REPORT OF THE COMMISSION OF INQUIRY
INTO THE DEATH OF
SQNLDR ADAM LUKE HUGHES         CSC.

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Appointment

1. On 26 July 2008 Air Chief Marshal Allan Grant Houston AC, AFC, Chief of the Defence Force, acting pursuant to the power bestowed by Regulation 109 of the Defence (Inquiry) Regulations 1983, appointed a Commission of Inquiry constituted by me for the purpose of inquiring into the circumstances surrounding the death of SQNLDR Adam Luke Hughes CSC.

2. LCDR Adam Johnson and SQNLDR George Kalimnios were appointed Counsel Assisting the Commission of Inquiry.

Terms of Reference

3. By of the same date, Air Chief Marshal Houston charged the Commission of Inquiry (hereafter, the Inquiry) with the task of obtaining evidence and providing to him a report detailing the findings of the Commission as to:

The circumstances surrounding the death of SQNLDR Hughes including without restricting the generality thereof:

a. the date and place of the death;

b. the manner and cause of death; and

c. any facts and circumstances establishing that the death arose out of, or in the course of his service in the Air Force.
d. the sufficiency of any actions and decisions taken by Defence personnel which are materially relevant to SQNLDR Hughes's death, both prior and subsequent thereto.

e. any weaknesses or deficiencies (isolated or systemic) in Defence systems, policies, equipment, practices, procedures and training proximately associated with SQNLDR Hughes's death.

4. The within report responds to the inquiries with which the Inquiry was charged in three sections:

Part A. The response to terms of reference a-e.
Part B. The response to terms of reference d-e.
Part C. Recommendations.

The Course of the Inquiry.

5. The Inquiry formulated an initial phase that focused on assembly of documentation with and of SQNLDR Hughes. Statements were taken from SQNLDR Hughes's relatives, friends, medical advisors, former colleagues and third parties thought likely to have information on one or more of the issues relevant to the Inquiry's interest. The Commission extracted from that material the facts that appeared uncontroversial surrounding SQNLDR Hughes's death; matter (a) in the Terms of Reference. Whilst any conclusions were necessarily tentative pending hearing of viva voce evidence from witnesses, some provisional views were formed on the need for inquiry into areas that appeared less uncontroversial. Further statements and documentation were obtained. A practice note was formulated and circulated.
6. Following consideration of the documentation and interviews with those witnesses whom the documentation suggested were likely to have relevant information, the Commission identified several additional avenues of interest.

7. The Inquiry commenced to take the oral evidence of witnesses at Victoria Barracks, Brisbane on 25 February 2009. Further hearings were conducted from time to time, as the availability of witnesses permitted. On 4 and 5 March 2009 the Inquiry took evidence from 11 witnesses, primarily from members of the Hughes family on his father's side and from friends of SQNLDR Hughes who reside in Tasmania. As the Inquiry progressed, four persons potentially affected by adverse comment were identified. Each was advised of the area of the Commission’s interest and representation was arranged pursuant to Regulation 121 of the Defence Force (Inquiry) Regulations.

Evidence was taken via a telephone hook-up on two occasions. Oral evidence concluded on 30 April 2009. Documents identified in the closing stages of viva voce evidence were subsequently obtained and admitted into evidence. Following the conclusion of oral evidence Mrs Hughes, the mother of SQNLDR Hughes sought to make a statement. The statement was recorded on the transcript but was not the subject of any questioning. Mr Mark Hughes SQNLDR Hughes's father subsequently sought to make a statement and arrangements were made to have a written statement from him admitted as an exhibit. Neither statement was on oath nor subject to cross-examination; the persons mentioned therein have not been afforded an opportunity to respond. I have taken the statements into account but I have made no findings based upon their contents.
PART A

The Death of SQNLDR Hughes – Terms of Reference (a)-(c).

9. Appraisal of available documentary material suggested that the date and place of SQNLDR Hughes's death were likely to be established reasonably precisely without controversy. As to the manner and cause of his death, term of reference (b), that too appeared susceptible of ready determination in a scientific sense. From that point, the questions arose:

(i) If SQNLDR Hughes died as a consequence of his own actions, did he die as a result of deliberate decision, or did he die accidently?

(ii) Whether suicide or accidental death, what factors played a part in the actions of SQNLDR Hughes that led to his death; in particular did SQNLDR Hughes's death arise out of or in the course of his service?

These matters when determined would provide a response to Terms of Reference (a)-(c). I address them first.

**The Date, Place and Manner of Death.**

**The Evidence.**

10. SQNLDR Hughes's mother Gail Hughes gave evidence that she had spoken to her son by telephone on Saturday evening 19 January 2008, at which time he had been at dinner with friends. She did not attempt to contact him on the Saturday as she knew he had arranged to get together with his cousin Kristian for the day. She did not phone him on the Sunday, believing he would have left early to travel to the Gold Coast where he was to lunch with his uncle and aunt. In the event he did not keep that arrangement.
11. SQNLDR Hughes spoke to his step-mother Karen Hughes by phone about 0400 hrs Sunday morning 20 January 2008 and to his aunt Carol Clayton by phone between 1430 and 1530 in the afternoon of the same day. This is the latest contact revealed by the evidence.

12. Attempts by his mother to contact him by phone on Sunday 20 January and Monday 21 January 2008 were unsuccessful. When his civilian employer contacted her in consequence of his non-arrival at the Clinic, Mrs Hughes had become alarmed and had travelled to SQNLDR Hughes's apartment at Newstead at about 1100, where she had discovered the body of SQNLDR Hughes on his bed. It is apparent that Mrs Hughes had feared for some time that SQNLDR Hughes would take his own life.

Wade Schmieder.

13. Wade Schmieder of Queensland Ambulance Service gave evidence, and his statement was tendered. At about 1100 on Monday 21 January 2008 QAS responded to an emergency call made by Mrs Gail Hughes. They found SQNLDR Hughes deceased on bed, in supine position on his back with hands folded across his sternum. The apartment lights were on; the deceased was dressed in day clothing, his wallet present. The apartment was very untidy but not ransacked. Mr Schmieder identified photographs of the scene as representative. He observed numerous pharmaceutical scripts and medications as depicted on the photographs, and formed the view that Dr Hughes had died at least four hours prior to his arrival, and up to eight hours.
Constable Anthony James Foster.

14. Plain clothes Constable Anthony James Foster of Queensland Police Service attended the scene whilst the ambulance personnel were present. He confirmed the scene as depicted in photographs taken by Crime Investigation Officers. There was no sign of forced entry, theft or assault; a wallet was present and contained cash. Constable Foster was advised by Mrs Hughes that the last person to see SQNLDR alive may have been Kristian Hughes. He made contact with Kristian Hughes, who asserted that he had seen the deceased about 1330 hours Saturday 19 January 2008. Crime Investigation detectives attended and assessed the scene and formed the view that there were no suspicious circumstances. Accordingly they declined to take over the matter. Constable Foster followed protocols in respect of relatives, reporting to the Coroner and arranging for the removal of the body to the government undertaker.

The Coroner’s Documents.

15. A Coronerial inquiry was carried out by Dr Michael Barnes, the Queensland Coroner. The documents constituting that Coronerial Inquiry were obtained from the office of the State Coroner, Queensland. That material included the report of an autopsy that was carried out on 22 January 2008. Of relevance to the Inquiry, the report records the presence in the deceased’s stomach of “a small amount of apparent pill residue.”

16. A report from the Forensic Toxicology Laboratory QHSS Brisbane of 9 May 2008 records the result of analysis of specimens received from the Coroner. The following results are relevant:
FEMORAL BLOOD

Alprazolam – 0.2 mg/kg
Morphine – 0.6 mg/kg*
Codeine – 2 mg/kg
Total Morphine (Morphine plus Glucuronides) – 1.6 mg/kg*
Paracetamol 110 mg/kg

URINE

Alcohol – 35 mg/100 ml
Immunoassay was ...positive for benzodiazepines and opiates

* The level of morphine is consistent with its presence as a metabolite of codeine.

17. Dr BB Ong, the doctor who carried out the autopsy on behalf of the Coroner reported

"The post-mortem examination was general unremarkable. The heart showed no pathology. The brain was essentially normal, showing no abnormality indicative of epilepsy. In summary, there was no pathology elicited that would account for death.

The main findings were in the toxicology analysis. Multiple drugs were detected. These included drugs that he was prescribed. These included venlafaxine (within therapeutic range) and alprazolam and its metabolite (known toxic range). Other drugs detected included benzodiazepines (both diazepam and oxazepam and their metabolites, which were all in therapeutic ranges), chlorpromazine (subtherapeutic), promethazine (therapeutic) and codeine and its metabolite (toxic range). Alcohol was detected in low level and only in the urine.

Interpretation from the toxicology results noted alprazolam and codeine in known lethal levels. The negative post-mortem examination together
with the toxicology results indicated that these drugs were responsible for his death”.

**Cause of Death**

1 (a) Mixed drug toxicity. (Emphasis added).

Dr Ong and Mr Neville Bailey.

18. Dr Beng Beng Ong, a forensic pathologist and Mr Neville Bailey, a team leader of the toxicology unit at Forensic and Scientific Services were called and gave evidence "together, as there were matters where each would defer to the other's expertise. Dr Ong observed that the diazepam and the oxazepam, though present in therapeutic levels, may have enhanced the respiratory-depressing effects of codeine, as might the alcohol consumed. 'The alcohol is likely to have been taken before the other drugs. After admission into evidence of the original report to the Coroner contained in Exhibit 2, an analysis of the deceased's stomach was carried out. This did not yield any information at variance with the original conclusions, but clarified and confirmed some technical matters.

19. For reasons that he explained, Dr Ong had difficulty in placing a precise time on SQNLDR Hughes's death, but agreed that such indicia as was available put the time of death at between dusk on Sunday night 20 January 2008 and dawn the following morning.

**Finding - Term of References (a)-(b):**

20. The evidence satisfied me that:
• The sole rational inference is that Dr Hughes died as a result of the toxic
effects of drugs that he had taken some hours before his death.

The deceased had ingested a wide range of prescription and non-
prescription drugs; he had been drinking at an early stage of the
ingestion period; the combination of the depressive effects upon his
respiration and the soporific effects of the drugs and alcohol taken
during the night of the 20\textsuperscript{th} of January or the early hours of the 21\textsuperscript{st} of
January 2008 had resulted in his ceasing to breathe, resulting in his
death.

• The principal drugs implicated were Panadeine Forte, codeine,
morphine, Paracetamol and Alprazolam.

• The combination of known factors suggests that death had taken place
during the night hours of Sunday/ Monday 20-21 January 2008.

21. I conclude that Adam Luke Hughes born 16 August 1976 died during the
period between late evening of Sunday 20 January 2008 and 5am on Monday
21 January 2008, at Newstead in the State of
Queensland. SQNLDR Hughes succumbed to the effects of respiratory
depression consequent upon the ingestion of drugs containing codeine and its
metabolite, morphine.

\textit{Accidental Death or Suicide?}

22. The next question that arose for determination was whether the taking of the
tablets containing the drugs that caused his death was intended to bring about
that death, or whether his ingestion of a lethal quantity of drugs was not
intended. Dr Ong confirmed that the likelihood of a medico taking 40 tablets of Panadeine Forte at once without realising the consequence was remote.

23. The circumstance that some of the medication containers found in SQNLDR Hughes’s apartment had been prescribed for his cousin Kristian Hughes, in particular for 40 Panadeine Forte tablets prescribed on Saturday 19 January 2008, raised a question.

The Final Contacts.

Kristian John Hughes.

24. Kristian Hughes said that he had back pain himself for which he was taking prescribed medications including Panadeine Forte. He said that Adam Hughes had prescribed medications for him “once or twice”.

25. He said that on the 17th or 18th of January 2008 he “might have” spoken to Adam Hughes by phone and Adam Hughes had agreed to prescribe Panadeine Forte and Halcion for him. As Kristian Hughes was proposing to be in Brisbane on Saturday 19 January, he arranged to meet him that day. The relevant prescriptions were for Panadeine Forte and Serapax, dated 17 January, and for Halcion tablets, dated 15 January 2008.

26. On the Saturday he said he had met Adam Hughes about 2pm and had spent 1.5 hours with him, driving around in SQNLDR Hughes’s car. During this time he said he had filled the prescription written for him by Adam Hughes for Serapax and Panadeine Forte, at two different pharmacies because the first pharmacy had not had Halcion or Serapax. They had returned to Adam Hughes’s apartment where they remained until 1730, when Kristian Hughes
left to meet his partner. Before leaving he said they had discussed the two drugs, and had them before them whilst doing so, having taken the drugs from his backpack for that purpose. It was "possible" he said that he was going to take some… He had not taken any of the drugs himself, and had left them behind in Adam Hughes’s apartment, "probably" by accident. The signature on the Medicare documentation engendered by the two purchases was in each case his own.

27. The evidence before the Inquiry strongly implied that Adam Hughes died from the combination of drugs and alcohol on Sunday night/Monday morning the 20th-21st of January 2008. Significant amongst the drugs implicated were the two blister packs of Panadine Forte prescribed for Kristian Hughes, each of which was empty of its original 20 tablets. That Kristian Hughes had removed the tablets from his backpack for the purpose of discussing them with Adam Hughes, had not taken any, and had failed to restore them to his backpack, which he took with him when he left, raised the question of the reliability of his evidence. He made no reference to any contact directed to retrieving them, and his conduct as described did not reflect that of a man in such pain that he had to ring a relative who was not his G.P. The different dates for the two prescriptions were not explained. In addition, telephone records showed three telephone communications between himself and Adam Hughes during the afternoon of Saturday 19 January; during the period when he said that he was with Adam Hughes. His explanation in this regard was unpersuasive. His account of the circumstances of acquisition of the drugs is only partially true. Further comment is outside my terms of reference.

28. Of the early morning conversation he had had by telephone that day with Adam Hughes, Kristian Hughes said that his cousin "didn’t sound too good" and that he may have been affected by alcohol. He said that he had told Adam Hughes he would need to clean himself up. Adam he said was in good spirits.
Kristian Hughes said that Adam Hughes had given him one of his watches "maybe that day". He did not see him again.

Gail Hughes.

29. Mrs Hughes the evidence of other witnesses revealed had for some time been on what she described as "suicide watch". She said that she had spoken by phone to SQNLDR Hughes on Friday evening 18 January, but had not sought to contact him on the following day, when she understood he was to spend the day with Kristian Hughes, nor on the Sunday, when she thought he was likely to have left Brisbane early to drive to Peter Hughes's home in had been arranged.

30. On Monday 21 January 2008 she had telephoned her son who had not answered, and had worried about his work commitments to the Clinic. When Clinic contacted her as SQNLDR Hughes had not attended for work, she left her own work immediately to drive to his apartment. Her feelings at that time demonstrate her premonition that her son had taken his life. On opening the door she saw the body of SQNLDR Hughes on his bed.

