cook, he suffered from all of the sequelae above associated with PTSD.*"[138]

315. Dr Turnier-Shea described Sergeant Cooke's PTSD as being among the worst cases she had seen, and being among the very worst cases of police officers with PTSD she had treated in her career. Although she described Sergeant Cooke as having "*excellent help seeking behaviours*", she said he had intermittent suicidal ideation and she considered him to be at risk in a "*moment of weakness*" particularly after the excessive consumption of alcohol.[139]

316. She saw Sergeant Cooke on 51 occasions in hospitals and on another 8 occasions as an outpatient. She first saw him on 27 February 2020 after a referral from his general practitioner. Dr Turnier-Shea thereafter managed Sergeant Cooke's PTSD symptoms with the medication regime, periods of treatment as an inpatient with Transcranial Magnetic Stimulation.

317. A significant issue for Sergeant Cooke in Dr Turnier-Shea's expert opinion (just as with Ms Prichard and Dr Lee) was his excessive consumption of alcohol.

318. The evidence at the inquest satisfies me to the requisite legal standard that the treatment received by Sergeant Cooke for his PTSD was entirely appropriate. Unfortunately, it is quite clear that his PTSD was not diagnosed until it was chronically entrenched and therefore in real terms not amenable to any treatment. His case illustrates the need for early diagnosis of the condition.

### The Second sergeant's position at Oatlands

319. It is necessary now to move from Sergeant Cooke's treatment to the position that he occupied at the time of his diagnosis of PTSD. I have already made mention of the fact that in July 2015 Sergeant Cooke was transferred to the position of Officer in Charge, Oatlands Police Station. I need to deal with the position at Oatlands both in the

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[138] *Supra*, paragraphs 12 – 13.
[139] Transcript.

context of Sergeant Cooke's operational role in it and what happened after his submission of his claim for workers compensation.

320. The evidence was that the position as Officer in Charge at Oatlands attracted a 35% country allowance (over and above the standard Sergeant's salary), together with an entitlement to occupy a police house which was either rent free or very cheap to rent (the evidence was not entirely clear on that point), and a $5000 annual community allowance. Thus for officers thinking about their retirement it was evidently an attractive position.

321. Initially, following Sergeant Cooke's lodging of a claim for benefits pursuant to the *Workers Compensation and Rehabilitation Act* 1988, Senior Constable Carlisle was appointed to take on the acting role of Officer in Charge, Oatlands to fill in whilst he was unwell. Her gazetted start date was 18 March 2019 and she actually commenced in the role 1 April 2019.

322. The practical effect of Senior Constable Carlisle filling in for Sergeant Cooke was that they were able to maintain the police house at Oatlands, and generally speaking their domestic arrangements were impacted as little as possible by the fact that Sergeant Cooke was unable to work.

323. The evidence was that while Sergeant Cooke was absent and in receipt of workers compensation benefits a second Sergeant's position was being created at Oatlands. The rationale for the creation of the second position was to preserve Sergeant Cooke's substantive role as Officer in Charge of the Station and to provide certainty and comfort to him that his position was safe. Clearly, the role of Sergeant needed to be filled and it seems that it was thought that by creating a second Sergeant's position it would ensure that the station would continue to have an active Sergeant in place. It seems to me that the solution was a creative one for what had proved to be a difficult issue. Senior Sergeant John Parker was appointed to fill that second Sergeant's position.

324. The evidence satisfies me that Sergeant Cooke was continually reassured in relation to the fact that he continued to occupy the substantive Sergeant's position. However, Senior Constable Carlisle's evidence was that when Sergeant Cooke found out that Senior Sergeant Parker had been appointed to the second Oatlands Sergeant's position, his health went into decline again. She said that in the months prior to Sergeant Cooke submitting his claim for workers compensation Senior Sergeant John Parker had contacted Sergeant Cooke asking about the Oatlands position and when,

or if, he was likely to be moving. Sergeant Cooke apparently told Sergeant Parker that he was happy and did not intend on moving in the near future. After Sergeant Cooke ceased the active role at Oatlands and was in receipt of benefits under the *Workers Compensation and Rehabilitation Act* 1988, Sergeant Parker again contacted Sergeant Cooke, something that apparently angered Sergeant Cooke (or so Senior Constable Carlisle said).[140]

325. On the subject of the creation of a second Sergeant's position not a single witness (from former Commissioner Hine to Senior Constable Carlisle) was able to identify any occasions in the past where such a step had been taken. To me it was plainly necessary that there be an actual Sergeant at Oatlands. Senior Constable Carlisle acting in that position had not been a successful appointment for various reasons, none of them relevant to the inquest. Senior Sergeant Parker was "offered" by the Northern Police District and selected to fill the "second" Sergeant's position. Evidently he was qualified for the position and considered suitable.

326. There is simply no logical reason or evidentiary basis to criticise Senior Sergeant Parker's behaviour in seeking to fill and then filling a second Sergeant's position at Oatlands. The only person who was critical of the arrangement was Senior Constable Carlisle. Inspector Burk gave evidence that Senior Constable Carlisle told her that the issue was not with her decision to create a second Sergeant's position but rather the person (i.e. Senior Sergeant Parker) she (Inspector Burk) was putting into the position.[141] Senior Constable Carlisle was asked about that point during her oral evidence but was unable to provide me with any assistance in relation to the issue. I consider her evidence about Senior Sergeant Parker to have been unfair to him and I must say, respectfully, somewhat irrational. Moreover, I observe that it is not the role of the Senior Constable to dictate to an Inspector of Police who will or will not be appointed to perform particular roles within a division.

327. Before I leave the matter, I note that neither of Sergeant Cooke's sons nor his sister, nor Constable Rowlands, all of whom were close to Sergeant Cooke, heard anything from him, let alone a complaint, about Senior Sergeant Parker taking up the second Sergeant's position at Oatlands.

328. To my mind, the creation of the second Sergeant's position at Oatlands to ensure that Sergeant Cooke was able to remain in the substantive role was a very reasonable act on the part of Tasmania Police, and particularly fair to Sergeant Cooke. The fact of the

[140] Exhibit C 8, *op. cit.*, paragraph 65 and following.
[141] Exhibit C 23, affidavit Phillipa Jane Burk, sworn 26 May 2021, page 7 of 15.

creation of the second Sergeant's position was in fact unprecedented. As I noted already no witness was able to recall a similar situation occurring in the past. This suggests to me that Sergeant Cooke was extremely highly regarded indeed and is completely inconsistent with any suggestion he was treated poorly or unfairly.

**The management of Sergeant Cooke's workers compensation claim**

329. There was some suggestion from some witnesses, and principally Senior Constable Carlisle (and to a lesser extent his sister, Michelle) that there were problems with the processing and management of Sergeant Cooke's workers compensation claim by the entity charged with that responsibility on behalf Tasmania Police, and Tasmania Police generally. It is unnecessary for me to traverse the issue of Sergeant Cooke's engagement with the workers compensation system other than to say I do not consider there is any factual basis for any criticism of the manner in which Sergeant Cooke's claim was managed. There were no delays, anomalies or issues associated with his claim. There were no delays in relation to authorising treatment or periods of hospitalisation. I do not consider that there is any evidence Sergeant Cooke's workers compensation claim was dealt with in any other way other than in accordance with the law.

330. I specifically note the evidence of his treating psychiatrist Dr Turnier-Shea that she had no difficulties at all with receiving approval for any course of treatment or admission. She said that the insurer was prompt in its responses and dealings.[142]

331. Objectively viewed, the evidence is only consistent with the conclusion that the management of Sergeant Cooke's workers compensation claim was professional, appropriate and done with a degree of compassion.

332. Indeed, as I pointed out above, Tasmania Police put in place Senior Constable Carlisle as the acting sergeant at Oatlands before Sergeant Cooke's workers compensation claim had even been submitted. Similarly, a referral to Dr Prichard took place, organised by Tasmania Police, before Sergeant Cooke's workers compensation claim had been accepted.

333. There is no actual evidence that supports a conclusion that Sergeant Cooke's return to work program (or programs) were poorly or inappropriately managed. The reality is, as Sergeant Cooke acknowledged to several people close to him, he was never going to be in a position to return to operational duties as a police officer. The reality

[142] Transcript.

is also that the number of non-operational positions within Tasmania Police are limited. Efforts were made to attempt to accommodate him, with placements at RDS, the Police Academy and within Management Review, but the severity of Sergeant Cooke's illness militated against any successful outcome in that regard. There is simply no objective evidence that lends support to Senior Constable Carlisle's criticism of the efforts of the appointed to Rehabilitation Consultant to assist Sergeant Cooke with a return to work program or programs.

334. It is also important to note Senior Sergeant Bennett's evidence that in late May 2020, Sergeant Cooke had disclosed to him that his diagnosis would preclude him from ever returning to work as an operational police officer, and that he found it hard to walk away from policing, which had been such an important part of his life.[143] Evidently, Sergeant Cooke knew that his future did not and could not involve policing.

**Inspector Burk's management of Sergeant Cooke**

335. Inspector Philippa Burk took over as Inspector of the Bridgewater Division in August 2019.[144] As such she assumed responsibility for Sergeant Cooke and the Oatlands Station generally (and Senior Constable Carlisle).

336. A significant amount of evidence was received at the inquest in relation to Inspector Burk's dealings with Sergeant Cooke. That evidence was principally from Inspector Burk herself and Senior Constable Carlisle. I considered Inspector Burk to be an accurate witness whose evidence was supported in all material particulars by comprehensive contemporaneous notes.

337. Senior Constable Carlisle was critical in many respects of several of the interactions between Inspector Burk and Sergeant Cooke (and herself – to the extent that interactions between Inspector Burk and her were at all relevant to Sergeant Cooke's death). I do not consider it necessary to deal with these interactions and criticisms in any detail. As with the criticisms of the management of Sergeant Cooke's workers compensation claim, return to work efforts and the appointment of Senior Sergeant Parker, it is enough for me to say I consider that there was no rational basis for any of the criticisms made by Senior Constable Carlisle of Inspector Burk. Nor is there any evidence, at all, that Inspector Burk's interactions with Sergeant Cooke were anything other than appropriate and professional.

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[143] Exhibit C 52, affidavit Andrew Leslie Bennett, sworn 20 April 2021, page 4 of 6.
[144] Exhibit C 23, *op. cit.*, page 1 of 15.

338. Finally, to the extent that it is relevant, I can see no basis for Senior Constable Carlisle's various complaints about her own management by Inspector Burk. Whether or not Senior Constable Carlisle had "*trust issues*" with Inspector Burk as she said, is not something that is relevant to the circumstances of Sergeant Cooke's death. I must say that, like her dealings with Sergeant Cooke, I consider the evidence demonstrates that Inspector Burk's dealings with Senior Constable Carlisle were both appropriate and professional. But, as I say, I do not consider that on the evidence there is any possible demonstrated connection between the circumstances surrounding Sergeant Cooke's death and Inspector Burk's management of Senior Constable Carlisle.

339. The only interaction that I consider it necessary to comment upon, because it relates peripherally at least to the question of the provision of Welfare Support, and also relates to the second Sergeant's position at Oatlands, is a meeting between Inspector Burk and Sergeant Cooke at the Rokeby Police Academy on 1 October 2019.

340. That morning, Inspector Burk attended a district management meeting. The evidence was that Bridgewater (along with Prosecution Services) were the two areas hardest hit with staffing issues. Inspector Burk met with her Commander after the meeting. At this point it appears that a decision was made that Senior Sergeant Parker was to be seconded to Oatlands.

341. Inspector Burk's evidence was that she decided she should tell Sergeant Cooke of the decision in relation to the Oatlands second Sergeant position immediately. Sergeant Cooke was actually on the first day of a return to work program at the Police Academy. Inspector Burk said that she telephoned him and said she would be coming down to see him. Inspector Burk gave evidence that Sergeant Cooke was apparently fine with her coming to see him. She also said she spoke to Sergeant Peter May, Sergeant Cooke's Wellbeing Support Officer.

342. Inspector Burk met with Sergeant Cooke at the Police Academy at Rokeby that afternoon. Inspector Burk's evidence was that it was her impression that Sergeant Cooke took the news well that Senior Sergeant Parker would be seconded to Oatlands to fill the newly created second Sergeant's position. She said that she reinforced it was still his substantive position.[145]

343. Senior Constable Carlisle's evidence about the meeting was different. She said that Sergeant Cooke was very upset after the meeting and that when she returned home

[145] Exhibit C 23, *op. cit.*, page 5 of 15.

late that night she found him intoxicated, "*crying, irrational and inconsolable*".[146] In addition, the evidence of Constable Rowlands is that Sergeant Cooke said that he had a disagreement with Inspector Burk about the filling of the second Sergeant's position at Oatlands.[147] I do note that neither Senior Constable Carlisle nor Constable Rowlands were present at the meeting between Sergeant Cooke and Inspector Burk. Indeed their evidence – that Sergeant Cooke appeared distressed following the meeting - is actually not inconsistent with Inspector Burk's evidence that he did not appear distressed during their meeting. It is entirely plausible that he maintained an outwardly calm demeanour during that meeting but became upset or distressed in its aftermath and felt able to display that upset to his partner and articulate it to a close personal friend.

344. I can see no basis to criticise Inspector Burk for the decision she made and for conveying that decision about the second Sergeant's position at Oatlands as soon as practicable to Sergeant Cooke. In fact if she had delayed in delivering that information she may well have been criticised for a delay.

345. If there is to be a criticism (and it is a very mild criticism indeed) of that meeting, it is the absence of a Wellbeing Support Officer to provide support to Sergeant Cooke. The evidence was that Inspector Burk telephoned Sergeant May, providing him with an update as to what had occurred and what she intended doing that afternoon. Sergeant May said in his evidence at the inquest that, on reflection, perhaps welfare support should have been provided to Sergeant Cooke at the Academy that afternoon.[148] However he also said that at no stage did Sergeant Cooke ever mention Inspector Burk's meeting on 1 October 2019 to him. Sergeant May said that it was his view that Sergeant Cooke was someone who could advocate for himself and understood well police business needs. I think that is a fair summary of the situation.

346. I should make it clear that I do not consider that the absence of Welfare Support on 1 October 2019 for Sergeant Cooke had any role whatsoever in his PTSD, or death. Moreover, the evidence is that Sergeant May's Welfare Support to Sergeant Cooke following the submission by him of his claim for workers compensation in relation to PTSD involved dozens of contacts face-to-face, by telephone, by email and by text message until the time of Sergeant Cooke's death. The tenor of that material

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[146] Exhibit C 8, *op. cit.*, paragraph 100.
[147] Exhibit C 28, *op. cit.*
[148] Transcript.

(particularly text and email) supports a conclusion that Sergeant Cooke was comfortable with the support being provided by Sergeant May.[149]

347. In summary, I do not accept that Sergeant Cooke was treated poorly or unfairly after by Inspector Burk. Even though I do not consider there is any demonstrated connection with Sergeant Cooke's death, I do not accept that Senior Constable Carlisle's treatment by Tasmania Police generally, or Inspector Burk in particular, was poor or unfair either. In fact, I consider that objectively viewed, the opposite is the case. Tasmania Police collectively, and a number of senior officers individually (from the then Commissioner down), took significant steps to attempt to provide all manner of appropriate support to Sergeant Cooke in particular, but also Senior Constable Carlisle.

**Suicide attempt in August**

348. In August 2020 a position became vacant at the Bicheno Police Station. Senior Constable Carlisle said in her evidence that Sergeant Cooke wanted her to be offered this position as she said he believed it would be the change of scenery he needed to assist in his recovery.[150] In that regard there is some support in the evidence at the inquest for that being Sergeant Cooke's opinion in the form of Sergeant Cooke messaging then Inspector Peter Harriss, who was responsible for the Bicheno Station, on 21 August and again on 26 August, asking if many applications for the position had been received.

349. Inspector Harriss replied to him the day after that and his evidence is that he considered those enquiries to be genuine and well-intentioned, rather than any attempt to influence or interfere in the selection process.[151] As things happened, Senior Constable Carlisle was not appointed to the position. She said in her evidence that her not obtaining the Bicheno position was the reason for Senior Sergeant Cooke's final admission to hospital. I am not sure that the explanation is as simple as that. As should be very clear from the narrative of Sergeant Cooke's mental illness and treatment that I have set out at some length above, he was a very ill man indeed by late August 2020. That illness was not due to an administrative decision taken by Tasmania Police in relation to an application for a transfer by Senior Constable Carlisle to a country station. Nonetheless, he was so ill that he was certainly very

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[149] Exhibit C 22, *op cit*, and Transcript.
[150] Exhibit C 8, *op cit*, paragraph 153.
[151] Exhibit C 27, affidavit Peter Harriss, sworn 2 February 2021.

vulnerable to any decision or event which was either unexpected or disappointing to him.

350. Sergeant Cooke also took the opportunity to discuss the potential for Senior Constable Carlisle's transfer to Bicheno directly with then Commissioner Hine on 26 August. Mr Hine gave evidence at the inquest that he was unwilling to involve himself directly in relation to any selection process for any position, something he conveyed to Sergeant Cooke. Mr Hine's evidence about this, which I accept, was that Sergeant Cooke appeared to be both understanding and accepting of his (Mr Hine's) position.[152]

351. On 27 August 2020, the evidence is that Sergeant Cooke attempted suicide. Notwithstanding the comments I made above with respect to his vulnerability to any perceived setback, there is no actual evidence that would support the conclusion that Sergeant Cooke being distressed or unhappy about progress in respect of Senior Constable Carlisle's application for the position at Bicheno was causally related to the attempt.

352. As far as the suicide attempt is concerned, the evidence was that Sergeant Cooke ingested a dangerously high amount of prescription medication. Given the circumstances in which Sergeant Cooke ingested the medication it seems reasonable to conclude that he did so with the express intention of ending his own life (extreme frustration or extreme distress without that intention may also be explanations but seem less likely). The circumstances which suggest suicidal intent include the evidence at the inquest of a Facebook post by Sergeant Cooke the same day and evidence from his sister Michelle and son Liam as to his evident distress that day.

353. Constable Tilley, someone who knew Sergeant Cooke well, particularly from their service together on the executive of the Police Association of Tasmania, was phoned by Senior Sergeant Bennett and told that Sergeant Cooke was unwell and that his welfare should be checked. Constable Tilley went directly to 21 Enfield Lane. He described Sergeant Cooke as not immediately recognising him. Very concerned for his welfare, Constable Tilley decided that it was necessary to get Sergeant Cooke to hospital.

354. An ambulance was summoned through RDS and the officers in attendance, which by now included Senior Constable Carlisle and Senior Sergeant Bennett, as well as Constable Tilley (although each were present as concerned friends rather than in an official capacity as such), woke Sergeant Cooke and escorted him to an Ambulance

[152] Transcript.

Tasmania stretcher. He was strapped down and required restraint and sedation before he could be transported by ambulance to the Royal Hobart Hospital[153] where he was admitted as an inpatient. He remained in the psychiatric unit at the Royal Hobart Hospital for a week before being transferred to St Helens Private Hospital, where he was admitted under Dr Turnier-Shea's care. This admission was his final one. During his stay as an inpatient, he received 20 treatments of Transcranial Magnetic Stimulation as well as participating in group therapy. His medications remained unchanged.

355. Sergeant Cooke was discharged from St Helen's Hospital on 25 September 2020. The discharge summary indicates that he was assessed upon discharge as being a clinical low risk. An appropriate care plan accompanied his discharge.[154]

**The last days of Sergeant Cooke's life**

356. On 9 October 2020, Sergeant Cooke attended the funeral of a former colleague, retired Sergeant Les Cooper.[155] Senior Sergeant Bennett described him at the funeral as appearing "*distant and angry*". Constable Tilley shook his hand and had a brief chat with him. After the funeral, Constable Tilley sent Sergeant Cooke a text but did not receive a reply.[156]

357. Sergeant Peter May, who sat next to him at the funeral, said he was "*a bit shaky but chatty and upbeat*".[157]

358. There was nothing unusual about his weekend. On Saturday 10 October 2020, Sergeant Cooke went to the Campania Tavern with an old police friend Mr John Barwick. The same day, his son Jarred also spoke to him and had what he regarded as a normal conversation with him.[158] Senior Constable Carlisle was participating in a promotion course for the rank of Sergeant at the Police Academy, Rokeby. After discussion, and having regard to her workload on that course, Sergeant Cooke told Senior Constable Carlisle she should get a room at the academy, rather than commuting backwards and forwards while she undertook the course.[159]

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[153] Exhibit C 19, affidavit Shane David Tilley, sworn 13 November 2020 page 3 of 4.
[154] Exhibit C 41, Hospital Records – St Helens Private Hospital.
[155] The late Sergeant Cooper and I were not related.
[156] Exhibit C 19, op. cit., page 4 of 4.
[157] Exhibit C 22, *op. cit*., page 20 of 22.
[158] Exhibit C 9, op. cit, page 3 of 3.
[159] Exhibit C 8, *op. cit*., paragraph 167.