Peta Hughes.

31. Ms Hughes said that alcohol had been a problem on their father's side of the family, and both she and her brother had had alcohol problems when they were younger. During the period in 2007 of which she was speaking, she was aware that her brother had been drinking, both from his speech and from tell-tale signs of empty bottles concealed in cupboards and baskets.

32. Following his attendance on Dr Cook in relation to his DVA claim, Ms Peta Hughes had seen her mother and brother arrive at their Apartment. Her brother was in obvious distress and looked defeated. In the
following days, shortly before his death, she had been awakened late one night by SQNLDR Hughes, who was throwing items of his clothing at her bedroom to awaken her. She let him in, and received the explanation that he had gone out to get an ice cream and had locked himself out of his apartment without his wallet, phone or keys. After waiting for an hour or so outside the apartment shared by his mother and sister for someone to open their security door, he had buzzed the property manager of the building, who had let him into the building, after which he had made contact with his sister, as described. The event she said had not been unusual, and she thought may have been occasioned by the fact that his partner had moved out. Ms Hughes had driven SQNLDR Hughes back home. That was the last time that she saw him alive.

Mark Hughes.

33. After a considerable period during which he was unable to make any contact with his son, Mark Hughes and his wife had been awakened by a call at 4am on Friday 18 January 2008, during which SQNLDR Hughes talked to Mrs Hughes for a considerable time, though he did not want to talk to his father at that time.

34. In the early hours of Saturday 19 January 2008, his wife had answered the phone at 4am to SQNLDR Hughes. It was a lengthy phone call and he learned that SQNLDR Hughes did not wish to speak to him. Mr Hughes expressed the view that his son might have been on drugs or alcohol at the time, and there did not appear to be a lot of sense in the phone call. It was however more than they had for a good while. A further phone call early that morning followed and Mr Hughes took the phone to talk to his son. There were he said issues weighing on his mind. He mentioned SQNLDR Hughes’s sexuality, and was sure that his son would believe “that I wouldn’t accept it”. A position he attributed to his former wife. SQNLDR Hughes was urging his father to read
books on the subject; he was declining to do so, stating that there was no need.
It was not sufficient for his son he said that he accept his son's homosexuality,
his son required him to understand it. Voices he said were raised, and his wife
took the phone back. During the call Mr Hughes said he learned that his son
was seeing a psychiatrist to which he responded that they were not necessary
and that he Adam should sort himself out. His son said that he was in a high-
risk range for suicide because of his age, sexuality and financial position. His
son he said wanted more from him, "but I didn't know what else to come up
with". He got annoyed with his son over the books issue "and I think things
might have just got a bit heated then". He had he said himself become upset
and gave the phone back to his wife. He denied Mrs Gail Hughes's assertion
that he had been kicking furniture in the background and yelling "he's no son
of mine".

Mr Hughes phoned his son later that same day, because of the manner in
which their earlier phone call had ended. He obtained his son's phone number
as he had called Carol Clayton, who had refused to answer. During his
conversation he said his son had asserted that he and Kristian Hughes "were
going to come down and slit my throat". His son he thought was obviously
affected by drugs or alcohol. Mr Hughes asserts that he telephoned Vivian and
Gwendolyn Adams to request Mrs Adams contact his former wife, which she
did. He was advised that contact had been made and that Mrs Gail Hughes had
asserted that there were no problems, nothing was wrong, a mountain was
being made out of a molehill. Mr Hughes asserted that after the death he was
told that Mrs Gail Hughes had asserted in that conversation that she was "on
suicide watch".

Karen Hughes.

Mrs Hughes the present wife of Mark Hughes received a phone call from
SQNLDR Hughes at 0400 on Saturday 19 January 2008, during which he
spoke to her for several hours. Apart from the incongruity of the hour, his speech she said was slurred and his conversation disjointed. He spoke of his inability to sleep, his loneliness and the absence of anything to involve him after work. He spoke of a break-up with his partner, which had been occasioned by his continuing depression. SQNLDR Hughes told his stepmother that he felt like jumping off a bridge; he was not prepared to talk to his father that morning as he was not ready to talk to him, but that he did love him. He spoke of his feelings the night he learned his father had been apprised of his sexuality. He told Mrs Hughes he had been seeing a psychiatrist and that he proposed putting himself into hospital. They discussed SQNLDR Hughes’s seeing a psychiatrist. She urged him to travel to Tasmania for a holiday, a suggestion that he misinterpreted as a suggestion that he return to Tasmania to live.

37. At about the same time the following morning, Sunday 20 January 2008, SQNLDR Hughes phoned again. Mrs Hughes said that he was agitated and not at all calm, though he was slow and disjointed in his speech. He told her that he had telephoned Heather Hagan at her home in Queensland but he now knew she was holidaying in Tasmania, staying with her sister, Carol Clayton. He wanted to obtain the telephone number of Mrs Clayton; Mrs Hughes declined to give him the telephone number. She had told him she said that he was welcome to ring her at any time, but not for the purpose of "backstabbing the family". It was the family she said who were trying to help him. During this conversation she said Adam had spoken to his father. In general terms she confirmed the nature of the conversation as outlined by Mr Mark Hughes; SQNLDR Hughes demanded of his father that he read material in order to understand homosexuality, with Mark Hughes asserting that he had no need to do so, indeed would not do so; it was sufficient that he was prepared (he said) to accept that Adam was homosexual.

38. Mrs Hughes had no further contact with SQNLDR Hughes before his death.
Mrs Hagan is a sister of Mark Hughes, whose permanent residence has for some years been on the - it was her habit to visit family in each year in January.

Mrs Hagan said that she did not see a lot of Adam in 2006 and 2007 but that he was the subject of discussion with her brother who lived in Queensland and with whom SQNLDR Hughes retained significant contact. She said that the topic of Adam's sexuality was a constant topic with Hughes and his wife. She said that she and her sisters had believed Adam to be homosexual for many years, and were anxious that Adam should in some way be reconciled with his father. The question amongst the sisters was whether the father should be told, a question on which opinions differed. Her view was that Mark Hughes was not stupid, and by inference, should have worked it out for himself by that time. When SQNLDR Hughes cut off contact with his father and stepmother in October 2006, she formed the view that it was time to discuss the homosexuality issue with her brother Mark.

When she visited Tasmania in mid January 2007, she had she said asked her brother Mark whether or not he had ever discussed with his son his sexual preference, to which he had replied no, though he had suspected he was homosexual, but did not want to believe it. This she said had been followed shortly after by an angry and abusive phone call from SQNLDR Hughes, who was angry that she had "told my father". Over the ensuing year the abusive phone calls to her increased and she said, expanded into allegations that she had ruined his career. The calls she said became increasingly bizarre, and by the end of 2007, SQNLDR Hughes was using language that she found extraordinary and out of character. He frequently expressed the hope that ill-
fortune of all kinds would engulf her. By the end of 2007 she said, "the phone
calls were "beyond anger" and were made at all hours of the day. Mrs Hagan
said that she recognised that he was not well; his slurred speech suggested he
was affected by alcohol or drugs - he had conceded to her that he had a drink
problem. Mrs Hagan had told SQNLDR Hughes that he must seek medical
help.

42. On 18 January 2008, she had received an early morning phone call at her
sister Carol’s home in Tasmania from SQNLDR Hughes. The conversation she
said was repetitive, and involved the usual accusations that she had ruined his
life. SQNLDR Hughes she said had accused his father of violence towards him
and asserted that he (Mark) was trying to hurt him. The conversation with
SQLDR Hughes she said suggested that he was either heavily intoxicated or
drugged. He repeatedly accused his father of violence, and stated that he was
suicidal. His language and accusations were such that she hung up the phone,
only to have it ring again immediately. She picked up the call she said, but she
would not speak to him. A third phone call she said she did not answer - it was
this unanswered call that conveyed to the family SQNLDR Hughes’s new
mobile phone number. Mrs Hagan told the Inquiry that her sisters were aware
of the abusive campaign towards her, she said that towards the end she had
told Karen.

43. SQNLDR Hughes telephoned her at her sister’s home again early the
following morning, but Mrs Clayton declined to put Mrs Hagan on the phone.
Mrs Hagan observed that throughout the year when she had been receiving
abusive phone calls, they would often be followed by a call from her sister-in-
law, Hughes, to apologise for the language used by SQNLDR Hughes.
This led her to believe that SQNLDR Hughes was either telephoning from her
brother home, or at least was apprising her sister-in-law of the calls that
he was making. She suspected that Hughes was encouraging SQNLDR
Hughes to continue a campaign against her, providing him with material of which he could not himself have known. By the end of 2007, he had ceased cordial relations with her, and was spending a lot of time with her brother whose family she said “very overtly accepted his homosexuality”. She described the family as split between and Hughes, with Gail and Peta, and the balance of the family.

Carol Beth Clayton:

44. Mrs Clayton, sister of Mark Hughes had not she said heard from SQNLD__Hughes for about a year until he had telephoned in the early hours of Saturday 19 January 2008, demanding to speak to Heather Hagan, who had arrived there the evening before. Mrs Clayton said that SQNLD__Hughes sounded almost asleep, his voice slurred. He told her he was depressed, and that his partner had left. His language she said was extremely bad. He accused her of failing to befriend his mother; of having argued with her. He had she said telephoned again, and she did not answer; that call had disclosed his new number. She discussed the call with Mark and Karen Hughes later that morning.

45. On Sunday 20 January she said he had phoned about 2:30-3:30pm. This call she said was very different in nature, it was she said “the old, caring Adam”. He had apologised for ringing her so late on the previous occasion and for the abusive tone of his call. He said to her that he had misunderstood the position “you didn’t argue with Mum”. Mrs Clayton said that she told Adam that she was going to tea with his father, and she enquired about children’s voices that she could clearly hear in the background. She said SQNLD__Hughes said there were no children there, she repeated that she could hear children, and he again repeated that there were no children there. She had no explanation for that incident. She did not have further contact SQNLD__Hughes again before his death.
46. Mr Adams had been a surrogate father to SQNLDR Hughes in Tasmania, and retained a close friendship with him. Asked whether he had any knowledge of SQNLDR Hughes's health in the last 12 months of his life, Mr Adams said that he was aware that he had had an epileptic seizure and was receiving psychiatric treatment. He was not the thought handling things too well.

47. In late 2007 Mr Vivian Adams and his wife had received phone calls which he described as erratic, which phone calls had occasioned his wife to make contact with SQNLDR Hughes's mother in Brisbane. From these conversations he believed that Mrs Gail Hughes was monitoring her son's health. The phone calls were characterised by the use of rough language going beyond that which was acceptable, bordering on abuse. Mr Adams formed the view that SQNLDR Hughes was affected by drugs or alcohol. In the days preceding SQNLDR Hughes's death, he had received a message at the same time as had Alan Roberts, which message he said utilised language such that he wiped it off before his wife could read it. He "thought he'd gone completely mad".

48. On 19 January 2009 Mark Hughes phoned him, stating that he was concerned about SQNLDR Hughes and asking him to ascertain from SQNLDR Hughes's mother if he was alright. Mrs Adams had telephoned Gail Hughes in the days immediately prior to SQNLDR Hughes's death, when she could not reach him by telephone. After telephone calls had been made, he passed on the message to Mark Hughes "Gail's keeping an eye on him". On the Monday he received a phone call from Gail Hughes, who said "We've lost Adam", going on to state that he had committed suicide. This he had passed on to Mark Hughes that day in much the same terms.
Mrs Gwendolyn Adams said that some stage in 2007 she had received a telephone call from SQNLDR Hughes. He was thrilled at the fact that he was to go into private practice. He liked the idea of making significant money. Mrs Adams said that she received a Mother’s Day card in 2007 from SQNLDR Hughes as she did each year, and she produced the card and read its inscription to the Inquiry. She knew that SQNLDR Hughes had been in hospital that year – he explained it to her on basis that his tablets were not agreeing with him. She was aware he had had an MRI scan, and that it was said that he had “gone ballistic” in his building. Pets she said had captured that episode on her mobile, and that Adam Hughes had not been able to believe it when shown the footage of his behaviour. She said that towards the end of 2007, she would get an occasional brief, crude message to pass onto her husband. At this time she said she was ringing him every few weeks – “we all knew he wasn’t right”. Gail she said had stated that she was “on suicide watch...going to see him twice each day”. This assertion she said had been made in December 2007. She was aware that SQNLDR Hughes had not spent Christmas with his mother and sister, and surmised that he may have been with Hughes. She believed that SQNLDR Hughes was waiting for the right time to tell her of his homosexuality.

Other Witnesses.

Mark Dennis Lees.

Mr Lees, a school friend of SQNLDR Hughes’s said that they maintained some contact, and their mutual interest in motor vehicles was the subject of exchanges from time to time. He knew of SQNLDR Hughes’s car accident in the Northern Territory, and had seen photographs of the vehicle. He said that
SQNLDR Hughes spoke to him the day after the accident stating that he was alright. He did not think that there had been anything unusual about any of the contact he had with SQNLDR Hughes during this period, but noted that he had changed phones at some stage. He was aware that SQNLDR Hughes was at some time in 2007 doing three days each week in private practice. He said that he had had a phone call from Hughes late in 2007 which was normal – they discussed stereo equipment that Dr Hughes was proposing to purchase and their respective motor vehicles.

51. In January 2008, Mark Lees received a phone call on his mobile phone, the screen displaying SQNLDR Hughes’s number. He answered the phone but there was no response from the caller. After some little time, he cut the call off, believing that Adam had triggered his number by accident. He did not see SQNLDR Hughes again.

Dr Nadine Sharples-Bissland.

52. Dr Sharples-Bissland is a paediatric specialist who with her now husband had attended medical school with SQNLDR Hughes in 2000-2001 at the University of Tasmania. He was at that time an intern in Launceston hospital and she was a medical student. She had maintained contact with him after he went to Queensland for his resident year and had seen him in September 2002 in Tasmania. They kept in touch by telephone and text messaging, and on occasion through mutual friends. She had seen little of him between 2005 and 2008 whilst each was engaged in their professional lives. His email correspondence did not contain any complaint of which she made mention.

53. SQNLDR Hughes had telephoned her in September 2007, following an incident that he described as “an epileptic episode”. From the medication that he disclosed he was taking she and her husband suspected that he had
psychological disturbance. That phone call had been triggered by SQNLDR Hughes seeking her professional advice on a paediatric problem. She was aware that he was unhappy at Tindal, which he described as remote, stressful and a place where he had to do everything.