359. His sister Michelle called in to 21 Enfield Lane to see him on Sunday 11 October 2020 at about 3.40 pm. In her evidence she said that Sergeant Cooke made coffee, they chatted and her brother told her how he would "kill" to be at work.[160]

360. On Monday, 12 October 2020, Senior Constable Carlisle left 21 Enfield Lane at 7.30 am to head to the academy.[161] She was participating in a promotion course for the rank of Sergeant at the Police Academy, Rokeby. Senior Constable Carlisle was staying at the academy, rather than commuting backwards and forwards, while she undertook the course. The pair spoke at 11.50 am just before Sergeant Cooke kept an appointment at noon with Dr Turnier-Shea.[162] In her evidence at the inquest, Dr Turnier-Shea said that Sergeant Cooke appeared to be fine. She expressly asked him about suicidal ideation and he denied having any. Nothing about Sergeant Cooke's presentation caused her any concern for his well-being. A plan was developed and agreed to by Sergeant Cooke for him to be re-admitted to hospital for continued inpatient treatment in approximately two weeks hence.

361. In her evidence, Senior Constable Carlisle said that Sergeant Cooke 'messaged' her that afternoon to check that she was still planning to stay away that night. She confirmed she was and Sergeant Cooke indicated that being so, he would meet up with Constable Rowlands for a beer. He exchanged messages with his sister and indicated that he would see her the next day. He messaged his son Jarred that afternoon as well.[163]

362. It is unclear where Sergeant Cooke went or what he did after his appointment with his psychiatrist, although he was in touch with family members by text. In any event, at 3.28 pm CCTV footage shows him arriving at the Campania Tavern. Constable Rowlands, arrived at 4.24 pm. While at the Tavern, Sergeant Cooke drank 10 schooners of beer before leaving at 6.45 pm (Constable Rowlands left after him at 7.05pm).[164] During their time together at the pub, Sergeant Cooke and Constable Rowlands discussed plans for AFL grand final day and the Melbourne Cup. Constable Rowlands said in his evidence that Sergeant Cooke appeared to him to be in "*good place… probably the best place [he] had seen him in a while*" that afternoon.[165] Constable Rowlands said that Sergeant Cooke was not intoxicated when they parted company.

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[160] Exhibit C 11, affidavit of Michelle Anne Cooke, sworn 18 June 2021, page 12 of 21.
[161] Exhibit C 8, *op cit*, paragraph 168.
[162] *Supra*, paragraph 169.
[163] The details of the SMS messages are all contained in Exhibit C 33.
[164] Exhibit C 31, affidavit of Eric Rolle, sworn 20 October 2020.
[165] Exhibit C 28, *op. cit*.

363. Sergeant Cooke then made his way to a takeaway chicken outlet at Sorell, bought some food for his evening meal and returned home. Whilst in Sorell the evidence is that he purchased some more alcohol from a bottle shop.

364. Constable Gavin Cashion, another of Sergeant Cooke's close friends, also gave evidence about the last hours of Sergeant Cooke's life. His evidence[166] was that Sergeant Cooke telephoned him at approximately 8.00 pm. Nothing about Sergeant Cooke's conversation with him gave rise to any concern. In fact Constable Cashion said that Sergeant Cooke "*sounded great*" and described the pair as joking as they discussed some upcoming Police Legacy events (both men were involved in the Police Legacy Organisation). The evidence is that Constable Cashion was the last person to speak to Sergeant Cooke.

365. At 11.17 pm that evening Sergeant Cooke sent a goodbye message by SMS to a number of people including his sons Jarred and Liam, his former wife Sonya and Senior Constable Carlisle. The message said "*the time has come; I can't stand it anymore. I love you all. Time to say goodbye. I'm sorry for everything I've done*". At least two of the recipients contacted RDS and Constables Ralph Newton and Melissa Finlayson hurried from the Sorell Station to his property in Campania, passing an ambulance that had also been dispatched on the way. Constable Newton knew, and was close to, Sergeant Cooke.

366. The police arrived and activated their body worn cameras at 11.54 pm. The ambulance arrived only moments behind them. The evidence of Constables Newton and Finlayson details how they found him hanging in a shed. They frantically attempted to take the pressure off Sergeant Cooke's body and remove the rope from around his neck. All this is graphically illustrated in the body worn camera footage.[167]

367. What occurred after Constable Carlisle arrived at the scene and what is described in the evidence of a number of witnesses as a refusal on her part to hand over Sergeant Cooke's mobile phone to Sergeant Adrian Mollon (who was in command at the scene) is also captured by police body worn camera footage. I do not think that there was anything suspicious or underhand about Senior Constable Carlisle's behaviour at the scene. To me, having regard to her evidence, the evidence of other offices at the scene and the body worn camera footage, her behaviour, although unhelpful, was characteristic of a person suffering terrible shock and very great grief.

[166] Exhibit C 26, affidavit Gavin Wayne Cashion, sworn 17 June 2021, page 8 of 10.
[167] Exhibit C 36.

368. At about 1.40 am, after exhaustive efforts of first aid at the scene, Sergeant Cooke was taken by ambulance to the Royal Hobart Hospital where he was pronounced deceased at approximately 2.30 am.

369. Before I consider the forensic pathology evidence it is necessary to deal with the nature of Sergeant Cooke and Senior Constable Carlisle's relationship. I turn to that issue now.

**Sergeant Cooke and Senior Constable Carlisle's relationship**

370. There was conflicting evidence as to whether or not the relationship was on foot as at 12 October 2020 or whether Sergeant Cooke and Senior Constable Carlisle had separated. There was some evidence that Sergeant Cooke was said to have said that he was sleeping in the shed. There was also evidence of him articulating general regrets about his life.

371. It is quite clear from the evidence at the scene, including body worn camera footage from the body worn cameras worn and operated by Sergeant Mollon, Constable Finlayson and Constable Newton[168] that there was no bedding in the shed, which leads me to conclude that Sergeant Cooke was not literally sleeping in the shed. This conclusion is supported by the extensive photographs of the scene taken by Senior Constable Rance Swinton[169] and tendered as evidence, none of which show any bedding being present in the shed either. None of the witnesses who were at the scene, including police and other friends, reported saying any sign of bedding in the shed either.

372. Against that is the fact that Jarred Cooke said in his evidence that his father told him he was living in the shed. I have no doubt Jarred Cooke's evidence was accurate. But it seems to me the most likely explanation for the apparent conflict in the evidence about this issue is, I think, Sergeant Cooke was perhaps speaking metaphorically about "living in the shed". Jarred's brother, Liam, was an equally impressive witness and also gave similar evidence at his father's inquest.

373. In any event, having heard and seen both men give evidence, there is no doubt in my mind that both were witnesses of the truth. I am quite satisfied Sergeant Cooke told Jarred he was living in the shed (or similar) in the time leading up to his death. I think

[168] *Supra.*
[169] Exhibit C 20, affidavit Senior Constable (Qualified) Rance Joseph Swinton, sworn 22 October 2020 (and attached photographs).

the explanation for the apparent contradiction may be as Liam said that Sergeant Cooke perhaps did not mean that he was literally living in the shed.

374. Despite Senior Constable Carlisle's evidence about the matter, I am quite satisfied that her relationship with Sergeant Cooke had, in practical terms, ended some time before his death, even though they continued to occupy the same residence. That conclusion is based on an acceptance of Jarred and Liam Cooke's evidence on the subject. It is also based on an acceptance of direct evidence about the matter from Ms Prichard and Dr Turnier-Shea both of whom I consider were obviously unbiased, objective and professional. Both had a close and well established therapeutic relationship with Sergeant Cooke. Both had contemporaneous notes in their records indicating Sergeant Cooke had told both – independently of each other – that he considered that his relationship with Senior Constable Carlisle was over.

375. In the end though, I do not think the status of Sergeant Cooke and Senior Constable's relationship was of any particular significance in the context of determining the circumstances of Sergeant Cooke's death. Dr Turnier-Shea's unequivocal evidence about the issue was that Sergeant Cooke was accepting of the fact that his relationship with Senior Constable Carlisle was at an end.

376. I do not think that there is anything particularly untoward about the fact that Senior Constable Carlisle gave evidence that the relationship remained on foot. It seems to me that two persons involved in a relationship can have different opinions about the status of that relationship. In the end I do not consider Senior Constable Carlisle was attempting to mislead the inquest and, as I have already said, the status of the relationship at the time of Sergeant Cooke's death was to my mind at best very much a second order issue in terms of his mental health. His mental illness was entirely due to his long service as a police officer. It may not have been assisted by relationship difficulties, but relationship difficulties did not cause his PTSD. Moreover, any difficulties within his relationship may have been caused or contributed to by his PTSD. But they did not cause his death.

**The reporting of Sergeant Cooke's death**

377. The fact of Sergeant Cooke's death was reported to the Coronial Division when the standard Police Report of Death to the Coroner was sent to a common email address at the Coronial Division, a little after 7.00 am that morning. Why the on-call Coroners Associate was not notified any earlier (given it was the fourth death by suicide of a police officer in a relatively short period) remains unexplained, despite a specific request at the time to Tasmania Police.

378. Further, I note that the Coronial Division is staffed, in part, by seconded sworn police officers, who amongst other things handle reports of death as they come in, a fact known to any police officer of any rank within Tasmania Police. All of the police officers working as Coroner's Associates in the Division as at October 2020 knew Sergeant Cooke – something that should have been known, and considered, by any officer with any command responsibility in the southern region of Tasmania Police. The fact of Sergeant Cooke's death was distressing to some of those officers, and a very great shock to all. That Tasmania Police failed to give their own staff the courtesy of a warning of Sergeant Cooke's death, in view of its professed concern about the welfare of all personnel, is both surprising and disappointing.

379. It seems probable that the failure to even consider the welfare of the police officers seconded to the Coronial Division was an unfortunate oversight. There is obvious room for improvement in the future in the manner in which the deaths of serving police officers are reported to the Coronial Division.

**Forensic and pathology evidence**

380. I return now to the Coronial investigation in relation to Sergeant Cooke. After he was pronounced dead, his body was formally identified at the hospital.[170]

381. The following day, 14 October 2020, at the hospital mortuary, an autopsy was performed by Dr Donald Ritchey. Dr Ritchey found a faint ligature abrasion around Sergeant Cooke's neck, which matched the rope ligature recovered at the scene, as well as clear evidence of peri-orbital and lower palpebral conjunctival petechial, but no evidence of any neck trauma. Dr Ritchey provided a report[171] in which he expressed the opinion that the cause of Sergeant Cooke's death was asphyxia due to hanging. I accept Dr Ritchey's opinion.

382. Samples taken at autopsy were subsequently analysed at the laboratory of Forensic Science Service Tasmania. Notably, an elevated blood alcohol concentration (0.161 g/100mL) was identified as being present in those samples.[172]

383. There is no evidence to suggest that there are any suspicious circumstances associated with Sergeant Cooke's death. I am satisfied that his death was the result of actions undertaken by him alone, voluntarily and with the express intention of ending his own life. I have no doubt that his lengthy service as a police officer and the PTSD that he

[170] Exhibit C 3, affidavit Genevieve Hickman, sworn 13 October 2020.
[171] Exhibit C 5B, affidavit of Donald MacGillivray Ritchey, sworn 27 January 2021, page 10 of 12.
[172] Exhibit C 6, affidavit Neil McLachlan-Troup, Forensic Scientist, sworn 14 January 2021.

developed as a direct consequence of that service was the principal factor in Sergeant Cooke's decision to take his own life.

384. In terms of the scope of the inquest, namely whether the management of Sergeant Cooke's workers compensation claim and/or return to work programmes had an adverse effect on his mental health, the answer, viewing the evidence as a whole is no. Sergeant Cooke was, as I hope the foregoing makes clear, extremely unwell. There were no anomalies about how his claim was managed and no evidence that the interaction with the workers compensation system had an adverse effect on his mental health.

**Welfare - procedures and protocol**

385. It was evident to me, as retired Commissioner Hine and Assistant Commissioner Bodnar both said in their evidence at the inquest that there had been considerable improvements in the area of well-being support in recent years. To my mind is not without significance that Inspector Richman was appointed to the position of Director of Wellbeing Support in July 2019 and tangible improvement appears to have followed. As Mr Lee submitted, Inspector Richman was a very impressive witness, clearly competent in the performance of his work with an excellent grasp of detail, and both passionate and dedicated. Obvious systems improvements include a transition from paper-based record-keeping to a modern file management system (IAPro), the introduction of mandatory well-being checks for some positions and improvements in information sharing whilst respecting privacy and confidentiality.

386. Despite the obvious improvements there is still room for further beneficial changes. To that end it is necessary to look a little into the history of welfare and welfare protocols, in the context of these four deaths.

387. At the time of Constable Hunt's death, there was no protocol, policy or guidance document in place in respect to welfare issues. I certainly consider that the absence of a protocol, policy or guidance document of any type contributed to the circumstances surrounding Constable Hunt's death in that it was likely to have been a factor in Constable Hunt interacting with Professional Standards in the absence of any welfare support.

388. Assistant Commissioner Bodnar, gave evidence of a Welfare Protocol having been developed in 2017, following Constable Hunt's death (but not necessarily, as I

understood, in response to it).[173] Assistant Commissioner Bodnar's evidence was that the protocol was intended to provide instruction as to the practical management and provision of welfare services to members of Tasmania Police who are subject to Professional Standards investigation. The protocol deals expressly with, *inter alia*, the subject of members' personal mobile telephones.

389. The approval history of the protocol indicates it was approved by then Commissioner Hine on 7 May 2017 and that the protocol was in effect from the date of approval. Since 7 May 2017, only one amendment was made to the protocol, and that relates to media comments (something not relevant to the deaths the subject of the inquest).

390. The protocol was updated for the final time on 24 August 2017, and was applicable at the time of Senior Sergeant Reynolds death.

391. Item (j) in the protocol provides:

> *"Where an affected member's telephone is taken possession of opportunity shall be provided to utilise a nominated telephone to make and/or receive calls in private for a reasonable time. The nominated telephone number is to be communicated to People Support and the Association if neither have a representative present*".

392. The obvious point is that even after what might have been considered clear 'learnings' from Constable Hunt's death, there is no reference in the document to the provision of a replacement mobile phone to a police officer who has had their personal mobile telephone seized. That still remained the case at the time the evidence in the inquest was heard, even after the removal of Constable Hunt and Senior Sergeant Reynold's mobile telephones, and the particular difficulties that presented in relation to contacting Constable Hunt.

393. In my view the evidence makes it clear that the removal and provision of replacement mobile telephones was an issue of which Tasmania Police were or should have been aware. Former President of the Police Association, Mr Allen said while being questioned by Mr Miller, that he recalled it was an issue in member's minds about their personal mobile telephones being taken in the context of an internal investigation. He gave evidence of attending a meeting with then Assistant Commissioner Donna Adams in relation to Constable Hunt's death. He said he specifically raised: *"The seizure of Paul's mobile phone without a replacement being offered by Professional Standards removed any support he could have sought or been offered, such*

[173] Exhibit H 50, affidavit Adrian Paul Bodnar, sworn 16 September 2019, Annexure A.

*as contact by the PAT, Police Welfare or his wife Jessica".* I have no reason at all to doubt Mr Allen's evidence.

394. The other area where protocols and procedures are to be found is in Chapter 8 of Abacus[174] which deals with the topic of members' rights, obligations and wellbeing.

395. The evidence of Inspector Gill was that the Abacus wellbeing provisions were first published on 22 January 2018 and came into effect on 1 March 2018. The relevant excerpt relating to the seizure of a police officer's personal mobile telephone was contained in then section 10.5.2.1. The provision is in the same terms as the part of the welfare protocol I have set out above.

396. Again, as with the Tasmania Police Welfare Protocol of August 2017, this provision was implemented after Constable Hunt's death but before Senior Sergeant Reynolds' death. It was also directly applicable therefore to the investigation by Professional Standards of Senior Sergeant Reynolds immediately before his death. It was also not applied when officers from Professional Standards executed the lawfully obtained search warrant upon Senior Sergeant Reynolds the night before his suicide.

397. Inspector Gill's evidence was that following review and consultation, the Abacus provisions relating to member's rights were included within chapter 8 of that document on 24 July 2020. The Welfare Protocol was expanded and then rescinded to be incorporated into chapter 8. The revised excerpt in relation to the seizure of a member's personal mobile telephone is at 8.6.6 and relevantly states:

> *"Where possession is taken of a member's device, the member will be provided with an opportunity to utilise a telephone (provided by Tasmania Police) to make and/or receive calls in private for a reasonable time (e.g. until the subject officer's phone is returned to them). The telephone number is to be communicated to Wellbeing Support and the Police Association of Tasmania if neither have a representative present. Professional Standards has a mobile including SIM card available for this purpose".*

398. It was not until 24 July 2020 that there was any reference to a mobile telephone (and I take "member's device" to mean "member's mobile telephone" despite the fact that the passage seems to make a distinction between "devices" and "telephones") in the

[174] The meaning of the acronym (or indeed if it was in fact an acronym) was never made clear but it is the Commissioner's Directions for Conduct and Complaint Management.

Welfare Protocol. This provision was added four years after Constable Hunt's death and almost two years after Senior Sergeant Reynolds' death.

399. Despite the policy amendment, it remains unclear how long the subject officer has the use of that mobile telephone for, whether it may be removed from the station and if it is, in effect, a replacement personal mobile telephone. The policy should be amended so it is clear that it is a replacement mobile telephone until such time as their own personal mobile telephone can be returned to them following either a manual or forensic search of that phone. In his evidence at the inquest, Commander Blackwood agreed that such an amendment to lend clarity to the provision was desirable. Inspector Richman said in his evidence on the subject that it was his understanding the intention was an officer provided with a replacement mobile telephone retained possession and use of it. He agreed, like Commander Blackwood, that clarification of the relevant part of the applicable policy would be helpful.

400. There is one other issue that needs clear guidance in relation to replacement mobile telephones, in so far as protocols and procedures of Professional Standards are concerned. It needs to be made very clear that a replacement mobile telephone (with active SIM, charger and pre-programmed Wellbeing Support numbers) should be listed as an item Professional Standards officers are required to possess as part of their standard equipment when any warrant is to be executed in relation to electronic devices including mobile telephones, or indeed in any case where there is even the potential for a mobile telephone to be voluntarily surrendered by a police officer the subject of investigation. To do so would ensure there is no repetition of what occurred in relation to both Constable Hunt and Senior Sergeant Reynolds.

401. Moreover, I note the following provision under 8.6.6 [emphasis added]:

> *"In a Code of Conduct matter, if an avenue of inquiry or investigation relates to information on a member's personal device, such as a phone or computer (other than a device provided by Tasmania Police), the inquirer/investigator is only to require access to the data (text, voice message, social media message, etc.) that relates to this particular matter under inquiry/ investigation.* ***<u>In the absence of consent</u>****, a member can be directed under the provisions of Section 46(3)(c)(ii) of the Police Service Act 2003 to provide any information or document or answer any question for the purpose of the investigation. As Section 46 of the Acts Interpretation Act 1931 clarifies a breach of the Code of Conduct to be an 'offence',* ***<u>a search warrant can be obtained if necessary</u>****. In some cases, a screen shot, or other download, may be*

> *requested by the inquirer/investigator to alleviate the need to seize a communication device".*

402. Two issues arise from this extract. First, I do not consider section 46(3)(c)(ii) of the *Police Service Act* 2003 to be wide enough and contain the necessary power to compel a subject member to be required to provide access to their personal mobile telephone, and certainly not for police to be able to seize it – something conceded expressly by Mr Miller on behalf of the Commissioner of Police.

403. The second point is the internal inconsistency in the passage with an apparently irreconcilable tension between power to make a lawful direction and obtain a search warrant. Mr Lee submitted, correctly in my view, that the entire provision is confusing and misleading. He submitted that there ought to be an amendment to this paragraph in 8.6.6. to make it clear that while a member of Professional Standards may request access to or to seize a subject member's personal mobile phone on a voluntary basis without legislative power, in the absence of such consent, a search warrant is required. I agree.

404. The final welfare issue, that arose in particular in the context of Constable Hunt's death is at point 3 of that document which provides, [emphasis added]:

> *"3.* ***<u>The Director</u>****, Wellbeing Support,* ***<u>will determine</u>*** *whether a support person or Wellbeing Support Officer should be present when service of a Notice or Order is to occur and make the necessary arrangements. Consultation with the police psychologist may occur where required".*

405. I consider this reposes too much discretion in the Director of Wellbeing Support. A failure on the part of the Director of Wellbeing Support to make that decision (as occurred in the case of Constable Hunt) would see a person in the future left in the same situation as Constable Hunt. In my view a Wellbeing Support Officer and representative of the Police Association of Tasmania should always be on hand when service of an order or notice on a subject member occurs.

406. Another matter is that, at point 9, the following provision appears:

> *"If the member does not request the attendance of a family member or support person, the member's rights and entitlements take primacy and their decision is to be respected."*

407. I do not consider this to be a workable provision in the protection of the welfare of an officer under investigation. The obvious problem with this provision is that if the subject member is so distressed as to be unable to think clearly given events which are unfolding at the time, it must be doubted that a clear and rational decision can be made about the accessing of welfare support consistent with their interests. Constable Hunt's case is a stark illustration of this point. For years court his conduct had been treated as "welfare" issue, and without any warning his case changed (appropriately, if arguably belatedly) from a "welfare" issue to a criminal investigation. That this occurred plainly took him off guard. It is inappropriate to leave decisions about the provision of welfare support to an affected member.