54. On January 19, 2008, she had circulated a text message to all her friends announcing the birth of her first child. SQNLDR Hughes telephoned her that day, his first contact for about six months. He talked at length both to Dr Sharples-Bissland and her husband, during which time he spoke of his relationship break-down, his forthcoming discharge from the ADF, his complaints that service had "played with his head somewhat", a situation to which he said deployments had contributed. They spoke of reunion; addresses were exchanged.

55. SQNLDR Hughes she said had spoken of his partner cheating on him, of earlier break-ups, and of the anger and upset that those had occasioned him. He spoke also of concern that his cat would be looked after and how to deal with his possessions. This latter she said was put in the context that he would have to move to a new apartment.

56. She said that SQNLDR Hughes was speaking in a happy, quick manner, and contrary to his custom, was freely discussing areas of his life previously kept private. She learned that he was taking medication as uppers and downers.

57. Dr Sharples-Bissland thought the conversation was disturbing at the time, and in light of the subsequent events believes it had the character of a last goodbye.

Robert William Morgan.

58. Robert William Morgan is a teacher who had grown up with SQNLDR Hughes at school as part of group of close friends whom he nominated as
Mark Lees, and Martin Kreusmann. They had stayed together as university students in an apartment in Hobart, shared an interest in Volvo motorcars, and maintained significant contact through until 2006-2007, after which time their contact had been much more fragmentary.

59. In late 2006 into 2007 he said, SQNLDR Hughes cut off contact with him, failing to return messages or respond in any way. He had he said called SQNLDR Hughes’s sister Peta from whom he learned in general terms that Adam Hughes was facing some issues, and had spent some time in a psychiatric ward. Months later he said he had received a phone call from SQNLDR Hughes, who stated that he had sustained PTSD for which he was seeking help, and of which he said that cutting off contact was a symptom. He said also in the course of a lengthy conversation that the experience he had had in Iraq and the Solomons had “messed with his head a bit”! Mr Morgan said that he had telephoned SQNLDR Hughes about a week later. SQNLDR Hughes he said appeared surprised that he had made such early contact; he appeared depressed, stated that he was no longer active in the RAAF and was working part-time in a surgery; he had just purchased a new BMW.

60. He was aware of SQNLDR Hughes’s homosexuality, something he had known since SQNLDR Hughes disclosed it to him in 2002 or 2003. He last spoke to SQNLDR Hughes in November or December 2007, no feature of which conversation was remarkable.

Alan Tasman Roberts.

61. Mr Roberts was a close friend of Mr and Mrs Vivian Adams, with whom SQNLDR Hughes had stayed on numerous occasions whilst growing up and thereafter. Through this friendship, Mr Adams had become close to SQNLDR Hughes, and the two older men had remained on close and cordial terms with the younger man until his death.
62. Mr Roberts said that he had not seen SQNLDR Hughes for about six months before his death; he had last seen him at lunch whilst he was on a holiday in Tasmania. He said that at that time SQNLDR Hughes was using bad language in front of Mrs Roberts, something he had never previously done.

63. He had not seen him again prior to his death, but on Saturday 19 January 2008 he had received a voice message from SQNLDR Hughes, the terms of which though unexceptional, had disturbed him to the point that he rang Mr Adams during the following Monday to inquire whether SQNLDR Hughes was alright. He learned that SQNLDR Hughes had taken his own life that day.

64. Mr Roberts said that the nature of the call suggested it was a goodbye call and it was for that reason that he had telephoned Mr Adams.

Finding:

65. These events provide strong confirmation that SQNLDR Hughes took his own life deliberately. No material examined by the Commission and no witness statement suggests complicity of any person directly in any decision by SQNLDR Hughes to take the drugs. Whether Kristian Hughes was or was not complicit in obtaining medication intended for use by SQNLDR Hughes was a question that I found inappropriate to resolve.

66. I conclude that SQNLDR Hughes had determined to take his life, and was responsible for the deliberate ingestion of the drugs identified in his body at autopsy.
Term of Reference (c) - Whether Death arose out of Service in the RAAF.

67. The Inquiry identified three areas of possible service influence in SQNLDR Hughes’s life that may have had relevance to his decision to take his own life. Those areas are:-

a) His specialist GP training and events to which he was exposed while on overseas deployment.

b) The events of the Lawton BOI conducted in 2006-7, upon which SQNLDR Hughes served.

b) Financial pressures.

- In addition, the Inquiry considered two other influences not directly associated with his service:

d) Alcohol and prescription drug addiction.

e) SQNLDR Hughes’s family relationships and his sexual orientation.

68. A suggestion that SQNLDR Hughes had been inveigled into joining the RAAF by over-enthusiastic recruiting promises received no support of any substance, and I put it aside.

SQNLDR Hughes’s Service with the RAAF.

69. SQNLDR Hughes joined the RAAF as an undergraduate medical officer on 23 June 1997. He was posted to RAAF College where he completed his studies in medical science, medicine and surgery. He graduated from the University of
Tasmania, Bachelor of Medical Science, Bachelor of Medicine and Bachelor of Surgery, with Honours.

70. Between 2000 and 2003 Dr Hughes was posted to the RAAF College where he completed his initial Officer training, and in July 2003 he commenced his operational postings at 1 Air Transportable Health Squadron, where he undertook a series of courses, some mandatory and some at his own instigation. In November 2004 he was posted to 322 Combat Support Squadron, RAAF Tindal, a major base near Katherine in the Northern Territory of Australia. He was awarded the Conspicuous Service Cross in the Queen's Birthday Honours List of 2007 for his contributions to RAAF Base Tindal and Health Care. SQNLDR Hughes was subsequently posted to 2 ATHS, and 322 CSW HSF.

Deployments.

71. The Inquiry heard that SQNLDR Hughes was deployed on four occasions:
   - Operation Anode (Solomon Islands) between 11 November 2003 and 11 February 2004;
   - Operation Catalyst (Iraq) between 7 May 2004 and 12 September 2004;
   - Operation Spire (East Timor) between 21 December 2004 and June 2005;
   - Operation Bali Assist II on 3-4 October 2005.

Evidence of SQNLDR Hughes's Family.

Gall Hughes.

72. On 23 April 2007 SQNLDR Hughes's mother told the Vietnam Veteran's Counselling Service that she felt there were issues of blame and guilt in relation to her son in consequence of psychological issues she thought had affected him in consequence of his service in East Timor. She stated also that
whilst deployed in the Solomons, one of his best friends was.

She said that SQNLDR Hughes had not wished to go to Iraq, but was concerned that it would affect his career advancement if he did not. She dated his return from Iraq as the point at which he had become significantly different in his personality. His problems in Iraq she attributed to the danger of the conditions and her son’s perception that the commanding officer was not suited to his position. Following his return from East Timor subsequently, he had been posted to Tindal where his usual work load she said, had been augmented by problems with flooding at Katherine. She said that during his Tindal period she frequently received calls from her son, which she described as distress calls. He became argumentative, edgy and melancholy and his sensitivity evaporated, and his relationship with his sister soured. Her own relationship with him she said deteriorated. She received calls at 3am from him which were irrational, and on occasion he broke down into tears. He asserted that he had not been able to sleep since returning from the Solomons.

Peta Hughes.

73. SQNLDR Hughes’s sister, Peta Hughes is a consulting geologist who has lived in Brisbane for some years. Ms Hughes spoke of SQNLDR Hughes’s early life, in terms that reflected the laudatory comments of all other witnesses able to speak on the topic. His passions she said, were his career in medicine, and his cars. His sleeping was disordered, he was not the relaxing type and his personal affairs were chaotic, to the point that his sister had his power of attorney whilst he was serving on deployment, and used it to tidy up his affairs whilst he was away.

74. Ms Hughes had some, and in most instances a considerable knowledge of a variety of incidents in SQNLDR Hughes’s life that emerged in the course of the Inquiry.
Ms Hughes received phone and email correspondence from SQNLDR Hughes whilst he was on deployment; and though she made reference to expressions of frustration whilst he was in Iraq, she did not make reference by SQNLDR Hughes within their correspondence to anything of particular concern to her brother. Much of the email correspondence contained photographic files that were accompanied by his commentary.

Of his posting to Tindal, she said that he was not happy, regarding it as a backwater that would not promote his career, and felt some sense of grievance when the basis upon which he had been requested to go to Tindal subsequently evaporated. Ms Hughes thought that her brother's attitude to his time at Tindal was that he had done everything he could reasonably do; he felt he had been banished there in the first place, and that his career was not being advanced by the low-level medicine involved. He felt that he had relieved another member for compassionate reasons but the RAAF had allowed it to turn into a long-term commitment.

She described the difficulties of his travelling to Brisbane from Tindal on a regular basis, when after driving to Darwin; he would take a flight that reached Brisbane in the early hours of Saturday morning, flying back on the Sunday afternoon. He was unimpressed by the work ethic of some of the staff at Tindal.

Following SQNLDR Hughes receiving notice of his deployment to East Timor from Tindal, he told his sister that he felt he had to do one more thing to prove himself in order to avoid being "stuck in Tindal forever". The night he was to leave, she said: "he had a breakdown when about to leave, "collapsed on the floor and just curled into a ball and started crying and saying 'I can't do it, I can't do it, I can't do it; I can't do it again'". A fellow medico determined to telephone his CO to recommend that he not be permitted to
deploy, but was dissuaded from doing so following SQNLDR Hughes's statement that she had to be stopped, otherwise his career was finished.

SQNLDR Hughes caught the relevant flight. During the Timor posting Ms Hughes said she didn't really have much contact with him. She heard of matters that had impacted upon him following his return, including matters relevant to injured children, with whom he had particular empathy. She said that SQNLDR Hughes saw deployment experience as being valuable, though he thought his service was not recognised by the RAAF.

Mark Hughes.

79. SQNLDR Hughes's father Mark Hughes gave evidence to the Inquiry in Launceston, Tasmania. He stated that he had parted from Mrs Hughes when SQNLDR Hughes was about 10, leaving him with his mother. He had contact with his son from time to time thereafter, and he had attended his son's graduation from RAAF Officer Training course at Point Cook. When SQNLDR Hughes was in Tasmania, he would stay with Vivian and Gwendolyn Adams at their

80. Mark Hughes said that SQNLDR Hughes was glad to go to East Timor when that posting occurred because it got him out of Tindal and furthered his career as a medical practitioner. Mr Hughes saw his son on several occasions for family gatherings during the time that he was East Timor, and detected no change in him.

81. Mark Hughes said that he and his present wife Karen had reasonable contact with SQNLDR Hughes by email and telephone during his deployment to the Solomons. His impression was that SQNLDR Hughes enjoyed the experience, and he did not speak to him of anything that worried him during his time there.
82. Of the Iraq deployment Mark Hughes said that his son appeared anxious about it but keen to go. He said that he had frequent email contact with his son during that time, and some phone calls. SQNLDR Hughes made no negative comments to him on his time in Iraq but did recount one experience where a car had been hit with a rocket 15 minutes after he had left it. His impression was that his son was glad to get out but had liked the experience it had given him.

83. Mark Hughes was aware that whilst in Iraq SQNLDR Hughes had been posted to Tindal, to which he was not keen to go. He was annoyed that another fellow had on dubious compassionate grounds gained the Brisbane position that he was expecting. At Tindal he found the work unchallenging medically and he had considerable administration to undertake. He worked at Katherine Hospital in his own time, for which he was paid, and where he felt his assistance was appreciated. He drove to Darwin from time to time, as Mr Hughes understood it.

84. On his return to Tindal he had less contact with his son, and on those occasions that he did speak to him, SQNLDR Hughes sounded as though he was drugged or drinking, a proposition he denied, asserting that it was simply because he was overworked.

85. SQNLDR Hughes when on deployment maintained contact with Mark Hughes's present wife Karen by email and photographs, which he saw. His son said nothing negative of his experience in Iraq. He was aware that his son was annoyed at the circumstances in which he came to be posted in Tindal, and did not think there was much of a medical challenge there. He was aware of the car accident, but believed that his son had not been hurt beyond a bit of bruising. He did not think his son planned to stay in the RAAF long term. He noticed no change in SQNLDR Hughes's mood or behaviour on those
occasions when he saw him,' though on occasion he sounded as though he was under the influence of drugs when speaking on the telephone from Tindal, and there was a period when he was unable to contact him by phone.

Karen Hughes.

86. Karen Hughes had married Mark Hughes, after his divorce from SQNLDR Hughes's mother Gail Hughes and had known Adam Hughes since he was 10 years old. She said that her relationship with him was very good, that she saw him regularly and spoke by phone with him often. She spoke of conversations she had had with SQNLDR Hughes over the period he had served in the RAAF. She recorded his mention of significant overwork, as did other witnesses at the Inquiry.

87. Mrs Hughes confirmed the uncontroversial detail of his pre RAAF days as outlined by other witnesses. She confirmed his regular contact with her whilst on deployment, by telephone and email. She detected nothing unusual about him, neither consequent upon their contact following deployments nor from the communications during deployment. She was aware of the distaste her step-son had for Tindal but stated that he accepted the decision and he did what he had to do. When contact there with him dropped off, as it had with others, they decided she should check which she did by phone, talking to him in what she described as "a really good chat"! She attributed his deficiencies in communication to overwork and tiredness. His mode of speech was she thought of the most concern.

88. He made no complaint of his arrangements for GP training. He was said planning to work in private practice, and work one day a week for the RAAF. She confirmed the break in contact following the late 2006 disclosure of his sexuality. Again she initiated contact with him and was rewarded with a
substantial email in return. She offered detail of the financial disagreement he had had with his sister. His response to her email had included reference to his anger at the manner in which the BOI had developed. She offered him advice as to how he might handle relations with his mother and sister. An email to him on his birthday in August 2007 went unanswered, and contact dried up until January.

Kristian Hughes.

89. Kristian Hughes is the 34 year old cousin of SQNLDR Hughes, the son of Hughes. Kristian Hughes was asked about SQNLDR Hughes's work strains over recent years. He said that he was aware that Adam Hughes did not like being based in Katherine (sic), because he did not like being away from his mother and sister in Brisbane. He appeared unfamiliar with the name “Tindal”. He said that SQNLDR Hughes had said nothing of his time in the Solomons; of his time in Baghdad, he had observed that it was an interesting, hard place, but made no specific complaint. He was unaware that Adam Hughes had spent time in East Timor, and he had not spoken of his duties with the RAAF interfering with his medical progress.

Vivian Trevor Adams.

90. Mr Adams. Mark Hughes is his first cousin, and he had known Adam throughout his life. Mr Adams spoke of the regular visits to his farm by SQNLDR Hughes as a boy, which visits increased after his parents had separated. He stayed with the family as a teenager and during his internship at Launceston Hospital, going to see his father occasionally. After SQNLDR Hughes joined the RAAF, Mr Adams saw him on occasion. When on leave SQNLDR Hughes would move into his old room.
at the Adams home. Contact with SQNLDR Hughes was regular, by phone calls, emails and photographs.