408. Mr Lee submitted, in effect, a prescriptive approach was appropriate. I agree. The significant advantage of a prescriptive approach to the provision of welfare support is that it avoids idiosyncratic or poor exercise of discretion (as in the case of Constable Hunt). Mr Lee suggested that the best approach (which has much to commend it) would seem to be:

a) For the Commander, Professional Standards to contact the Director of Well-being Support and the Secretary of the Police Association of Tasmania and request that each have a representative available to be present at the search, meeting or interview on a particular date on a particular time but without revealing the identity of the subject officer.

b) For the Commander, Professional Standards to arrange a time to collect the Well-being Support Officer and representative of the Police Association of Tasmania and transport them to the place of the search, meeting or interview.

c) For the Well-being Support Officer and the representative of the Police Association of Tasmania to be present at a nearby location ready, willing and able to provide support and assistance to the member as required.

d) In the event of any geographical impediments to physical presence (and in a jurisdiction the size of Tasmania and having regard to the spread of members of the Police Association of Tasmania and well-being support officers throughout the state any such geographical impediments seem unlikely) then arrangements be made for attendance and support by audiovisual link, telephone or other electronic means.

**Fatigue management policy**

409. Just as there was no welfare protocol in place at the time of the death of Constable Hunt, Tasmania Police had no fatigue management policy at any time, up to and including as recently as when the evidence at the inquest was publicly taken at the end of 2022. The absence of any fatigue management policy was, I consider, a direct factor in Sergeant Cooke's death.

410. There was extensive evidence in relation to the delays associated with the development of the policy. There was an obvious delay of several years on the part of the Police Association of Tasmania replying to a request for comment from Tasmania Police. That delay was unhelpful and not in the best interests of the members of the Association. Nonetheless, it did not absolve Tasmania Police from acting on the issue. The fact that as at 6 December 2022 the policy only existed in draft[175] is regrettable.

411. It is essential that the issue of fatigue management be addressed urgently by the development and implementation of an appropriate Fatigue Management Policy for Tasmania Police.

**Early detection of PTSD**

412. Sergeant Cooke obviously suffered from the effects of PTSD for a long time before it was diagnosed. Every health care professional whose gave evidence inquest unanimously agreed that his PTSD was entirely attributable to his service as a police officer. Every health care professional also agreed that earlier detection of PTSD increases the chances of successful treatment and recovery.

413. Upon evidence at the inquest I find that that a major barrier to the early detection of PTSD was a failure on the part of some officers, particularly older male officers, to seek assistance before it was too late. Constable Cashion and Constable Rowland essentially said as much. Sergeant Cooke's psychological records show him accessing psychological assistance in 2016 but not reporting any symptoms of PTSD. It is not unreasonable to conclude that in Sergeant Cooke's case if his symptoms had been diagnosed earlier the potential for him to make some recovery from PTSD would have been significantly enhanced.

414. How to assist in early detection of the symptoms of PTSD is a vexed question. Constable Rowlands, who was extremely candid in relation to his own PTSD, and who impressed me as an intelligent and sensitive man when he gave his evidence, suggested

[175] Exhibit G 3A

what might be called a "points" system. In general terms he suggested that a system be implemented which awards "points" to different types of incidents depending on their severity and potential impact and when a predetermined designated points threshold is reached an automatic referral for psychological assessment is generated.

415. There is to my mind considerable merit in such an approach. It avoids to a large extent the need for self-reporting. It assists in the de-stigmatisation of PTSD. It provides for the potential, at least, for earlier detection of symptoms of PTSD and therefore earlier medical intervention and medical treatment.

416. It was also clear from evidence at the inquest that the ability of supervisors to have easy access to more information about an officer's accrued leave, amount of over time worked, TOIL accumulated and such like would assist in relation to detecting potential symptoms of PTSD earlier. Improvements in relation to personnel file record-keeping could conceivably assist supervisors being able to identify circumstances in which police officers are fatigued, working excessive overtime, taking insufficient leave and similar.

417. Finally, there is considerable merit, in my view, in expanding the program of formal and regular psychological review for all officers, to attempt to detect symptoms of PTSD as early as possible.

**Formal Findings**

418. On the basis of the evidence at the inquest, I make the following formal findings pursuant to section 28(1) of the *Coroners Act* 1995 in relation to the death of Paul George Hunt:

a) The identity of the deceased Is Paul George Hunt;

b) Paul George Hunt died in the circumstances set out earlier in this finding as a result of actions undertaken by him alone, voluntarily and with the express intention of ending his own life;

c) The cause of Paul George Hunt's death was a self-inflicted contact range gunshot (shotgun) wound; and

d) Paul George Hunt died, aged 32 years, on 8 July 2016 at 46 Old Bangor Road, Mt Direction, Tasmania.

419. On the basis of the evidence at the inquest, I make the following formal findings pursuant to section 28(1) of the *Coroners Act* 1995 in relation to the death of Paul James Reynolds

    a) The identity of the deceased is Paul James Reynolds;

    b) Paul James Reynolds died in the circumstances set out earlier in this finding as a result of actions undertaken by him alone, voluntarily and with the express intention of ending his own life;

    c) The cause of Paul James Reynolds' death was a self-inflicted contact gunshot (rifle) wound; and

    d) Paul James Reynolds died on 13 September 2018, aged 54 years, in a motor vehicle at Avenue Road, Parkham in Tasmania.

420. On the basis of the evidence at the inquest, I make the following findings pursuant to section 28(1) of the *Coroners Act* 1995 in relation to the death of Simon Graham Darke

    a) The identity of the deceased is Simon Graham Darke;

    b) Simon Graham Darke died in the circumstances set out earlier in this finding as a result of actions undertaken by him alone, voluntarily and with the express intention of ending his own life;

    c) The cause of Simon Graham Darke's death was a self-inflicted contact range gunshot (pistol) wound; and

    d) Simon Graham Darke died on 6 February 2019, aged 45 years, at 7 Caitlin Court, Midway Point, Tasmania.

421. On the basis of the evidence at the inquest, I make the following formal findings pursuant to section 28(1) of the *Coroners Act* 1995 in relation to the death of Robert Anthony Cooke

    a) The identity of the deceased is Robert Anthony Cooke;

    b) Robert Anthony Cooke died in the circumstances set out earlier in this finding as a result of actions undertaken by him alone, voluntarily and with the express intention of ending his own life;

c) The cause of Robert Anthony Cooke's death was asphyxia due to hanging; and

d) Robert Anthony Cooke died on 13 October 2020, aged 49 years, at the Royal Hobart Hospital, Tasmania.

**Recommendations**

422. A coroner has a duty, "wherever appropriate, to make recommendations with respect to ways of preventing further deaths and on any other matter that the coroner considers appropriate".[176] It is well recognised that there are limits to the making of recommendations; recommendations must arise out of, or enjoy a clear evidentiary nexus to, the findings at the inquest and avoid "*philosophical self-indulgence*".[177]

423. I do not consider that there are any particular learnings from Constable Darke's tragic death because I do not consider that the evidence supports a conclusion that anything about his service as a police officer caused or contributed to his taking his own life.

424. The situation in relation to the other three officers is, in my view, materially different. There were particular issues in relation to Constable Hunt's engagement with Professional Standards involving the absence of welfare support and the unlawful removal of his telephone which formed part of the circumstances of his death. There was an issue in relation to the failure of officers from Professional Standards to provide Senior Sergeant Reynolds with a replacement mobile telephone despite the development of a policy in the wake of Constable Hunt's death. Finally, the evidence at the inquest revealed significant issues in relation to the identification at an early time of PTSD and poor or non-existent fatigue management in the context of Sergeant Cooke's death.

425. I consider that the evidence at the inquest justifies the making of the following **recommendations** pursuant to section 28 of the *Coroners Act* 1995:

i). That Tasmania Police immediately develop and implement a Fatigue Management Policy.

ii). That all applicable Tasmania Police documentation be amended to ensure, in the case of any interaction between Professional Standards and a member the subject of a misconduct or criminal investigation, that the following occur in relation to welfare support:

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[176] See section 28 (2) of the *Coroners Act* 1995.
[177] *Chief Commissioner of Police v Hallenstein* [1996] 2 VR 1 at page 7 per Hedigan J.

- The Commander, Professional Standards is to contact the Director of Wellbeing Support and the Secretary of the Police Association of Tasmania and request that each have a representative available to be present at the search, meeting or interview on a particular date at a particular time but without revealing the identity of the subject officer.
- The Commander, Professional Standards is to arrange a time to collect the Wellbeing Support Officer and representative of the Police Association of Tasmania and transport them to the place of the search, meeting or interview.
- A Wellbeing Support Officer and a representative of the Police Association of Tasmania are to be present at a nearby location ready, willing and able to provide support and assistance to the member as required.
- In the event of any geographical impediments to physical presence of either a Wellbeing Support Officer and /or a representative of the Police Association of Tasmania then arrangements be made for attendance and support by audio-visual link, telephone or other electronic means.

iii). That Tasmania Police amend all relevant documentation in Abacus to make clear that it is mandatory to provide a member who has had their personal mobile telephone seized by Professional Standards be provided with a replacement mobile telephone (including active SIM, charger and with pre-programmed well-being support numbers in that mobile phone) and that the member so provided is able to retain possession of that mobile telephone until such time as their own personal mobile telephone has been returned to them by Professional Standards following any forensic examination or use in any court proceedings as an exhibit.

iv). That Tasmania Police amend any necessary and applicable procedures and protocols relating to Professional Standards to ensure that officers from Professional Standards carry a replacement mobile telephone as part of their equipment at all times so as to enable the provision of a replacement mobile telephone to any officer as required at short notice.

v). That Tasmania Police investigate the feasibility of introducing a "points system" whereby points are coded into IAPro (or some other platform) to represent the category and sub-category of events a police officer is required to attend; with points to be allocated based on the severity of the incident and the

officer's role within it; and when an officer reaches a critical points threshold an automatic referral to a psychologist is triggered.

vi). That Tasmania Police conduct mandatory six monthly wellbeing screening of all operational police officers for PTSD.

vii). That Tasmania Police amend its annual performance review document for police officers to ensure a record is made of all and any attendances at, and participation in, mental health and wellbeing courses, modules and screenings.

viii). That Tasmania Police amend all relevant policy documents so as to require police officers to electronically submit their hours worked each day (including TOIL) at the end of their shift (or prior to the commencement of their next shift if there are operational reasons why they may be unable to do so) so as to enable up-to-date information as to hours worked to be captured, rather than at the end of each fortnightly pay cycle.

ix). That Tasmania Police investigate the feasibility of developing an on-line Wellbeing Snapshot Matrix available to the supervisor setting out at least the following information in respect of any individual police officer:

- Annual leave – balance and last period taken.
- Personal leave – balance and last period taken.
- Long service leave – balance and last period taken.
- TOIL – balance and last period taken.

426. Counsel assisting submitted that I consider making a recommendation that Tasmania Police give consideration to the next Director of Wellbeing Support being a psychiatrist, with particular expertise in PTSD and Major Depressive Disorder, and preferably with management experience. Counsel for Tasmania Police opposed the making of such a recommendation submitting, I think with some justification, that the present model, involving "the engagement of external providers, delivers optimal results". There is certainly is room for debate as to the relative merits of a psychiatrist being appointed as the Director of Wellbeing Support, given that significant part of that role is administrative and managerial as opposed to clinical. However viewing the matter as a whole I consider that making such a recommendation is not supported by the evidence adduced at the inquest.