91. He said that SQNLDR Hughes was nervous when first flying into Iraq, but the Iraq deployment had not worried him at all, and he said nothing to suggest that he was either shocked or worried by any aspect of his experience there.

92.

93. Of Tindal he recorded that Adam grew to hate the posting, which he said involved long hours and a barren social life. Mr Adams was aware in general terms of the appointment to the Lawton Board of Inquiry, but SQNLDR Hughes had not conveyed any dissatisfaction in respect of the matter to him. He added that he had not made contact in 2007, though he had seen SQNLDR Hughes in July when he visited Tasmania, at which time there was no hint of any major problems.

Gwendolyn Adams.

94. Mrs Adams said that she and her husband had treated SQNLDR Hughes like a son and that they had a very close relationship. During his time in the RAAF she had received constant telephone calls from him and she had phoned him herself. She recounted an incident when she had been obliged to go to a funeral, leaving her husband behind at a time when he had a significant back
problem. Adam she said had insisted on flying to Tasmania to care for her husband while she was away.

95. Mrs Adams said that she was aware that SQNLDR Hughes worked long hours—she described him as a workaholic who loved the RAAF. He had she recounted spoken to her brother-in-law before joining up—he was a Commodore. She said SQNLDR Hughes believed that he was valued in the service; on one occasion he had consulted her about the purchase of a gift for a senior officer whom he knew to have gone out of his way to give him assistance. He knew, she said that he had been helped by senior officers in his career.

96.

97. In Iraq she said she had received from him a lot of email traffic. SQNLDR Hughes had spoken of the level of security but had spoken of the deployment as "pretty ordinary". He had enjoyed barbecues on the tower and she added, "I think he enjoyed it (Iraq)".

98. Of his return to Tindal she said "I think that's why he decided to get out"; the place was "not for singles". She said she never received anything worrying in his emails and added that she would often ring him. She knew of his service on the Lawton Board of Inquiry.
Other Witnesses.

SQNLDR David Timothy Taplin.

99. SQNLDR Taplin's evidence was primarily that contained in his statement. SQNLDR Taplin had served with SQNLDR Hughes in Baghdad and had shared accommodation with him. He regarded SQNLDR Hughes as a friend and had maintained contact with him after their service together. SQNLDR Taplin had heard no complaint of substance from SQNLDR Hughes at any time.

100. Mark Lees, Systems Manager at the Maritime College in Launceston was one of a group of friends surrounding SQNLDR Hughes during his school and university days, and had shared an apartment with him in Hobart whilst they were studying. They remained in regular contact.

101. He said he knew nothing of any incentive offered to SQNLDR Hughes to join the RAAF, and knew of no issue arising out of his deployment to the Solomons.

102. Of Tindal he said that they would be in contact on an irregular basis, perhaps each three months, maintaining contact by phone and emails. Of that period he gained the impression that SQNLDR Hughes was busy, and that the base was located away from everyone else.

103. SQNLDR Hughes was deployed to Iraq for Operation Catalyst in mid 2004, where he served for approximately six months. He had been with SQNLDR Hughes before he departed to his deployment to Iraq, and recalled nothing of
significance in relation to that deployment. He maintained casual contact with him during that period by email and photographs, and described him as "not down" at that time. He maintained similar contact whilst SQNLDR Hughes was in East Timor, and reported no matter apparently troubling him at that time.

Robert William Morgan.

104. A long-time friend, Mr Morgan had communicated with SQNLDR Hughes by email during the time that SQNLDR Hughes was deployed in Iraq. He believed that SQNLDR Hughes had enjoyed his time in Iraq; he spoke of becoming a barber as well as the doctor. He was aware of SQNLDR Hughes’s service on the Board of Inquiry, which he had described as good for his career. He knew also of SQNLDR Hughes’s time in Tindal; he had mentioned that he ran the bar and had been promoted to Senior Medical Officer. He knew of the car accident.

LAC Martin Helax Kruesmann.

105. LAC Kruesmann is currently posted to 6 Squadron Equipment Section at RAAF base Amberley. He had attended secondary schooling with SQNLDR Hughes, and they were close friends at that time, and had later attended the University of Tasmania together. LAC Kruesmann described their undergraduate years together, and spoke of times when each had been assailed by depression at university. The terms in which he did so did not suggest anything beyond angst of the kind experienced by many students of that age during late evening discussion on university premises. LAC Kruesmann said that it certainly hadn’t alarmed him at the time and their thoughts related to matters that had occurred in the past.
106. The two men had remained in occasional contact after university, when SQNLDR Hughes had moved to Queensland. They communicated whilst SQLNDR Hughes was at Tindal. Whilst he speculated on SQNLDR Hughes's motivations, he did not report anything significant concerning Tindal in their correspondence. He described a perceived change in SQNLDR Hughes following his return from Iraq, though in unspecific terms:

107. He was in civilian employment in Darwin when SQNLDR Hughes was passing through there on a regular basis, and saw him on occasions in that city. He was at that time he said taking a lot of painkillers and on one occasion asked for Panadeine Forte prescribed for LAC Kruemann's wife, taking four tablets immediately and pocketing the rest. SQLNDR Hughes he said did that on more than one occasion, and had commented that the Panadeine Forte no longer seemed to work for him. He complained only of headache. LAC Kruemann noted no particular changes in SQNLDR Hughes physical appearance but noted that he had trouble sleeping and that he was living his life at significant pace. He spoke, as most witnesses did, of SQNLDR Hughes's private nature. SQNLDR Hughes had told him that he was in a relationship with a female hairdresser in Brisbane. He had himself determined to join the RAAF in mid-year 2006, at which time SQNLDR Hughes had advised him against doing so. SQNLDR Hughes he said was himself at that time thinking of seeking discharge. His attempts to contact SQNLDR Hughes in the period after that time were unsuccessful, and he had no further contact.

Father Barker.

108. Father Barker is a Catholic priest, and the parish priest of Central Tasmania. He is a Division 2 Chaplain who had been in regular contact with SQNLDR Hughes during much of his time in the RAAF. Fr. Barker spoke of the period when both had been in Baghdad, and described the conditions which had been
there encountered. It is unnecessary to record those observations; Fr. Barker
did not suggest that SQNLDR Hughes had attached any importance to any of
them, and had made no comment or complaint to him, despite using Fr. Barker
to unburden himself.

109. SQNLDR Hughes had however said been concerned by what Father Barker
described as bullying by the CO of the Detachment, and had been distressed by
the illness of another CO who though suffering from cancer, had stayed on in
service. SQNLDR Hughes felt guilt that he had not sent the CO home, though
what she did was in accord with her own wishes.

110. He recorded that SQNLDR Hughes served an extra month beyond the five
associated with the detachment, which involved in him adjusting to the new
influx of service personnel.

111. Fr. Barker described an incident in which a US soldier hitching a ride on an
Australian C-130 was struck by a random shot as the aircraft was taking off,
resulting in his death. The plane returned to Baghdad airport, where personnel
including SQNLDR Hughes were engaged in the removal of the American’s
body and a rudimentary cleaning up of the aircraft. Fr. Barker did not suggest
that this incident engendered any particular complaint by SQNLDR Hughes.
Other evidence did not place SQNLDR Hughes amongst those required to
clean the aircraft, and I think it unlikely that he was.

112. Of SQNLDR Hughes’s posting back to Tindal, he observed that that occurred
after he had left Baghdad. He was however, familiar with Tindal, describing it
as an unpopular posting and one where professional development is difficult.
He said that personality, seniority and competency issues arose at Tindal, with
junior medicos often obtaining more GP training than those senior to them. He was not aware of any particular complaint by SQNLDR Hughes in this regard.

113. Dr. Robin O'Toole discussed SQNLDR Hughes's deployments overseas from time to time; SQNLDR Hughes he said did not ever complain about it, through he suspected that his requests to deploy to Timor were made with a view to getting away from Tindal.

WOFF Steven Mathew Holland.

114. Warrant Officer Holland met SQNLDR Hughes when each was deployed to the Baghdad international airport in 2004. WOFF Holland identified some issues that had arisen on the deployment, instancing an issue with management difficulties of the commanding officer, the death of a US national, the capture of a few key figures, the illness and subsequent death of and the need for a time for those who ate their evening meals at Camp Southern Victory to travel there in full body armour. He did not relate any of these incidents other than the illness of directly to SQNLDR Hughes. The Inquiry had heard more detailed evidence in relation to the commanding officer, the death of the US national and the dining facility, which evidence appeared unchallenged. No documentary evidence of the day suggested any greater involvement by SQNLDR Hughes, nor that he was affected in any way by the deployment.

Legal Action.

115. Brian Charles Smith is a solicitor with Bennett and Philp, Lawyers of Brisbane. When a partner with another firm Templeton Smith, he was consulted by Mrs Gail Hughes and SQNLDR Hughes on 17 April 2007, shortly after SQNLDR Hughes had been discharged from the New Farm Clinic.
116. Mr Smith produced notes of that which he had been told by SQNLDR Hughes and Mrs Hughes in April 2007. On the basis that those notes provided an insight into matters of concern to SQNLDR Hughes at that time, they were admitted into evidence as Exhibit 52.

117. The instructions given to Mr Smith by Mrs Hughes and SQNLDR Hughes were in contemplation of an action against the Commonwealth on behalf of SQNLDR Hughes directed to seeking compensation for damage inflicted upon him by his RAAF service. As such, Mr Smith believed that they contained the areas of concern present to SQNLDR Hughes’s mind at that time. The statement prepared for signature by Mrs Hughes (which is unsigned) records that SQNLDR Hughes asserted that whilst in Iraq "there were rockets being embedded metres from him, car bombs going off and he had a command officer who was not suited for the position."

I find no other reference in the document that might be construed as a complaint arising out of SQNLDR Hughes’s service.

118. There is a short file note within Exhibit 52 recording an attendance on Mr Smith on 17 April 2007. The sole entry relevant to the Inquiry reads “Adam said that he did make complaints in relation to his condition. In July 2004 he was in Iraq. He has a Scottish CO – he caused gross harassment in Iraq”. Mr Smith kindly had his lengthy handwritten notes transcribed, and I have added both notes and the transcription to exhibit 52. The handwritten notes of SQNLDR Hughes’s instructions contain no reference to the

and no reference to direct involvement of SQNLDR Hughes in any traumatic incident in Iraq. Of the investigation that followed
abandonment of the BOI the document records only "the investigation caused grief".

119. By 20 July 2007 Mr Smith had written a letter confirming his instructions that the matter was not to proceed.

Permanent Impairment Claim and Medical History.

120. On 29 August 2007 SQNLDR Hughes applied for Permanent Impairment Benefits to the Military Rehabilitation and Compensation Group, Department of Veterans' Affairs. That claim was based on assertions of the existence of post traumatic stress disorder, depressive disorder, panic disorder, alcohol abuse, bilateral sensorineural hearing loss, bilateral tinnitus and lumbar disc degeneration, with facet joint osteoarthritis. The evidence considered by MRCC included reports from Dr Rodney, psychiatrist, Dr Andrew Patten, orthopaedic surgeon, and Dr Askew, ENT. The report of Dr Rodney was dated 21 January 2008, the day on which SQNLDR Hughes was found deceased; the other two reports pre-date his death. The claim was resolved after SQNLDR Hughes’s death.

121. The MRCC determined that there were thoracic lumbar spine deficits, hearing loss and tinnitus, and emotional and behavioural impairment. It attributed 53 points to that last impairment and comparatively minor impairment to the other two conditions and awarded compensation accordingly. In its combined impairment report the MRCC accepted the following disabilities:

- post traumatic stress disorder
- depressive disorder
- panic disorder
- alcohol abuse
- bilateral sensorineural hearing loss
- bilateral tinnitus

122. In assessment of emotional and behavioural impairment, the assessor recorded, "Recent panic and anxiety attacks causing inability to work, evidence of periods of extreme distress and preoccupation. Evidence on file notes physical manifestations of anxiety and confusion, tachycardia and sweating, with support required by work staff. Evidence on file shows that distraction by psychological issues led to practical difficulties, such as with driving, handling appointments and other matters. Evidence on file suggests that work hours had been modified, and sick leave (or other leave) taken. Evidence suggests that member was unsure of his ability to continue in his work. There is no information about domestic relationships."

123. The other aspects of the claim are not relevant to the inquiry.

124. The MRCC wrote to Dr Rodney on 14 January 2008. Dr Rodney reported on 21 January 2008, seemingly based on his knowledge of SQNLDR Hughes rather than on any recent examination. Dr Rodney reported that at his first assessment of SQNLDR Hughes on 5 March 2007, he had gained an impression that he had a depressive syndrome associated with his work in the Air Force, with a secondary problem of alcohol abuse. He recorded also the five month deployment in Baghdad, said to have been "extremely traumatic", and which had involved self-medication with Luvox for a number of weeks, because "he was so agitated". The Board of Inquiry experience too was said to have been stressful, and SQNLDR Hughes was complaining of agitation, teariness, sleep disturbance, poor concentration, loss of appetite and abuse of alcohol on a regular basis. He told Dr Rodney he was in a stable homosexual
relationship. Dr Rodney thought there to be features of post traumatic stress disorder and panic disorder, with intermittent mild panic attacks at that time. If Captain Hume’s dates are correct, Dr Rodney’s examination was on the same day as SQNLDR Hughes’s luncheon with Captain Hume and Mr Cullen, recorded later herein.

125. Dr Rodney saw him on two further occasions, by which time he had a marked exacerbation of his illnesses, and required admission to a private clinic in Brisbane, with gross anxieties and inability to sleep. Dr Rodney believed him to fulfil the criteria for chronic post traumatic stress disorder, major depressive disorder, alcohol abuse and panic disorder according to DSM IV criteria. He records a grand mal fit following discharge from hospital after one week. Dr Rodney reported that SQNLDR Hughes’s mental state had fluctuated since that time, slowly getting better and when last seen on 16 December 2007, he had appeared much more settled. He was by that time working full time at the Clinic and had cut down on alcohol consumption. Dr Rodney assessed his prognosis as “good”, and thought him to be in remission from the major depressive disorder.

126. Dr Rodney believed the trauma in Baghdad was a causal factor, and attributed the PTSD to experiences of that deployment. Dr Rodney had reported on SQNLDR Hughes in terms consistent with his report of 21 January 2008 by reports of 30 April 2007 and 31 July 2007 to Dr Castrisos.

127. By 6 July 2007 Dr Castrisos was foreshadowing to Dr Rodney the likelihood that he and Dr Shumack were likely to recommend that SQNLDR Hughes should be discharged from the RAAF, medically unfit for further service, a recommendation to which SQNLDR Hughes was said to be agreeable.
On 14 January 2008, Dr Rodney reported to Dr Castrics that he had reviewed SQNLDR Hughes before Christmas 2007, at which time “he was very stable and responding well to his current medication...there have been no further episodes of alcohol abuse and overall I think he is quite stable.”

Following his deployments to the Solomon Islands in 2003 and Iraq in 2004, SQNLDR Hughes was scheduled to deploy to Timor L’Este on 20 December 2004. Whilst en route friends of Flight Lieutenant Hughes (as he then was) who farewelled him in Brisbane were sufficiently concerned about his emotional state and risk of self-harm as to make a telephone call to RBMC. FLTLT Hughes was met on arrival at Darwin Airport. He was intoxicated, and was escorted off the plane to RBMC, who referred him to PSS/NT for assessment for risk of self-harm and psychological suitability for deployment. FLTLT Hughes claimed that the matter had arisen out of misunderstanding, and denied any suicidal ideation or mental health problems.

A Defence Force psychologist Captain Kaine on 20 December 2004 assessed FLTLT Hughes for risk of self-harm and psychological suitability for deployment. His report records no overt signs of psychological instability. It records FLTLT Hughes’s denial of current or past suicidal ideation, with nil mental health history. Captain Kaine recommended

1. Flight Lieutenant Hughes presents as psychologically robust and is not considered to be at risk of self-harm. 2. It is recommended that Flight Lieutenant Hughes is suitable for deployment to Timor L’Este.

On 5 February 2007 WGCDR Kelley reported that SQNLDR Hughes “has a number of issues in his life”. WGCDR Kelley assessed him to be burnt-out from long working hours and responsibilities at Tindal and on the BoI. Of the
latter he recorded that the investigations that followed the incident of
December 2006 had resulted in "political shenanigans that have added a depth
of disillusionment and immense concern. If the BOJ is disqualified, he will
unfairly lose face and self-esteem".

132. Dr Kelley recorded the breakdown of a relationship, in terms that suggest that
SQNLDR Hughes was concealing from Dr Kelley his homosexuality. SQNLDR Hughes was given sick leave by Dr Castrisos, who prescribed some
sleeping pills but no other medication.

133. A Medical Employment Classification Review record of 2007, otherwise
undated, reviews SQNLDR Hughes's medical history to a point shortly before
August 2007, concluding: "the aetiology of Dr Hughes’ depressive disorder is
considered multi-factorial and complex. Dr Rodney considers there are
features consistent with PTSD and the board would recognise that SQNLDR
Hughes’ symptoms are at least temporally related to his operational service
overseas in Baghdad and Timor and associated with military stressors. . . . The
Board considers SQNLDR Hughes is medically unfit for further services as a
RAAF medical officer.". . . On 15 October 2007 SQNLDR Hughes commenced
long service leave, due to expire on 14 January 2008.

134. A Member's Health Statement completed by SQNLDR Hughes on 31 July
2007 records his acceptance of his inability to continue in service.

135. On 29 October 2007, the MECRB determined that SQNLDR Hughes was
MEC401 medically unfit for further service. SQNLDR Hughes was at the
time of his death transitioning out of the Air Force. He had attended 1 ATHS
on Wednesday 16 January 2008 where he undertook a final medical
examination prior to his discharge. On the same day he had determined with
WGCDR Walker that his formal discharge date would be 10 March 2008,
he had removed his personal effects from 1 ATHS. On 14 January 2008
SQNLDRL Hughes accepted the Medically Unfit for Service decision by the
Medical Employment Classification Review Board, and acknowledged that his
service would end no later than 10 March 2008.

The Dr Cook Interview.

136. In a note apparently made on 8 October 2008 that does not disclose its maker,
Mrs Hughes attributed considerable weight to the appointment with Dr Cook
as a stressor on her son.

137. On 11 January 2008, SQNLDRL Hughes had attended a psychiatrist, Dr Cook,
on referral from the Department of Vетéran's Affairs. At the outset of the
consultation, Dr Cook had disclosed to SQNLDRL Hughes that his son was a
doctor and a SQNLDRL in the RAAF, which circumstance had caused
SQNLDRL Hughes to abort the interview and provoked him to send a lengthy
e-mail to WGCDR Walker at 9:52 pm that evening. The e-mail is addressed
"Dear Michelle and Ed", the latter a reference to Dr Castrisos.

138. The e-mail suggests to the lay mind, or at least to my lay mind significant
underlying disturbance in its author. SQNLDRL Hughes devotes a significant
part of his e-mail to what he described as a "deeply irritating problem", that of
the relationship of Dr Cook to a SQNLDRL doctor, his son, who SQNLDR
knew, a relationship that SQNLDRL Hughes saw as compromising the
psychiatrist's impartiality. He records an attempt to contact the director of the
MLRSA to seek an explanation "how such mistakes could be made?"
requesting that someone "senior" call him back to offer an explanation. No call
he said was received. He records also having delayed the psychiatric
appointment through apprehension, stating that he had had panic attacks in the
week before the appointment requiring him to take three days off work. He
complains of potential financial distress should he be unable to work as a GP, and refers to a car accident in which he was involved while visiting the orthopaedic surgeon. He attributes that accident to his mental state—“distracted, anxious, tachycardic and not of right mind”.

139. He observed of the email addressees “I cannot fault your care and support throughout this prolonged process. IATHS has been magnificent in its support. Unfortunately where it ends, and without the constant support of my family, I am not sure whether I would be at work or not.”

140. The email expresses a belief that an unbiased opinion is needed from a psychiatrist with no military experience or contact. I read it as a plea to the addressees to assist him to achieve that end, as SQNLDR Hughes believed that the originally nominated psychiatrist was the only one utilised by the DVA for assessments in Queensland.

141. Whilst I do not doubt that the incident subjectively caused SQNLDR Hughes considerable concern, the incident cannot in my view be regarded objectively as serious, nor was it a service failure.

**SQNLDR Hughes's Reports.**

142. The reports by SQNLDR Hughes from Iraq were produced to the Inquiry by GPCAPT Leschinskas. In accordance with their secret classification I read them in Chambers. Under appropriate security they were read by Mrs Gail Hughes, who returned them without comment. They contain no complaints by SQNLDR Hughes relevant to the Inquiry.

**Finding - Deployments.**

143. On the evidence before the Inquiry, there is no basis established before me that the service conditions experienced by SQNLDR Hughes before his death
in January 2008 had any significant influence on SQNLDR Hughes's decision to end his life.

144. Whilst the Inquiry accepts that exposure to war conditions, in Iraq in particular would inevitably have been accompanied by emotionally disturbing experiences, no evidence emerged of any incidents that affected or appeared to affect SQNLDR Hughes in a manner significant to the state of SQNLDR Hughes's mind in January 2008.

145. Any service contribution to his distressed state was on the evidence before me not great, and was general in nature only. Whilst I recognise that some support is to be found in service records for the proposition that service whilst on deployment has played a role in the psychological condition of SQNLDR Hughes, the evidence before me did not rise to a level that would justify a finding that SQNLDR Hughes's death arose out of or in the course of that service.

The Lawton Board of Inquiry.

146. On 18 September 2006 the Chief of the Defence Force appointed a Board of Inquiry to investigate the circumstances surrounding the death of Captain Paul Lawton on 31 August 2006. The Board of Inquiry consisted of the President, Mr Frank Cullen and SQNLDR Hughes. It heard evidence between 17 October 2006 and 20 December 2006 for a total of 15 days.

147. It is unnecessary to deal with any aspect of the actual sittings beyond observing that several witnesses observed that SQNLDR Hughes took his duties very seriously, and played a significant part in the complex medical issues that arose within the Inquiry.
148. The Board concluded its formal hearings on 20 December 2006 in Melbourne, and a number (but not all) of the legal personnel involved including Mr Cullen and SQNLDR Hughes found themselves together at a hotel at which a number of them had been staying. In the course of an impromptu drink together in the bar, one of the legal representatives read out a list of mock awards relating to Counsel involved and some of the witnesses, including one at least who was a person potentially at risk of an adverse finding. Several days later an email was circulated by the same representative to all who had been involved in the BOI, repeating the awards he had earlier read out and adding several additional ones, including one identifying SQNLDR Hughes. The email brought to the attention of one of the Counsel who had not been present at the hotel a mock award reflecting on his client, a person potentially adversely affected. Following discussion with his client, he sought to have the BOI reconvened to hear submissions on the incident and its implications. Mr Cullen declined that request and shortly thereafter the witness in question took action in the Federal Court of Australia directed to restraint of the delivery of any report by the BOI pending review by the Federal Court, on the grounds of apprehended bias.

149. Interested parties commenced discussion with media outlets; the matter aroused political interest and comments critical of the refusal to reconvene were made from the Federal Court bench. Whilst the matter was awaiting further hearing in the FCA, ACM Houston proposed that he dissolve the BOI and appoint a new Board. The Applicant for relief supported the proposed course and the Federal Court consented to it. Appropriate orders were made by the court, the effect of which was to bring the Federal Court proceedings to an end upon CDF making a decision to dissolve the BOI. On 13 February 2007 ACM Houston dissolved the Board of Inquiry and brought the matter back before the Federal Court to ensure that that course was not at variance with any views held by the court.
150. The sole relevance of these events to this Inquiry turns upon the effect that the events had upon SQNLDR Hughes. The Inquiry had before it files relating to the Lawton BOI produced on summons by the Inspector General, Australian Defence Force, and the Defence Support Group of the Department of Defence. The Inquiry heard evidence from Mr Cullen and the Counsel Assisting the BOI, CAPT R.W.G Hume RFD RANR.

The Lawton BOI File.

151. From the correspondence and documents of the period it is apparent that the hearings of the Lawton BOI were on occasion stressful to SQNLDR Hughes, as was the IGADF Inquiry which followed the mock awards event.

152. On 24 January 2007 IGADF directed GPCAPT Kathleen Powell and LTCOL David Tyler to enquire into the matter, to collect evidence, make findings and recommendations, and submit a written report in relation to the mock awards incident. On 25 January 2007 SQNLDR Hughes was advised of that Inquiry and that he was to be interviewed by telephone by GPCAPT Powell on Monday 29 January 2007. The Federal Court action had started on 22 January 2007 and stood adjourned to 26 February 2007. An email address error resulted in SQNLDR Hughes not receiving the Terms of Reference of the IGADF Inquiry, engendering an email from SQNLDR Hughes in which he asserts that the non-receipt of the Terms of Reference "represents a considerable burden on me, particularly given the long weekend which I shall be working over" and in which he asserted "I am now sincerely distressed that I am potentially affected..." The error was remedied soon after.
153. A further email from GPCAPT Powell to SQNLDR Hughes of 29 January 2007 advised him that GPCAPT Powell and LTCOL Tyler wished to see him at the Rendezvous Hotel, Brisbane, about 1130hrs on Monday 5 February.

154. On 30 January 2007 SQNLDR Hughes sent a lengthy email to GPCAPT Powell, copying it to WGCDR Taylor and WGCDR Walker. This email recorded what SQNLDR Hughes termed "a mysterious phone call from Mr Richard Miller", of which event he recorded "I am starting to become quite disturbed". SQNLDR Hughes asserts that Mr Miller said to him "This could have been avoided if the Board President or you had acted differently." The email closed with a request for legal Counsel to represent him "particularly given Mr Miller’s comments WRT "how this could have been avoided". A handwritten note on that email records that a GPCAPT identified by initials, probably GPCAPT Powell spoke to SQNLDR Hughes on 1 February 2007 to advise him that GPCAPT Hanna was arranging legal assistance for him. On the same day IGADF suspended the IGADF Inquiry pending resolution of the Federal Court proceedings.

155. On 30 January 2007 ACM Houston contacted the representatives of those involved in the mock awards incident, seeking their views as to whether he should dissolve the board and appoint a new board. These letters were copied to Mr Cullen and to SQNLDR Hughes. On 6 February 2007, ACM Houston advised relevant government ministers of his in-principle intention to dissolve the Lawton Board of Inquiry.

156. Following dissolution of the board ACM Houston received advice concerning the immunities to which members of the board were entitled. On 22 February 2007 IGADF recorded that only the President, SQNLDR Hughes
and CAPT Hume RFD RANR, Counsel Assisting the Lawton BOI were still to be interviewed. IGADF determined to proceed, and to seek independent legal advice were any of the witnesses remaining to be interviewed to raise objection.\textsuperscript{108} On 6 March 2007 IGADF directed GPCAPT Powell and LTCOL Tyler to re-commence the Inquiry. On the same day SQNLDR Hughes emailed GPCAPT Powell following a telephone conversation in which SQNLDR Hughes declined to provide a statement without first seeking legal advice. The email recorded "I am highly surprised that I have not received formal notification...its reappearance...extends and adds to my angst regarding the whole matter."

157. The following day GPCAPT Powell responded. Arrangements were made for SQNLDR Hughes to receive legal advice from SQNLDR Quirk. Further correspondence between SQNLDR Hughes and GPCAPT Powell followed concerning a suitable date for interview and on 15 March 2007 a voice-recorded record of interview took place between SQNLDR Hughes and GPCAPT Powell. SQNLDR Hughes spoke of exchanges between himself and Counsel for Dr Gall and of exchanges in which it had been suggested that he had prejudged Dr Gall. SQNLDR Hughes recorded also the impact of the BOI on his relationship and his disappointments at the representation arrangements in the Federal Court.

158. On 1 February 2007 WGCDR Walker asked psychiatrist WGCDR Kelley to see SQNLDR Hughes in consequence of his stress and disturbed sleep. He recorded that "some recent events associated with the BOI have caused him a great deal of stress."
159. SQNLDR Hughes was diagnosed by Dr Estensen in April 2007 with Post Traumatic Stress Disorder. In a Member’s Health Statement of 31 July 2007 SQNLDR Hughes recorded of his experience on that BOI “I was poorly informed of my position throughout and this was immensely stressful for me. At this time I became unwell...” That health statement was part of an application to the Medical Employment Classification Review Board. Its terms and those of the supporting documentation generated at the time strongly suggest that SQNLDR Hughes envisaged and probably desired an MUFS classification. On 23 July 2007 WGCBDR Walker reported that SQNLDR Hughes had been on sick leave, was classified as non-effective, and had “recently been working reduced hours twice a week at 1 ATHS as part of his rehabilitation plan”.

160. In evidence Mark Hughes said that he learned of his son’s appointment to the Board of Inquiry in 2006, and at one time it was contemplated that he and his wife would spend the weekend in Melbourne with SQNLDR Hughes though that had not happened.