427. Counsel for Tasmania Police submitted I should recommend that the Commissioner of Police make use of the powers conferred by section 29 of the *Police Service Act* 2003 to recommend the termination of the appointment police officers who are suffering

from post-traumatic stress disorder and the prognosis is that they will remain unfit to return to their duties. In support of the submission that I should make such a recommendation, Tasmania Police points to the uncontradicted evidence at the inquest from Ms Prichard that "psychiatric discharge" ought to come sooner once it is apparent that a police officer will not be returning to their duties. There was considerable strength in Ms Prichard's opinion in my view.

428. In its submissions, the Police Association of Tasmania opposed the making of any such recommendation, arguing that "the suggested additional recommendation made by Tasmania Police on page 20 of Mr Miller's submission that the *Police Services* [*sic*] *Act*, section 29 be amended to permit [*sic*] power to the Commissioner of Police to terminate police officers who are suffering from PTSD and whose prognosis is that they will remain unfit to return to their duties, is opposed". The Association, in support of the submission asserts that such a recommendation, without explaining why, would be outside the scope of the inquest. I do not accept that this is so. It is directly relevant to the circumstances of Sergeant Cooke's death.

429. Further, the Police Association submitted that there are a number of police officers in this state who joined the Tasmania Police Service before 1999 and as such are subject to the Retirement Benefits Fund Defined Benefits Contributory Scheme. There was no evidence, at all, about this issue at the inquest. Even if there was any evidence about the matter, it is difficult to see how a contingent superannuation entitlement could possibly be relevant to whether any recommendation should be made by a coroner, obliged as a coroner is to make recommendations under the *Coroners Act* 1995 with "respect to ways preventing further deaths"[178].

430. However, and more to the point perhaps, it is important to point out that, in fact, Tasmania Police made no such submission. It was not submitted that I should recommend amendment of section 29 of the *Police Service Act* 2003. Rather, Tasmania Police's counsel submitted that I should recommend that the power which is already reposed in the Commissioner to, in appropriate cases of ill health, recommend to the relevant Minister that the Minister recommend to the Governor that the appointment of a police officer be terminated, actually be utilised in appropriate cases.

431. That having been said, I do not consider that it is appropriate to accept the Commissioner of Police's suggestion that I, in effect, recommend to her that she exercise a power that she already has. I think it reasonable to proceed on the basis

[178] See section 28 (2) of the *Coroners Act* 1995.

that in all cases, including situations where police officers are suffering from PTSD with a poor prognosis, that the Commissioner will act appropriately in appropriate cases.

**Comment**

432. As with the issue of recommendations provided there is a sufficient evidentiary nexus matters subject of the inquest a coroner is permitted to "comment on any matter connected with the death including public health or safety or the administration of justice". [179] No issues arose at the inquest on the evidence with respect to public health or safety. The administration of justice was touched upon in the context with the conduct of investigations by Tasmania Police Professional Standards, and in particular the filming of any interaction with an officer the subject of an investigation.

433. In that latter respect, I consider it is appropriate to **comment** that Tasmania Police Professional Standards should ensure that all dealings with police officers the subject of investigation of allegations, whether for criminal or disciplinary matters, be recorded in full by video.

**Conclusion**

434. The death of any member of the community by suicide is a tragedy. The suicide of serving police officers, whatever their individual circumstances, is particularly tragic for serving members of the police force and the community at large. My sincere hope is that some improvements and learnings can emerge from the deaths of Constable Hunt, Senior Sergeant Reynolds, Constable Darke and Sergeant Cooke.

435. I wish to express my particular thanks to Mr Cameron Lee, counsel assisting, who I consider did an outstanding job in marshalling and presenting the evidence in a professional and dispassionate manner.

436. In conclusion, I express my sincere and respectful condolences to the families of the men whose deaths I have examined.

**Dated:** 1 September 2023 at Hobart in the State of Tasmania

**Magistrate Simon Cooper**

**Coroner**

[179] See section 28 (3) of the *Coroners Act* 1995.

*MAGISTRATES COURT of* TASMANIA

CORONIAL DIVISION

# ANNEXURE A - LIST OF EXHIBITS

## GENERAL EXHIBITS

| NO. | TYPE OF EXHIBIT | NAME OF WITNESS | DATE TENDERED |
|---|---|---|---|
| G1 | AFFIDAVIT | PRESIDENT/INSP COLIN RILEY | G1-G14 tendered 21.11.2022 |
| G2 | CHANGES TO DPFEM'S HEALTH & WELLBEING SUPPORT PROGRAM SINCE 2016 | TASMANIA POLICE | |
| G3A | EMAIL RE FATIGUE MANAGEMENT POLICY AT TASMANIA POLICE | DPFEM | |
| G3B | DRAFT FATIGUE MANAGEMENT FRAMEWORK BOOKLET | DPFEM | |
| G4 | INDEPENDENT REVIEW OF THE EFFECTIVENESS OF DPFEM'S HEALTH AND WELLBEING AND WORKERS COMPENSATION FOR EMPLOYEES SUFFERING FROM MENTAL HEALTH RELATED ILLNESS | THE INDEPENDENT REVIEW PANEL | |
| G5 | REPORT ON WELFARE OFFICERS AND WELFARE TRAINING | DIRECTOR MATTHEW RICHMAN, WELLBEING SUPPORT | |
| G6 | WELLBEING SUPPORT PEER MANUAL V1.0 (10.01.2022) | DPFEM | |
| G7 | REPORT ON DEATHS BY SUICIDE IN SERVING POLICE | DR ANDREW GARRETT | |

| | OFFICERS | | |
|---|---|---|---|
| G8 | THE POLICE GAZETTE 29.04.2021 | DARREN HINE, COMMISSIONER OF POLICE | |
| G9 | REPORT ON THE MENTAL HEALTH OF FIRST RESPONDERS | FEDERAL SENATE | |
| G10 | WORK HEALTH, SAFETY AND WELLBEING POLICY (DRAFT V1.0) | DPFEM | |
| G11 | WORK HEALTH AND SAFETY CONSULTATION GUIDELINES (DRAFT V1.0) | DPFEM | |
| G12 | MENTAL HEALTH & WELLBEING STRATEGY 2021-2026 | VARIOUS ORGANISATIONS | |
| G13 | ABACUS AMENDMENT MEMBERS RIGHTS SECTION 24.07.2020 | WELLBEING SUPPORT | |
| G14 | AFFIDAVIT AND ANNEXURES | MATTHEW RICHMAN | |
| G14A | ANNEXURES TO RC3 | MATTHEW RICHMAN | 9.12.2022 |
| G15 | MEMO AND ATTACHMENT | DAVID GILL | 22.11.2022 |
| G16 | EXPERT GUIDELINES BOOKLET | VARIOUS ORGANISATIONS | 22.11.2022 |
| G17 | AFFIDAVIT AND ANNEXURE | MALCOM DIREEN | 29.11.2022 |
| G18 | FIONA SMITH'S PERFORMANCE REVIEW JUNE 2018 | TASMANIA POLICE | 1.12.2022 |
| G19 | FIONA SMITH'S PERFORMANCE REVIEW JUNE 2019 | TASMANIA POLICE | 1.12.2022 |
| G20 | CHAPTER 8 OF ABACUS EXTRACT | TASMANIA POLICE | 2.12.2022 |
| G21 | INDEPENDENT REVIEW OF THE EFFECTIVENESS OF DPFEM'S | THE INDEPENDENT | 2.12.2022 |

| | | | |
|---|---|---|---|
| | HEALTH AND WELLBEING AND WORKERS COMPENSATION FOR EMPLOYEES SUFFERING FROM MENTAL HEALTH RELATED ILLNESS<br>(note same as **G4**) | REVIEW PANEL | |
| G22 | AFFIDAVIT AND ANNEXURES | INSP DAVID GILL | 7.12.2022 |
| G23 | JOURNAL ARTICLE 'WHY SUICIDE ERADICATION IS HARDLY POSSIBLE' | SAXBY PRIDMORE MD | 7.12.2022 |
| G24 | EMAIL AND SUBMISSION FROM THE POLICE ASSOCIATION OF TASMANIA | INSP COLIN RILEY | 7.12.2022 |
| G25 | LETTER TO THE COMMISIONER OF POLICE RE MENTAL HEALTH | COLIN RILEY, PAT | 7.12.2022 |
| G26 | LETTER FROM THE COMMISIONER OF POLICE RE MENTAL HEALTH | DONNA ADAMS, COMMISIONER OF POLICE | 7.12.2022 |

MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

# ANNEXURE B - LIST OF EXHIBITS

**Record of investigation into the death of Paul George Hunt**

| No. | TYPE OF EXHIBIT | NAME OF WITNESS | DATE TENDERED |
|---|---|---|---|
| H1 | REPORT OF DEATH | CONST CHRISTOPHER KNIGHT | H1-H58 tendered 21.11.2022 |
| H2 | LIFE EXTINCT AFFIDAVIT | DR MICHELLE ROGERS | |
| H3 | AFFIDAVIT OF IDENTIFICATION | MORTUARY AMBULANCE | |
| H4 | POST MORTEM AFFIDAVIT | DR DONALD RITCHEY | |
| H5 | TOXICOLOGY REPORT | MIRIAM CONNOR | |
| H6 | VACIS PATIENT CARE REPORT | AMBULANCE TASMANIA | |
| H7 | MEDICAL RECORDS | DR CATHERINE STRINGER | |
| H7A | MEDICAL RECORDS (DISC) | RHH | |
| H8 | AFFIDAVIT | PETER MACZI | |
| H9 | AFFIDAVIT | CONST SIMON TAYLOR | |
| H10 | AFFIDAVIT | ROBYN WHEELER | |
| H11 | AFFIDAVIT | JAYNE DONNELLY | |
| H12 | AFFIDAVIT | DEUTSCH KADIMA | |
| H13 | AFFIDAVIT | ADRIAN MADIM | |
| H14 | AFFIDAVIT | JESSICA HUNT | |
| H15 | AFFIDAVIT | MATTHEW HUNT | |
| H16 | AFFIDAVIT | LOUISE GREATRIX | |
| H17 | AFFIDAVIT | COMMANDER ROBERT BONDE | |
| H18 | AFFIDAVIT | DET SGT VIRGIL | |

| | | | |
|---|---|---|---|
| | | ROWE | |
| H19 | AFFIDAVIT | DET SGT TROY MORRISBY | |
| H20 | AFFIDAVIT | DET SGT BERNARD PETERS | |
| H21 | AFFIDAVIT | SNR SGT ANDREW BENNETT | |
| H22 | AFFIDAVIT | SGT PETER BORISH | |
| H23 | AFFIDAVIT | CST DANIEL SMITH | |
| H24 | AFFIDAVIT | I/C CST ALISON MACKAY | |
| H24A | AFFIDAVIT | PATRICK ALLEN | |
| H24B | FILE NOTE | PATRICK ALLEN | Tendered 28.11.2022 |
| H25 | AFFIDAVIT | SGT ANDREW HANSON | |
| H26 | AFFIDAVIT | DET SGT DARREN TURNER | |
| H27 | AFFIDAVIT | DET CST CHRISTOPHER KNIGHT | |
| H28 | AFFIDAVIT | SNR SGT JUSTIN BIDGOOD | |
| H29 | AFFIDAVIT | SNR SGT PAUL REYNOLDS (Deceased) | |
| H30 | AFFIDAVIT & ANNEXURES | INSP JOHN WARD | |
| H31 | AFFIDAVIT | SNR CST BRETT PULLEN | |
| H32 | AFFIDAVIT | BUCK ROGERS (TASPOL) | |
| H33 | AFFIDAVIT & RWP RECORDS | SNR SGT ROBYN HARPER | |
| H34 | AFFIDAVIT | SGT PETER | |