161. Mark Hughes was unaware that the Lawton Commission had been abandoned.

162. Mrs Karen Hughes said that SQNLDR Hughes had spoken to her about his role on the Lawton Board of Inquiry and had emailed her after the Inquiry had become derailed – she recalled that it was a very angry email. She spoke of her discussions with him on the BOI, but recalled no matter of significant complaint.
163. Of the Board of Inquiry incident, Ms Peta Hughes said that her brother felt a bit betrayed, having put a lot of pride and effort and time into the Inquiry. He really didn’t understand what was going on she said.

Captain Robert W G Hume RFD RANR.

164. Captain Humé was Counsel Assisting the Board of Inquiry into the death of Captain Paul Lawton, conducted in the later months of 2006, but disbanded by order of CDF on 13 February 2007. Captain Hume confirmed the factual background to the BOI that was apparent to the Inquiry from its initial enquiries. Mr Cullen and SQNLDR Hughes had in a social setting following the conclusion of the hearings been exposed to an incident that it was claimed would raise in the mind of reasonable onlooker a reasonable apprehension of future bias on their part. Mr Cullen did not agree, and had declined a request to reconvene the hearing for the purpose of hearing submissions on the incident. That decision was the subject of critical comment by a Federal Court judge, Gray J., when the matter came before him. Both Mr Cullen and SQNLDR Hughes believed that the allegation lacked any serious foundation; both were extremely disappointed that they were unable to conclude the task with which they had been charged. In SQNLDR Hughes’s case he thought his career prospects may have been affected. Both he and Mr Cullen took umbrage at the remarks made in the Federal Court by the presiding judge, and were dissatisfied that their position in relation to the matter had not been defended by those appearing for the Commonwealth of Australia. In accordance with custom they had filed only a submitting appearance in the court, and had put on no evidence.

165. As the Inquiry’s interest in the Lawton BOI was limited to the effect if any that participation in that inquiry had had upon the health of SQNLDR Hughes, Counsel Assisting at my direction removed from witness statements provided
to the Inquiry any material that went beyond that boundary before the statements were tendered in evidence.

166. Captain Hume's statement makes plain that he had developed a close friendship with SQNLDR Hughes and Mr Cullen, and that they spent some time together, including after the conclusion of the Lawton Inquiry. He refers to matters covered in detail by other witnesses, such as SQNLDR Hughes's application, his intelligence, and his occasional lapses with alcohol. He confirmed also the reaction of SQNLDR Hughes to the events following the conclusion of the taking of evidence in the Lawton Inquiry. He recorded his post-BOI meetings with SQNLDR Hughes and Mr Cullen when they had met for lunch on three occasions in 2007, 30 March, 5 June and 12 December.

167. At the first of those, that of 30 March, Capt Hume noted no change in SQNLDR Hughes, mentally or physically. SQNLDR Hughes spoke of normal matters, and had recently purchased a new car of which he was very proud.

168. At the luncheon of 5 June 2007 he learned that SQNLDR Hughes had been in the New Farm Clinic for four weeks earlier that year with a psychiatric disorder arising out of PTSD. SQNLDR Hughes told Captain Hume that his time in New Farm Clinic followed his request to a colleague "to administer the Indicia tests for PTSD", and was attributable to that condition. He recorded his impression that SQNLDR Hughes was looking and acting as if he was very well, as SQNLDR Hughes claimed to be.

169. On 12 December 2007 when the three men lunched again, SQNLDR Hughes again appeared to him to be very well, offering no hint of disturbance at that time.
170. In his oral evidence, Captain Hume elaborated on the matters contained in his statement. He said that SQNLDR Hughes had not made any mention of financial concerns after he had sorted out his position with his bank in early 2007. He was, said Captain Hume engaged in wealth accumulation. He was under the impression that SQNLDR Hughes had diagnosed his own PTSD prior to his admission to the New Farm Clinic, and confirmed that he had seen no apparent change in him at the luncheon of 5 June 2007. Of the luncheon on 12 December 2007 he repeated that SQNLDR Hughes looked well and added that the principal subject of inquiries as to health that day was himself. SQNLDR Hughes had not mentioned that he was in the process of separating from the RAAF, though Captain Hume had understood that there was a good chance. He stated that his impression was that SQNLDR Hughes had enjoyed being at Tindal, finding the Katherine hospital a challenge, although by reason of the isolation, his posting there was impacting on managing his property portfolio. He had not received any complaint of other matters from SQNLDR Hughes, who said he was happily settled at Amberley.

Mr. Frank Cullen.

171. Mr Cullen is a retired Western Australian Magistrate.

172. Mr Cullen’s statement was redacted from a larger statement, a matter on which he commented at the outset of his evidence, prompting me to record that I had directed Counsel Assisting to excise from any statement tendered to the Inquiry any material critical of any person in respect of the conduct of the Lawton Inquiry. Mr Cullen accepted my right to do that, though indicating that he did not agree with my ruling.
Mr Cullen’s statement recorded the factual matters concerning the general conduct of the Lawton Inquiry as recorded above, confirming the benefit he had obtained from SQNLDR Hughes’s medical expertise. He recorded also SQNLDR Hughes’s reference to financial pressures in 2006, and his occasional resort to alcohol. SQNLDR Hughes said had no difficulty with the workload imposed by the BOI. He confirmed SQNLDR Hughes’s adverse reaction to the institution of the FCA proceedings, the manner in which they were conducted, the decision of CDF to dissolve the Lawton Inquiry, the investigation undertaken by IGADF and its resumption after the conclusion of the FCA proceedings.

At the first post-BOI luncheon to which Captain Hume had referred, that of 30 March 2007, he offered a view at variance with that of Captain Hume. SQNLDR Hughes Mr Cullen said was totally different, had gained weight, and to him was obviously on high levels of medication. SQNLDR Hughes had not complained to him of any matter arising out of his deployments, of which deployments Mr Cullen was aware. Asked about any detailed discussions arising out of SQNLDR Hughes deployment Mr Cullen recalled nothing of significance.

In oral evidence Mr Cullen said the financial pressures of which SQNLDR Hughes had spoken were related to the long delays in receipt of his expenses. In expansion of SQNLDR Hughes’s reaction to the BOI events, he said that when he saw him at the time of the Federal Court proceedings, SQNLDR Hughes was less outgoing and withdrawn. He elaborated on SQNLDR Hughes’s drinking, and referred to an email during 2007 in which SQNLDR Hughes had stated that he was self-medicating and drinking excessively. Of the luncheon in June, he said that SQNLDR Hughes had put on weight and was “well-medicated”, his demeanour was slow and he observed that his pupils were dilated. He confirmed that SQNLDR Hughes told them that he had
recently been in the New Farm Clinic. Mr Cullen remained with SQNLDR Hughes after Captain Hume departed – SQNLDR Hughes did and said nothing of concern to him. SQNLDR Hughes he said did say at some stage that the PTSD may have been triggered by the events of the BOI and the IAGDF investigation. He had spoken of compensation and the possibility that the events in Melbourne had "pushed him over the edge". He was at that time in the hands of a solicitor, and was making a claim for compensation.

176. Mr Cullen said that SQNLDR Hughes stopped responding to his emails and telephone calls about April 2007. At some time after the June lunch with Captain Hume, Mr Cullen recalled receiving an email in which SQNLDR Hughes stated he was very much enjoying working at the Clinic, a proposition repeated when he met SQNLDR Hughes subsequently, probably at the December 2007 lunch with Captain Hume. Mr Cullen said that in contrast to his appearance in June, SQNLDR Hughes was totally different; his confidence had returned, he was bright and he looked physically better.

Finding – BOI.

177. I accept that SQNLDR Hughes was distressed, angry and bemused by the legal steps that negated his considerable work on the BOI, I observe that those to whom he made later complaint were directly or indirectly relevant to the compensation claim he was investigating in 2007, and he made little complaint in respect of the BOI to close friends with whom he shared confidences of his service experience. Nor does the incident feature largely in the medical histories taken after the event. He was accused of no malpractice or failure by any person; his sole involvement was as the second member of a board, the legal member of which had declined a request to reconvene. His own lack of culpability in the outcome had been affirmed by Mr Cullen and Captain Hume,
and he had received a letter of appreciation from ACM Houston, which letter WGCNR Walker said had cheered him considerably.

178. Whilst the contribution of the events surrounding the BOI to SQNLDR Hughes's state of mind in mid-January 2008 if any, must surely be a matter beyond reliable determinability, I do not find it to have contributed to SQNLDR Hughes's death. The criticism of the Judge before whom the stay application came was mild, limited to querying why the BOI had not reconvened. This was a matter on which SQNLDR Hughes would be expected to have deferred to his judicially experienced senior, the President. No doubt, SQNLDR Hughes was told this, and it was in any event obvious to any intelligent person. Any lingering angst based on concern at the perception of criticism should have been resolved by the receipt of and the contents of the letter from ACM Houston, as the evidence suggests it was.

Financial Pressures.

179. On 20 July 2007 a firm of Brisbane solicitors wrote to SQNLDR Hughes noting that he did not intend to proceed with a claim for damages for post traumatic stress. By statutory declaration after SQNLDR Hughes's death, Gail Hughes asserted that she had been financial dependent on her son, that he had with his sister financed the home in which she lived, and that they had purchased a unit for her future accommodation at another location. Both properties carried mortgages. Her son she said paid for numerous other services on her behalf.

180. In around September 2006 Ms Peta Hughes and her brother had had a falling out, the basis of which she said she did not understand. Other evidence identified the basis as a belief by SQNLDR Hughes that his sister was
benefiting from their joint ownership of properties in Brisbane significantly more than he, and a dissatisfaction that his sister was permitting a man to stay there. She accepted that her brother thought that she "was ripping him off" in respect of the two properties they had bought together. Cordial relations were not resumed until he was in the New Farm Clinic in March the following year.

181. Of his financial affairs, Ms Peta Hughes said that he was constantly spending, not managing his money, was meeting the totality of the rent after his partner left and had been paying most of the bills prior to that time in any event. She and her mother had discovered that he was shopping online and generally buying goods that he did not need and sometimes did not even unpack. His purchases were far from inexpensive, and he maintained over ten credit cards, all highly active, and that cumulatively reflected a debt over $50,000. Ms Hughes was not aware that his income from the RAAF ceased in January, 2008, when he went onto leave without pay. He had his income from the Clinic.

182. By undated submission on behalf of SQNLDR Hughes LEUT Clutterbuck points out that "SQNLDR Hughes had to utilise his long service leave and leave without pay to facilitate his completion of his undergraduate specialist training program." SQNLDR Hughes was employed during this period by Clinic.

183. A number of witnesses spoke of SQNLDR Hughes’s fondness for expensive cars and stereo equipment. There are several conversations attributed to SQNLDR Hughes in which he mentioned two large mortgages. He was the owner or part owner with his sister of two properties in Brisbane and the owner of a new S-series BMW motor vehicle acquired in 2006. His complaints of payment during the Lawton BOI were related to slow payment. He had
declined the opportunity of posting and probable promotion to Canberra as Director of Military Medicine, of which GPCAPT Leschiwakas gave evidence. A friend, Robert Morgan was aware of an offer to SQNLDR Hughes to work at Mt Isa as a G.P at a salary of $400,000 pa.

Finding,

184. There is no direct evidence of any financial pressure and no evidence of any circumstances likely to entail major outgo of any kind. Certainly any stress generated by cash shortage had no real connection with SQNLDR Hughes's service. As the matter is peripheral to the Inquiry and was not the subject of detailed investigation, I content myself with stating that no financial stresses were established by the evidence before me.

Other Influences.

185. No other service-related complaints were suggested to the Inquiry and none came to its notice. Whilst there was evidence of irritation and concern on the part of SQNLDR Hughes related to his service, and while his mental state must have intensified his distress, it should be kept in mind that at the time of his death he was all but discharged from the RAAF and had a civilian career before him. None of the events of which there was evidence before the Inquiry was objectively of a nature such as to generate suicidal intentions. I accept that it is likely that some general disappointment at the manner in which his career in the RAAF concluded could well have contributed to SQNLDR Hughes's depression, and I have no doubt that few suicides are entirely rational. But I am unable to conclude that the evidence adduced before the Inquiry would justify any finding that SQNLDR Hughes's service experiences viewed objectively contributed in any meaningful way to his decision to end his life.
186. I turn to consideration of the further factors that came to the Inquiry's attention.

**Drug Dependency.**

187. I have recorded the evidence of SQNLDR Hughes's friends and family bearing on his use of drugs and alcohol in 2007. Evidence supporting this abuse by SQNLDR Hughes was obtained by interpretation of Service and Commonwealth records.

**Dr. Robin O'Toole.**

188. Dr Robin O'Toole was between 1998 and 2008 a member of the RAAF... Dr O'Toole met SQNLDR Hughes in late 2004, when both were posted to RAAF Tindal, and they became close friends as well as medical colleagues. They were together at Tindal from late August 2004 until March 2006 when Dr O'Toole deployed overseas to MEAO. Dr O'Toole saw SQNLDR Hughes briefly in late September 2006 on return from deployment for the purposes of handover to him, at which time he was shocked by the deterioration he observed in SQNLDR Hughes's appearance. SQNLDR Hughes at that time was leaving Tindal en route to RAAF Amberley.

189. Following SQNLDR Hughes's departure from Tindal, Dr O'Toole found that there were many tasks associated with the base that were only partially completed, a situation much at variance with his knowledge of SQNLDR Hughes's character. Dr O'Toole saw SQNLDR Hughes at Amberley on 14 January 2008 when SQNLDR Hughes called into Dr O'Toole's office to congratulate him on promotion to SQNLDR and appointment as SMO. SQNLDR Hughes was attending his discharge medical appointment with Dr. Castrisos. His appearance Dr O'Toole said was dishevelled and unkempt, his demeanour was flat, and his voice was slurred. In the light of his present
knowledge, he attributes that situation to the medications SQNLDR Hughes was taking. SQNLDR Hughes discussed his discharge with Dr O'Toole and they parted with plans to make further contact.

190. Dr O'Toole stated that he became aware at some stage that SQNLDR Hughes was writing repeat prescriptions for himself for an anti-reflux medication, and that he was taking a dosage greatly exceeding the usual. He suspected SQNLDR Hughes was obtaining scripts from multiple doctors. Whilst SQNLDR Hughes was in Melbourne in the course of the Lawton BOI, Dr O'Toole knew that SQNLDR Hughes had continued some work-related activities at Tindal whilst undertaking the BOI in Melbourne.

191. Dr O'Toole was asked to look at a copy of Exhibit 30, being a LAHPS patient history and a products dispensed activity statement, both relating to SQNLDR Hughes. The first he said recorded all prescriptions dispensed to SQNLDR Hughes from the Amberley pharmacy; the second is a similar document recording prescriptions to SQNLDR Hughes as recorded on the Defence-wide central prescription database. A further document described as a FRED Patient History was obtained which document recorded some or all of the medications dispensed to SQNLDR Hughes during his RAAF career. Dr O'Toole had obtained two further documents at the request of the Inquiry,
being copies of patient history reports relating to pharmacy items dispensed to SQRNLDR Hughes specifically at HSFTDL which do not appear on the pharmacy record from FRED. A further report listing items dispensed for the purpose of maintaining a Thomas Pack was shown to him.

192. Of the Thomas Pack record Dr O'Toole observed that a number of the drugs on that list were not usual items for use in a Thomas Pack and were probably personal prescriptions for SQRNLDR Hughes. The extraneous items included codeine phosphate a schedule 8 drug, dispensed to SQRNLDR Hughes by the civilian pharmacist at Tindal and prescribed by another doctor. The date of filling the prescription 12 February 2007 identifies a date by which SQRNLDR Hughes had been posted to RAAF Amberley.

193. Dr O'Toole was concerned at the extent of the analgesics dispensed to SQRNLDR Hughes, particularly those listed in Schedule 8.

194. With a copy of Exhibit 30 before him Dr O'Toole stated that a number of entries generated concern. He identified prescriptions apparently for several opiate based medications, stating that he did not recall ever to have had a medical condition that would require the levels of medication prescribed, both as to the character of the drugs and the quantities. He added that the circumstance that the pharmacist had signed for the medications was itself concerning.

195. Dr O'Toole observed of four prescriptions in June 2006 attributed to a pharmacy a week apart did not seem to fit medical history. Dr
O'Toole identified the second script as the type likely to be given on discharge from hospital, and could not see why having received a substantial dose of Pethidine, an opioid analgesic, he would four days later require Pethidine, Panadeine and Prodene in doses that seemed to be far in excess of opioid analgesic that would normally be prescribed.

196. The next entry of concern was a script for two codeine phosphate tablets, a drug utilised on other occasions by SQNLDR Hughes. The particular script was written in its entirety in an unknown hand, save perhaps for SQNLDR Hughes's signature. Because the drug is a schedule 8 medication, it is required to be in the prescribing doctor's hand. That script was dated 2 October 2007, a date after SQNLDR Hughes had left Tindal, and was for a man described by Dr. O'Toole as "a rather healthy individual".

197. Dr O'Toole described the system, and observed that written scripts are required to be retained. He said "there is a lack of scripts written out to Dr Hughes that match up either to the patient report on the computer or again, to the central repository, so there are multiple gaps in that process." Due to an imperfect understanding of requirements for reconciliation of drugs prescribed, he said resupply of drugs at Tindal was effected merely by provision of a list to the supplier, which list may or may not correlate with the drugs actually prescribed. Dr O'Toole made the point that a degree of flexibility in the system was important for reasons that he outlined.

198. Dr O'Toole drew attention to the circumstance that prescriptions irrelevant to the Thomas Pack such as hair-loss medication were recorded in the wrong computer record. The record for SQNLDR Hughes he said has a large number and frequency of prescription medications of opiate based or higher level pain relief medications, in addition to sleep and weight-loss medications that
themselves raised issues. Checking would be difficult in the absence of many
of the original scripts. In a discussion about checks and balances, Dr O'Toole
observed that problems are occasioned by the use in the services of different
health management systems that are not compatible. This contrasted with "any
off the shelf electronic health record system that is used in general practices
throughout Australia can do that. In that they can keep a record of what you
have prescribed. They don't necessarily keep a record of what you've
dispensed...but the pharmacies do keep a record of what you've dispensed and
I believe that there is a nation-wide record, particularly for medication that
are drugs of addiction that allow for there to be a cross-checking to try and
overcome a lot of the doctor-shopping that happens in the outside world."

199. The problems at Tindal he said are present though to a lesser extent in other
bases, where there is a minimum of two pharmacists working. Dr O'Toole said
that the problem of computers not talking to each other related to the absence
of installation of appropriate software to permit dispensing software and health
records software to communicate, a problem present in the larger bases as well
as Tindal.

FLTLT Sarah Clark.

200. FLTLT Sarah Elizabeth Clark is a Nursing Officer who served with
SQNLDR Hughes at RAAF Tindal between January 2006 and the end of 2006,
when he transferred to RAAF Amberley. During that period SQNLDR Hughes
was the SMO, and for most of the time was the OIC of the HLF.

201. SQNLDR Hughes she said would leave Tindal every weekend he was able to,
spending time in both Darwin and Brisbane. When returning from Brisbane he
would fly back into Darwin, probably about midnight on Sunday night, driving
from Darwin back to Tindal to resume work on Monday morning. She
described in detail the unusual hours worked by SQNLDR Hughes, and his
method of avoiding directions not to work so late. 'She had she said a role at base commander meetings attended by SQNLDR Hughes, which role involved her keeping him awake and noting matters that he may have missed. She reported that she had been told by one of SQNLDR Hughes's office assistants that she and her co-worker would frequently clear empty alcohol bottles from his office bins in the mornings before he arrived at work. She was directly aware she said that SQNLDR Hughes was prescribing drugs for himself, both to keep himself awake and to assist him to sleep. The drug Duromine she said was one such drug which though a weight loss drug SQNLDR Hughes stated kept him awake, with weight loss "a nice side effect".

202. Of the records contained in exhibits 30 and 35, FLTLT Clark observed that the quantities of Panadeine Forte, if truly required, would necessitate entries on his medical documents indicating an injury. The volume of Diazepam and Temazepam demonstrated excessive intake, outside that which would normally be prescribed. Standard procedure she said required the entry into medical documents of any prescriptions. She suspected SQNLDR Hughes was not completing PM105’s, which enter into the medical history (UMR) the medication prescribed.

203. The civilian pharmacist she said was present from 0730 to 1630 each day. The medical officers had access directly to the pharmacy outside those hours, during the pharmacist's lunch break and whenever she was not there. The relationship of the pharmacist with the doctors she said was poor, and there was no pharmacist for some months prior to a replacement's arrival about March 2007. It was very difficult for her she said, seeing what was going on and being unable to do anything about it. The option of falling back on civilian staff was not available should SQNLDR Hughes not be there. Requests for back-up staff she said were not successful. A nursing officer is presently in charge and there is no OICSMO. SQNLDR Hughes she said was not able to
slow down and self-medicated in order to manage. She had at one point spoken to the Padre urging him to say something as she could not. SQNLDR Hughes said continued to rely on Tindal after his posting to Amberley, she thought because he could not or would not allow others to take over obligations he had had.

204. In further evidence, attention was drawn to entries on the 8 and 9 February 2006, each being a prescription for Endone and Tramal, the Endone tablets totalling in quantity 70. Endone is an oral morphine tablet; a potent pain relief drug classified as a section 8 drug of addiction. Endone in a civilian setting cannot be accessed without supervision, and requires an audit sign-off at the end of each shift. Tramal is also a strong pain relief medication that can be a drug of addiction, as can Panadeine Forte, which contains codeine. Both prescriptions were written by a Dr The circumstances suggested to FLTLT Clark that the essentially identical prescriptions signal that SQNLDR Hughes has prevailed on to re-write the prescription, perhaps by asserting loss of the first, before filling both.

205. Referred to the Tindal records, FLTLT Clark's attention was drawn to entries for SQNLDR Hughes for Panadeine Forte in May and June 2005. The quantities represented in her view a large quantity to go through in that period of time for a person who had no physical injury. FLTLT Clark accepted that SQNLDR Hughes may have used the drug for the relief of back pain. An entry on 30 June 2005 relating to the prescription of Codapane, an over-the-counter medication may have been susceptible of the same explanation. On 8 July 2005 a prescription had been filled for 20 Temazepam tablets, normally prescribed only three tablets at a time. 3 August 2005 saw Prodeine a straight codeine drug dispensed. It is a drug falling in strength between Panadeine and Panadeine Forte. That entry was amongst entries over three months demonstrating prescription quantities of codeine. The regularity of vitamin prescriptions she said supported her view that SQNLDR Hughes was not
eating sufficiently to nourish himself, and exceeded that which he would be allowed to prescribe for a patient unless they had a documented vitamin deficiency. On 29 August 2005 a further prescription for 20 Panadeine Forte tablets was filled. FLTLT Clark said that it was not an appropriate treatment for chronic back pain to simply keep taking drugs of this kind. She drew attention to significant quantities of a drug called Nexium a prescription drug used in the treatment of gastroesophageal reflux, sometimes two months' worth in one day and at a later time, four packets dispensed on one day. She drew attention to prescriptions for Valpam, the same family as Temazepam, a benzodiazepine drug. Between 3 April 2006 and 9 April 2006 Valpam, Nurofen Plus, Duromine and Valpam were dispensed. Valpam is valium - 100 tablets were dispensed to SQNLDR Hughes on 19 April 2006. Nurofen Plus contains codeine but not paracetamol, which latter drug can be taken only up to 4 grams per day before risking liver damage.

206. FLTLT Clark drew attention to a range of prescription drugs containing codeine, some being schedule 8 drugs. An entry for Codeine phosphate a drug of addiction filled in February 2007 was she pointed out after he had left Tindal. An entry for Nexium of November 2006 she believed was dispensed at a time when SQNLDR Hughes was in Melbourne on the Lawton BOL. Five prescriptions for Nexium are seen between 3 October 2005 and 28 November 2005, four of them on the same day. Quantities of Nexium of that order FLTLT Clark said evidence a lot of pain from reflux, a consequence of stress and failing to eat.

207. FLTLT Clark stated that after graduation from officer training in June 05 she was posted to Tindal for two months, where she found there were no nursing officers, and she had only the assistance of a reservist who worked two days a week. She observed that there were no civilian nursing staff, no civilian medical doctors and she was the sole registered nurse. When she returned to Tindal in January 2006 she was one of two nursing officers, a third position was unfilled. A civilian nurse was procured on a two-day a week basis in mid-
2006, which enabled the medical staff to cover night flying. Applications for civilian staff she said were refused, leaving three nursing officers, three medical officers and medical assistants to cover day and night flying and a dependency that varied between 700 and 2000 personnel. The SMO appointed after SQNLDR Hughes was posted to Amberley she said declined to see patients as he was fully engaged in administration. He did not work the hours that SQNLDR Hughes was accustomed to work. FLTLT Clark elaborated on the problems at considerable length, and she regarded the situation that had existed at Tindal as unsatisfactory, remaining so to the present day.

208. FLTLT Clarke described SQNLDR Hughes as dedicated and over-worked. Her description and that of others properly characterises SQNLDR Hughes as a workaholic. FLTLT Clarke spoke emotionally of the difficulties confronting the medical staff in Tindal, the inability to attract civilian or other medical staff, the strains imposed on medical service personnel obliged to be on call at Tindal during lengthy periods of night flying exercises, poor relationship with the part-time civilian pharmacist and the complete absence of back-up for doctors who were on leave for relatively short periods of time. The picture she painted was more graphic but consistent with the conditions described by others. The shortcomings described were significant and could undoubtedly bear heavily on morale. FLTLT Clarke became emotional when discussing the shortcomings at Tindal, and her evidence was interrupted to allow her time to recover herself.

209. Asked to suggest any areas to which attention might be directed, FLTLT Clark nominated restrictions on access to the pharmacy, how access might be given to the pharmacy by medicos in remote places and the need for an imprest cupboard for certain prescription drugs, as she said is standard practice in other RAAF facilities. The doctors she said were acting as pharmacists in effect, with a series of knock-on problems relating to resupply of drugs. In short, she thought the arrangements relating to the pharmacy and the absence of civilian
staffing at Tindal were the two big issues. These situations she compared unfavourably with other RAAF facilities.

**Group Captain Karen Leschinskäs.**

210. GPCAPT Leschinskäs is a medical officer, currently the officer commanding HSW. Conscious that FLT LT Clarke’s experience at Tindal ended in January 2009, I raised the issues of which she had spoken with GPCAPT Leschinskäs, who was interposed during FLT LT Clarke’s evidence. GPCAPT Leschinskäs acknowledged many if not all of the shortcomings described and informed the Inquiry of some steps taken in recent times.

**Dr John Carter.**

211. Dr John Carter is an experienced general practitioner and a member of the Clinic which employed SQNLDR Hughes whilst he was training for his GP fellowship. Dr Carter was also involved with SQNLDR Hughes’s health care from January 2007.

212. Dr Carter was asked by the Inquiry to peruse the records in exhibit 40 relating to the dispensing of drugs to SQNLDR Hughes by RAAF. From his own records and the records to which he was given access, he noted that he had initially seen SQNLDR Hughes for health purposes on 22 January with complaints of severe diarrhoea and abdominal cramping with associated fever. He had at that time prescribed a Schedule 8 drug, codeine, a drug he did not normally prescribe for diarrhoea. It was prescribed he said because SQNLDR Hughes asserted that he found only codeine to be of benefit for his gastro problems and had approached him to obtain a script for that drug. Dr
Carter agreed that whether that incident suggested drug dependency at that time was equivocal.

213. Dr Carter reported that at Clinic on 26 February 2007 SQNLDR Hughes was confused and disorientated, and he had sent him off for CT scans and blood tests that day. Dr Carter recalled a second episode similar to that of 26 February 2007, when on 10 September 2007 two patients had expressed concern about SQNLDR Hughes's speech, he had been sent home by Dr Carter and had taken a week off. By this time SQNLDR Hughes was under the care of Dr Rodney, a specialist psychiatrist. SQNLDR Hughes was not fit for duty during that week and was thought by his employers to be disabled by post-traumatic depression and possibly alcohol. Dr Carter had not at that time contemplated the possibility of drug abuse.

214. Perusal of the Clinic records suggests the possibility of manipulation and that SQNLDR Hughes's own input into medication may have resulted in some drugs being prescribed that were not the most appropriate to his stated condition. On 5 January 2008 SQNLDR Hughes had obtained Panadeine Forte and Temazepam through one of Dr Carter's partners. The system as it existed meant that the Clinic treatment was not known to those treating him within the RAAF, and vice versa.

215. Exhibit 41 records prescriptions for medications prescribed for SQNLDR Hughes whilst a patient at the Banyo Clinic. The pharmaceutical dispensing records from RAAF Tindal and RAAF Amberley exhibits 30 and 31 were shown to Dr Carter. Perusal of those records together led Dr Carter to conclude "there does appear to be some excessive use of drugs".
216. SQNLDR Hughes complained to Dr Carter of chronic back pain, which he attributed to his service and for which he asserted that he was unable to take simple analgesia such as paracetamol, the drug Dr Carter described as the first line treatment of choice for chronic back pain. Dr Carter had not treated SQNLDR Hughes for back pain, but observed that the records showed that numerous paracetamol products had been prescribed to SQNLDR Hughes, as had codeine-based medications, regarded as the next level up. Endone is a Schedule 8 drug with much more addictive potential, and is more powerful than codeine. It should be used Dr Carter said only for short term use in relief of acute pain.