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| | | ANDRICOPOULOS | |
| H35 | AFFIDAVIT | SNR CST ANN EDGE | |
| H36 | AFFIDAVIT | SNR SGT LUKE MANHOOD | |
| H37 | AFFIDAVIT & ANNEXURE | INSP JOANNE STOLP | |
| H38 | AFFIDAVIT 4.10.2016 | SGT FIONA SMITH | |
| H39 | AFFIDAVIT | DET CST OLIVIA ELDERSHAW | |
| H40 | AFFIDAVIT | PAUL BEAUMONT (TASPOL) | |
| H41 | AFFIDAVIT | NATHAN ROBINSON (TASPOL) | |
| H42 | AFFIDAVIT & PHOTOGRAPHS | I/C CST BRETT TYSON | |
| H43 | SUICIDE NOTES | PAUL HUNT | |
| H44 | TAXI CCTV IMAGES (DISC) | TAXI COMBINED SERVICES | |
| H45 | STATUTORY DECLARATION AND BWS FOOTAGE (DISCS X 2) | CRAIG AVNELL | |
| H46 | INTERVIEW TRANSCRIPT | KATIE HAYES | |
| H47 | INTERVIEW TRANSCRIPT | KATE DENNIS | |
| H48 | INTERVIEW TRANSCRIPT | KIRSTEN MILNE | |
| H49 | INTERNAL INVESTIGATIONS INTERVIEW (DISC) | TASMANIA POLICE | |
| H50 | AFFIDAVIT AND ANNEXURE | ADRIAN BODNAR | |
| H51 | AFFIDAVIT AND LETTER | COLIN RILEY, PAT | |
| H52 | PERSONNEL FILE | TASMANIA POLICE | |
| H53 | PERSONAL DOSSIER | TASMANIA POLICE | |

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| H54 | WORKERS COMPENSATION FILE | TASMANIA POLICE | |
| H55 | WELLBEING DOCUMENTS | DPFEM | |
| H56 | MEDICAL EXAMINATIONS & REPORTS | TASMANIA POLICE | |
| H57 | IAPRO HOLDINGS (3 FOLDERS) | TASMANIA POLICE | |
| H58 | AFFIDAVIT (19.07.2022) & ATTACHED RUNNING SHEET | SGT FIONA SMITH | |
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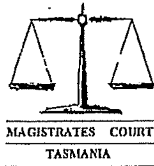


*MAGISTRATES COURT of* TASMANIA

CORONIAL DIVISION

# ANNEXURE C - LIST OF EXHIBITS

**Record of Investigation into the death of Paul James REYNOLDS**

| No. | TYPE OF EXHIBIT | NAME OF WITNESS | DATE TENDERED |
|---|---|---|---|
| R1 | REPORT OF DEATH | A DET INSPECTOR CRAIG FOX | R1-R38 tendered 22.11.2022 |
| R2 | AFFIDAVIT – LIFE EXTINCT | DR MICHELLE ROGERS | |
| R3 | AFFIDAVIT OF IDENTIFICATION | I/C CONST BRETT TYSON | |
| R4 | AFFIDAVIT OF IDENTIFICATION | COLIN O'CONNOR | |
| R5A | INTERIM POST MOTERM REPORT | DR CHRISTOPHER LAWRENCE | |
| R5B | POST MOTERM REPORT | DR CHRISTOPHER LAWRENCE | |
| R6 | TOXICOLOGY REPORT | NEIL MCLACHLAN-TROUP | |
| R7 | AFFIDAVIT | SHARON REYNOLDS | |
| R8 | STATUTORY DECLARTION 22.02.2022 | KAREN CAREY | |
| R8A | AFFIDAVIT 31.10.2022 | KAREN CAREY | |
| R9 | AFFIDAVIT | MARK GRIFFITHS | |
| R10 | AFFIDAVIT | S/CONST SIMON TRIFFITT | |
| R11 | AFFIDAVIT | I/C CONST THOMAS MOIR | |
| R12 | AFFIDAVIT | INSP PHILIPPA BURK | |

| R13 | AFFIDAVIT AND PHOTOGRAPHS (DISCSX2) | I/C CONST BRETT TYSON | |
|---|---|---|---|
| R14 | AFFIDAVIT | S/CONST SIMON TAYLOR | |
| R15 | AFFIDAVIT | SCOTT RIGBY | |
| R16 | AFFIDAVIT | SERG TERRENCE REANEY | |
| R17 | AFFIDAVIT | JAMES DILGER | |
| R18 | AFFIDAVIT | DET INSP MARK WRIGHT | |
| R18A | SEARCH WARRANT | DET INSP MARK WRIGHT | |
| R19 | AFFIDAVIT | DET SERG STEPHEN HERBERT | |
| R20 | AFFIDAVIT | I/C CONST ANGELA PHIPPS | |
| R21 | INTERVIEW TRANSCRIPT + DISC | JOSHUA SMITH | |
| R22 | SUICIDE NOTE | PAUL REYNOLDS | |
| R23 | MEDICAL RECORDS + DISC | VARIOUS | |
| R24 | BANK STATEMENTS | BEVERLEY REYNOLDS | |
| R25 | PROFESSIONAL STANDARDS INTERNAL INVESTIGATIONS FILE | TASMANIA POLICE | |
| R26 | WELLBEING SUPPORT DOCUMENTS | DPFEM CISM | |
| R27 | LETTER TO AGED CARE FACILITY & REPLY | EMMERSON PARK | |
| R28 | POWER OF ATTORNEY | BERVERLEY REYNOLDS | |
| R29 | FIREARM LICENCE SEARCH | TASMANIA POLICE | |
| R30 | ICE TRANSPORT SEARCH | TASMANIA POLICE | |

| R31 | IDM REPORT | TASMANIA POLICE | |
|---|---|---|---|
| R32 | THANK YOU CARD | CHRISTINE EGGER | |
| R33 | IAPRO HOLDINGS | TASMANIA POLICE | |
| R34 | PERSONNELL FILE | TASMANIA POLICE | |
| R35 | WORKERS COMPENSATION FILE | TASMANIA POLICE | |
| R36 | AFFIDAVIT 19.07.2022 | SGT FIONA SMITH | |
| R37 | AFFIDAVIT | IAN ADAMS | |
| R38 | AFFIDAIVT | DET SNR CST WILLIAM PATMORE | |
| R39 | RECORD OF SEARCH WARRANTS | INSP DAVID GILL | Tendered 24.11.2022 |
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MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

# ANNEXURE D - LIST OF EXHIBITS

**Record of investigation into the death of Simon Graham DARKE**

| No. | TYPE OF EXHIBIT | NAME OF WITNESS | DATE TENDERED |
|---|---|---|---|
| D1 | REPORT OF DEATH | CONST KAITLIN SULMAN | D1-D55 tendered 24.11.2022 |
| D2 | LIFE EXTINCT AFFIDAVIT | DR K MYKKANEN | |
| D3 | AFFIDAVIT OF IDENTIFICATION | MORTUARY AMBULANCE | |
| D4 | AFFIDAVIT OF IDENTIFICATION | INSP CRAIG TWINING | |
| D5 | POST MORTEM AFFIDAVIT | DR DONALD RITCHEY | |
| D6 | TOXICOLOGY REPORT | CRAIG GARDNER | |
| D7 | AFFIDAVIT & AMBULANCE TAS RECORDS | LISA TREVASKIS & AMBULANCE TAS | |
| D8 | AFFIDAVIT | GRAHAM DARKE | |
| D8A | AFFIDAVIT 16.11.22 | GRAHAM DARKE | |
| D9 | AFFIDAVIT (FOUND DECEASED) | CONST JAMIE HARRISS | |
| D10 | AFFIDAVIT(FOUND DECEASED) | CONST TEAGAN WALKLEY | |
| D11 | AFFIDAVIT(FOUND DECEASED) | SGT STEVEN KEISELIS | |
| D12 | AFFIDAVIT | ANGELA DARKE (nee VIRGONA) | |
| D13 | AFFIDAVIT | KIMBERLY FREEMAN | |
| D13A | COURT FILE | KIMBERLY FREEMAN | |
| D13B | FVMS REPORT AND TEXT | KIMBERLY FREEMAN | |

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| | MESSAGES | | |
| D14 | AFFIDAVIT AND TEXT MESSAGES | SIMONE BERTOZ | |
| D15 | AFFIDAVIT | JULIE PADMAN | |
| D16 | AFFIDAVIT | SGT ANN EDGE | |
| D17 | AFFIDAVIT | SHANNA SWEENEY | |
| D17A | SHANNA SWEENEY FVMS RECORD | TASMANIA POLICE | |
| D18 | AFFIDAVIT | SGT DANNY JACKSON | |
| D19 | AFFIDAVIT | JESSICA LYNDON (POLICE) | |
| D20 | AFFIDAVIT | INSP JOHN WARD | |
| D21 | AFFIDAVIT | INSP MATHEW RICHMAN | |
| D22 | AFFIDAVIT | ARTHUR ALFORTE (POLICE) | |
| D23 | AFFIDAVIT | AARON WOOLEN (POLICE) | |
| D24 | AFFIDAVIT | CONST ANDREW HERBERT | |
| D25 | AFFIDAVIT | CONST GARETH AUKER | |
| D26 | AFFIDAVIT AND AVL RECORD | SGT JOHN TOOHEY | |
| D27 | AFFIDAVIT | SGT PETER MAY | |
| D28 | AFFIDAVIT | INSP TROY MORRISBY | |
| D29 | AFFIDAVIT | JOHN LAMPKIN, DPFEM | |
| D30 | AFFIDAVIT | S SGT BENJAMIN DUFFEY | |
| D31 | AFFIDAVIT | SGT STEWART | |

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| D32 | AFFIDAVIT AND PHOTOGRAPHS (WITH CD) | CONST TANIA CURTIS | |
| D33 | AFFIDAVIT AND PHOTOGRAPHS (WITH CD) | SGT SCOTT KREGOR | |
| D34 | SUICIDE NOTES | SIMON DARKE | |
| D35 | FORENSIC EXAMINATION ON USB AND MOBILE PHONE | TASMANINA POLICE | |
| D36 | CALL LOGS AND IDM REPORTS | TASMANINA POLICE | |
| D37 | BALLISTICS REPORT | I/C CST STEPHEN DENHOLM | |
| D38 | DOMESTIC VIOLENCE INCIDENT REPORT | TASMANIA POLICE | |
| D39 | DOMESTIC INCIDENT IDM REPORT | TASMANIA POLICE | |
| D40 | CARDEX CARDHOLDER REPORT | TASMANIA POLICE | |
| D41 | EQUIPMENT ISSUE REGISTER | TASMANIA POLICE | |
| D42 | VEHICLE TAKEOVER REGISTER | TASMANIA POLICE | |
| D43A | WELLBEING AND SUPPORT DOCUMENTS | DPFEM | |
| D43B | CRITICAL INCIDENT STRESS MANAGEMENT DOCUMENTS | DPFEM | |
| D44 | ALL RECORDS ON USB | TASMANIA POLICE | |
| D45 | IAPRO HOLDINGS | TASMANIA POLICE | |
| D46 | RELATIONSHIPS AUSTRALIA RECORDS | RELATIONSHIPS AUSTRALIA | |
| D47 | RECORDS OF COMPLAINTS AND INVESTIGATIONS | TASMANIA POLICE | |
| D48 | EXTRA INFORMATION RELATED TO INVESTIGATION | DAVID PROVAN AND FRANCIS ABOUD | |

| D49 | MURDOCH CLARK FILE | MURDOCH CLARK LAWYERS | |
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| D50 | RECORDS OF WORK HOURS 6.12.2018-6.02.2019 | TASMANIA POLICE | |
| D51 | AFFIDAVIT (19.07.2022) | SGT FIONA SMITH | |
| D52 | AFFIDAVIT | JANICE DARKE | |
| D53 | AFFIDAVIT | CST FRANCIS ABOUD | |
| D54 | AFFIDAVIT | CST IAN PROVAN | |
| D55 | AFFIDAVIT | CST SAMUEL TILLEY | |
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*MAGISTRATES COURT of* TASMANIA

CORONIAL DIVISION

# ANNEXURE E - LIST OF EXHIBITS

**Record of investigation into the death of Robert Anthony COOKE**

| No. | TYPE OF EXHIBIT | NAME OF WITNESS | DATE TENDERED |
|---|---|---|---|
| C1 | REPORT OF DEATH | Sgt Adrian Mollon | C1-C56 tendered 24.11.2022 |
| C2 | AFFIDAVIT – LIFE EXTINCT | Dr Martin Watson | |
| C3 | AFFIDAVIT OF IDENTIFICATION | Sgt Genevieve Hickman | |
| C4 | AFFIDAVIT OF IDENTIFICATION | Cst Angus John Dobner | |
| C5A | INTERIM POST MORTEM REPORT | Dr Donald Ritchey | |
| C5B | AFFIDAVIT – POST MORTEM REPORT | Dr Donald Ritchey | |
| C6 | AFFIDAVIT – TOXICOLOGY REPORT | Neil McLachlan-Troup | |
| C7 | PATIENT CARE REPORT + AUDIO FILES (USB) | Ambulance Tasmania | |
| C8 | AFFIDAVIT | S/Con Elizabeth Carlisle | |
| C9 | AFFIDAVIT | Jarred Cooke | |
| C10 | AFFIDAVIT | Liam Cooke | |
| C11 | AFFIDAVIT 18.06.2021 | Michelle Cooke | |
| C11A | AFFIDAVIT AND ANNEXURES 27.10.2022 | Michelle Cooke | |
| C12 | AFFIDAVIT | Cst Melissa Finlayson | |
| C13 | AFFIDAVIT | Cst Ralph Newton | |

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| C14 | AFFIDAVIT | Sgt Adrian Mollon | |
| C15 | AFFIDAVIT | Cst Sean Dougan | |
| C16 | AFFIDAVIT | Cst Matthew Duncan | |
| C17 | AFFIDAVIT | Insp Jason Elmer | |
| C18 | AFFIDAVIT | Commander Robert Blackwood | |
| C19 | AFFIDAVIT | Cst Shane Tilley | |
| C20 | AFFIDAVIT AND PHOTOGRAPHS | S/Cst Rance Swinton | |
| C21 | AFFIDAVIT | Cst Tania Curtis | |
| C22 | AFFIDAVIT | Sgt Peter May | |
| C23 | AFFIDAVIT | Insp Philippa Burk | |
| C24 | AFFIDAVIT | Cst Sonya Cooke | |
| C24A | AFFIDAVIT 10.10.2022 | Cst Sonya Cooke | 30.11.2022 |
| C25 | AFFIDAVIT | Insp Matthew Richman | |
| C26 | AFFIDAVIT | Cst Gavin Cashion | |
| C27 | AFFIDAVIT | Insp Peter Harris | |
| C28 | AFFIDAVIT | Cst David Rowlands | |
| C28A | AFFIDAVIT 18.10.2022 | Cst David Rowlands | 30.11.2022 |
| C29 | AFFIDAVIT | Nicholas Becker | |
| C30 | AFFIDAVIT | Venessa Dale Mason | |
| C31 | AFFIDAVIT | Eric Rolle | |
| C32 | INVESTIGATION RUNNING SHEET | Tasmania Police Service | |
| C33 | MOBILE PHONE EXAMINATION RECORDS + USBs x2 | S Cst D Shaw | |
| C33A | PHONE EXAM REPORT AND REQUEST SUMMARY | S Cst D Shaw | |

| C33B | EXTRACTION REPORT AND FACEBOOK MESSAGES | S Cst D Shaw | |
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| C33C | RE-EXAMINATION REPORT | S Cst D Shaw | |
| C33D | RE-EXAMINATION RECORDS ON USBX1 | S Cst D Shaw | |
| C34 | POLICE LAPTOP/TABLET CONTENTS + USB<br>(Everything not printed, check USB) | Tasmania Police Service | |
| C35 | SORELL CCTV FOOTAGE (USB) | 911 Bottle shop<br>BWS Bottle shop<br>Celebrations Bottle shop | |
| C36 | POLICE BODY CAM FOOTAGE + RADIO DISPATCH SERVICE CALLS (USB) | Tasmania Police Service | |
| C37 | BANK STATEMENTS | ANZ Bank Ltd | |
| C38 | MEDICAL RECORDS + USB<br>(Check USB for full file) | Dr Mark Nelson<br>(Lindisfarne Clinic)<br>1 – Correspondence<br>2 – Kessler Psychological Distress Scale (K10) forms<br>3 – Visits<br>4 – Medical Certificates<br>5 – Injury Management Plans<br>6 – Nursing Discharge Summaries | |
| C39 | MEDICAL RECORDS | Dr Warwick Bishop<br>(Calvary Hospital)<br>7- Correspondence<br>8- Cardiac Diagnostic | |

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| | | Report<br>9- Echocardiography Reports<br>10- Cardiac Catheter Report<br>11- Holter Monitoring Report | |
| C40 | HOSPITAL RECORDS | Royal Hobart Hospital | |
| C41 | HOSPITAL RECORDS | St Helens Private Hospital<br>12 – Admission 2 September 2020<br>13 – Admission 2 June 2020<br>14 – Admission 16 April 2020<br>15 – Admission 28 February 2020<br>16 – Admission 13 February 2018<br>17 – Admission 21 May 2012 | |
| C42 | PROFESSIONAL STANDARDS INTERNAL INVESTIGATIONS FILE + USB | Various | |
| C43 | INJURY MANAGEMENT ADVISORY SERVICES FILE + USB | Various | |
| C44 | POLICE DOSSIER + USB | Tasmanian Police Service | |
| C45 | PSYCHOLOGY RECORDS | Dr Jacqueline Prichard | |
| C46 | PSYCHIATRIST RECORDS | Dr Yvonne Turnier-Shea | |
| C46A | AFFIDAVIT | Dr Yvonne Turnier- | |

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| | | Shea | |
| C47 | PSYCHIATRIST REPORT | Dr Leonard Lee | |
| C48 | DOCUMENTATION PREPARED FOR CORONER BY WELLBEING SUPPORT | CISM:<br>1 – MVA<br>2 – MVA 1995<br>3 – MVA 1996<br>4 – Murder/Suicide 1997<br>5 - MVA 2003<br>6 – MVA 2005<br>7 – MVA 2008<br>8 – MVA 2009<br>9 – MVA 2009<br>10 – Murder 2013<br>11 – MVA 2014<br>12 – Fire 2016<br>13 – MVA 2016 | |
| C49 | WORKER'S COMPENSATION FILE + USB | WorkSafe Tasmania | |
| C49A | 2009 WORKERS COMPENSATION FILE | WorkSafe Tasmania | 30.11.2022 |
| C50 | CORRESPONDENCE | Various | |
| C51 | CV + LETTER | Robert Cooke | |
| C52 | AFFIDAVIT | Snr Sgt Andrew Bennett | |
| C53A | EMAIL RE FATIGUE MANAGEMENT POLICY AT TASMANIA POLICE | Insp David Gill, DPFEM | |
| C53B | DRAFT FATIGUE MANAGEMENT FRAMEWORK BOOKLET | DPFEM | |
| C54 | RECORDS OF MEETINGS | DPFEM | |

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| | WITH THE COMMISSIONER OF POLICE | | |
| C55 | CHRONOLOGY AND DOCUMENTS RE MEETINGS WITH COMMANDER CERRITELLI | DPFEM | |
| C56 | AFFIDAVIT | Darren Hine | |
| C57 | OVERTIME ROSTER | ROBERT COOKE | 29.22.2022 |
| C58 | OVERTIME PAYSLIPS | ROBERT COOKE | 29.22.2022 |
| C59 | NOTEBOOK ENTRIES | INSP PHILIPA BURK | 25.11.2022 |
| C60 | WEBEOC RUNNING LOG | INSP DAVID GILL | |
| C61 | LAKE ECHO EVACUATION PLAN | INSP DAVID GILL | |
| C62 | BRANDUM TO BREONA EVACUATION PLAN | INSP DAVID GILL | |
| C63 | AFFIDAVIT | D/INSP MELANIE GROVES | 30.11.2022 |
| C64 | EMAIL AND DRAFT REQUEST FOR TRANSFER | S Constable Elizabeth Carlisle | 2.12.2022 |
| C65 | INCIDENT SUMMARY AND APOLOGY EMAIL | TASMANIA POLICE | 8.12.2022 |