217. Had Dr Carter known of the drugs obtained through Tindal by SQNLDR Hughes, he would have considered drug dependency, and would have been much more cautious in trying to pin him down in terms of his medications. That SQNLDR Hughes was taking medications additional to those prescribed by his treating doctors was in his opinion a deleterious factor in his psychiatric condition.

Dr Edwin Castrisos.

218. Dr Castrisos is a specialist general practitioner who provided medical services to SQNLDR Hughes from time to time from 5 February 2007. His initial contact was at the instigation of SQNLDR Hughes's CO, WGCDR Walker, who was concerned at SQNLDR Hughes's reaction to the unfolding events of the challenge to the Lawton BOI, and the resumption of the IGADF's Inquiry into it. On that date Dr Castrisos diagnosed SQNLDR Hughes as suffering from acute anxiety, stress and sleep disturbance for which he prescribed him sleeping medication. Dr Castrisos recommended sick leave for five days, and had arranged to follow up.
219. Before that occurred, Dr Carter referred SQNLDR Hughes to Dr Rodney. Dr Castrisos became aware that SQNLDR Hughes had been admitted to the New Farm Clinic by Dr Rodney, and requested a medical report from him. That report is dated 30 April 2007.1 Dr Rodney provided a further letter to Dr Castrisos on 31 July 2007. Dr Castrisos’s role was limited to reviewing SQNLDR Hughes’s medical management, which was primarily in the hands of the doctors at Clinic. Dr Castrisos said that his records showed that on the first occasion he saw SQNLDR Hughes, he reported only difficulty sleeping and feeling stressed, referring to the Board of Inquiry, his posting, his GP training and his unsettled domestic situation since he had left Tindal. Dr Castrisos had no record of any medication that SQNLDR Hughes may have then been on, and SQNLDR Hughes’s assertion that his stress and anxiety were of recent onset suggested no need to go into his past medication history. The extensive records containing pharmaceutical prescriptions provided to Dr Castrisos by the Inquiry had not been sighted by him.

220. His consultation was directed to a relatively commonplace situation, and called for no more than short term management, and as such would not normally have suggested any requirement to go into a patient’s history of prescriptions. Dr Castrisos agreed that the pharmaceutical history should have been available on the medical file. They were in this case not there! ‘Had they been, Dr Castrisos said he would have been alerted to a deeper issue, one that should have been apparent to the doctors at Tindal in 2006, if indeed they were prescribing those medications. Dr Castrisos observed that when SQNLDR Hughes arrived at Amberley, his medical standard was MEC 1, and there was no indication that he had been under medical care in Tindal through 2005 and 2006. Had the record been available to Dr Castrisos, it would have raised his suspicion as to the existence of an addiction and other psychiatric issues. Management would certainly been different, and he may well have
sought immediate specialist assessment by a psychiatrist. Dr Castrisos observed that it is a well recognised syndrome that many air crew consult privately outside the Air Force system to avoid the creation of a record in their Air Force records.

221. Dr Castrisos observed that another source of information not generally available or placed on the medical file is a patient's psychology record. This may be an important omission, particularly where a more thorough assessment is undertaken to formulate a diagnosis. Dr Castrisos was aware that SQNLDR Hughes had seen WGC DR Kelley, the base psychologist, but he did not have access to any report of the outcome.

222. Dr Castrisos believes that the medical record and the pharmaceutical record of a service member are available so far as consultations and prescriptions within the RAAF medical service are concerned. Prescriptions obtained outside the Defence health system, so far as their cost is met by the Medicare system are recorded by the Commonwealth. In general private practice, a patient's complete medical and pharmaceutical record can be retrieved instantly from the pharmaceutical records. The system called HealthKEYS he said does not perform its intended purposes of providing a full computer record of a serviceman's notes and pharmaceutical records. Thus, the pharmacy records at Amberley do not interact with those at Tindal or any other base. The information he said is part of the medical record; it's just retained in the computer of a different pharmacy. In the present case the information on his aggregated pharmacy records contains gaps in the history available to other doctors on previous occasions. The pharmacy records suggest that on numerous occasions the obtaining of a script has not resulted in the making of a record on SQNLDR Hughes's medical file.
Dr James Rodney.

223. Dr Rodney is a consultant psychiatrist with over 30 years experience in that speciality. Dr Rodney saw neither SQNLDR Hughes's ADF psychological or medical file prior to the Inquiry.

224. Dr Rodney had seen SQNLDR Hughes on referral of Dr Carter in February 2007. He diagnosed a major depression and dysthymia upon which was superimposed anxiety, panic disorder and PTSD symptoms, and alcohol abuse. Whilst he was later persuaded that SQNLDR Hughes probably did have PTSD, Dr Rodney remained sceptical of that diagnosis, stating that SQNLDR Hughes gave no account of any life threatening incident, and while he made reference to a constant threat of bombardment in Iraq, he did not identify anything that might constitute repeated trauma or any extraordinary single traumatic event. Dr Rodney observed that there was much information that SQNLDR Hughes would not share with him, adding that "I never felt that we really engaged and worked well together".

225. Dr Rodney saw SQNLDR Hughes on ten occasions and during the time that he was in the New Farm Clinic. SQNLDR Hughes made no complaint of chronic pain to Dr Rodney, though he had told him of an accident that had caused him lower back pain. Dr Rodney's notes contain no other reference to back pain. SQNLDR Hughes neither mentioned it again nor asked for a script in respect of it, which surprised Dr Rodney as he conducts a pain clinic as one of his sub-specialities. His reaction to the list of medications recorded in exhibits 30, 31 and 42 was one of shock, and he thought it indicative of the refusal of SQNLDR Hughes to disclose important information to him. Whilst Dr Rodney had enquired of SQNLDR Hughes’s current medication he had no
knowledge of the medications to which SQNLDR Hughes had had access. Dr Rodney now believes that that omission was deliberate.

226. Dr Rodney believed that the information contained in records of drugs prescribed was an exceptionally important feature in the present case, and would have placed him "on a different level immediately. You'd be on a different standing of management straight from the word 'go'...". "Taken to the ADF psychological file, Dr Rodney stated that it would have been useful to have had the information it contains, describing the information as invaluable.

227. The psychology information of February 2007 included reference to SQNLDR Hughes's contemplating whether to seek discharge from the RAAF. SQNLDR Hughes had made no mention of problems with his GP training as a stressor, and SQNLDR Hughes appeared to be proceeding satisfactorily on that path. He had mentioned his involvement in the BOI only in passing. Of SQNLDR Hughes's sexuality Dr Rodney said that it was three or four sessions before he confirmed SQNLDR Hughes's homosexuality. The relationship in which SQNLDR Hughes then was Dr Rodney described as very stressful and it was a subject that they did explore. Dr Rodney's opinion was that the major stressor in his life was his intimate relationships, with all sorts of issues with his family remaining unresolved as well.

228. Dr Rodney speculated that following his break-up "there may have been some further contact with his partner", a proposition that was proven correct by Mr Wright's evidence confirming contact in the days prior to SQNLDR Hughes's death. Dr Rodney said "when the depression deepened and when he would
come back to see me was usually around the time that there were further partnership difficulties’.

229. Had the available pharmaceutical records come to his attention they would have made an enormous difference, changing his focus to the problems of addiction to a narcotic, refocusing the therapy completely. Incidents when SQNLDR Hughes appeared to have been disorientated from drugs and alcohol were not disclosed to him by SQNLDR Hughes. The fact that SQNLDR Hughes telephoned a number of old friends immediately prior to his death suggests that the death was planned and premeditated. That circumstance he thought was a very serious sign of severe suicidal intent!

230. The Inquiry observed that a number of the medications recorded in SQNLDR Hughes’s records were prescribed by SQNLDR Brent Barker who is currently undertaking a specialty course in the United Kingdom. SQNLDR Barker has both medical and pharmaceutical qualifications and has examined the records contained in exhibit 30.

231. SQNLDR Barker has provided a statement dated 9 June 2009, which statement arrived after evidence concluded. As it has not been the subject of cross-examination I have not taken it into account directly. I have however recognised that the matters raised by SQNLDR Barker therein are certainly worthy of investigation should my recommendation relating to the pharmacy at Tindal be accepted. I have accordingly admitted the document into evidence as exhibit 59.
Finding-Drug Dependency.

232. There is no doubt that at least for the last 12 months of his life and probably since 2005 SQNLDR Hughes had a significant drug dependency, and abused alcohol from time to time. The medical evidence of Dr Ong suggests that SQNLDR Hughes had been drinking before commencing to take the drugs that proved fatal, but it is clear from the round of goodbyes undertaken by SQNLDR Hughes that his decision had been made over the days prior to his death. The extent to which SQNLDR Hughes’s abuse of drugs and alcohol contributed to his overall depression can only be a matter of opinion. I judge its contribution to have been substantial.

Family Relationships and Sexual Orientation.

Gail Hughes.

233. Mrs Gail Hughes described erratic behaviour on the part of her son in 2007 leading to his admission to the New Farm Psychiatric Clinic, and further erratic behaviour subsequently, necessitating his partner to call paramedics to attend. She described an incident where she observed her son apparently talking on a mobile phone when in fact he had no phone in his hand and appeared merely to be talking into his hand. Shortly before making the statement to the Vietnam Veterans’ Counselling Service, SQNLDR Hughes’s partner called her as he thought SQNLDR Hughes was having a seizure. She attended but he refused to go to hospital – paramedics were called and he agreed to go back to see Dr Rodney, which he apparently did.

Mark Hughes.

234. Mark Francis Hughes gave evidence in Launceston, Tasmania. He said that his son was an ambitious high achiever at school and university. His motive in joining the RAAF he said was mainly to obtain the funding for his university
and he did not think that he was proposing to make a career of it, regarding it as a means of advancing his medical career.

235. Mr Hughes had parted from his first wife when SQNLDR Hughes was about 10 years old. He has not had contact with his former wife for many years, and his daughter Peta has not spoken to him for a long time.

236. Mr Hughes's sister Heather Hagan told him of SQNLDR Hughes's homosexuality, which Mr Hughes said he had suspected for several years. He said that would not have been a problem with him, adding that his former wife would have told their son that it would be. He was aware of the dispute between his son and his sister in Brisbane which he understood followed Peta permitting a boy to move in with her to their shared unit.

Karen Hughes.

237. Mrs Karen Hughes the step-mother of SQNLDR Hughes stated that the regular flow of communication with SQNLDR Hughes had ceased in October 2006, but that she was aware that he was having issues with his mother and sister over jointly owned property. She had communicated with him on that matter and had emailed him for his birthday in August 2007, after which she had had no contact until January 2008 when she received two early morning phone calls.

238. Mrs Hughes spoke of the anger and distress of SQNLDR Hughes through 2007 following his father's sister disclosing his homosexuality to his father. He had said he had been waiting for an opportunity to speak to his father and Vivian Adams and was resentful that his aunt had in fact spoken to his father on the subject before that opportunity arose. This matter was a recurring theme throughout the evidence of the Tasmania-based witnesses and the actions of SQNLDR Hughes directed towards his aunt thereafter establish that the event generated significant disturbance in SQNLDR Hughes's mind.
Ms Peta Hughes described the early stages of her life and that of her brother

Of his sexuality, Ms Peta Hughes said that she had been aware of it since 2002. To SQNLDR Hughes it was "a little bit in conflict with his career within the RAAF, so he very much felt it was important that he keep those two lives separate, which meant that he was largely living two lives." It became she said a very big issue for him at Tindal. In contrast to the position in a city. The restrictive atmosphere of Tindal she said led to his travelling to Brisbane and making himself progressively more and more tired. She said that he had undertaken considerable research to determine whether he could change his sexuality; he had concluded that there was a genetic component and had he lived, would have investigated that a lot further. He did not she said come to terms with it and knew that it was not an accepted thing in the Defence forces. His friends fell into different groups, non-work friends, work friends, and "a very narrow group of friends whom he trusted with everything".

Ms Hughes described her brother as both physically deteriorated and psychologically affected in the period after he was hospitalised in the New Farm Clinic. He was she said lacking in self confidence, largely disoriented, and on occasions slurring his speech and failing to finish conversations. She and her mother had on one occasion videoed him in that state, causing him to burst into tears when it was shown to him later. His knowledge of his shortcomings led him to question his ability to operate as a medical professional.
242. Of his duties at the Clinic she said he appeared to be functional for a certain number of hours a day "and then after that medication wore off or he may just walk out of the site where he could let some of that stress go, he just fell off the perch." At home she described him as sitting comatose in the chair, slurring his words and unable to finish a conversation. She and her mother often drove him home to ensure his safe arrival though he lived just three blocks away.

243. Ms Hughes described a particular episode in late August of early September 2007 when she was wakened in the early hours of the morning by her front door being slammed, and found her brother crying on the floor, saying that he wanted to kill himself. SQNLDR Hughes stayed in this state for some time, continuing to express suicidal thoughts. He said that he was scared of what he had become, and was in conflict over living a number of lives. He had largely ceased contact with his friends who were endeavouring to reach him from time to time. He was failing to turn up to family appointments. It was she said shortly after that time that his partner Justin Wright moved out of their apartment. His friends she said were endeavouring to contact him through her.

244. SQNLDR Hughes had a relationship with Justin Steven Wright from about mid 2005 that whilst it suffered serious deterioration in the latter months of 2007, endured until SQNLDR Hughes's death. Ms Hughes described that relationship in 2007 as disturbed and very volatile, with interdependency between the two men. She described her brother as having major mood swings during 2007 that Justin had to deal with on a daily basis. She considered them to be on an intellectually different level, with different careers, a significant age gap and basically not compatible. The parting she
thought came about finally because SQNLDR Hughes believed that Justin had formed another relationship

Justin Steven Wright.

245. Justin Wright formed a relationship with SQNLDR Hughes in mid 2005, at which time SQNLDR Hughes was based at Tindal. SQNLDR Hughes travelled to Brisbane from Tindal either each weekend or each second weekend, and on occasion Mr Wright travelled to Darwin to join SQNLDR Hughes. This routine permitted them to spend Saturday evening and Sunday together. Mr Wright working during the day on Saturday. Mr Wright described SQNLDR Hughes as a borderline alcoholic. He described SQNLDR Hughes’s antipathy to Tindal in terms that included the air travel necessary for them to be together.

246. Of the Board of Inquiry period he said SQNLDR Hughes offered no complaint, nor did he complain of arrangements relating to his GP training. Following the BOI he said SQNLDR Hughes’s drinking became more relevant to their relationship and he discussed leaving the RAAF. These discussions he said involved SQNLDR Hughes feigning illness, with responses that Mr Wright was to make if asked. The plan he said involved SQNLDR Hughes giving him books he was to read in order to obtain appropriate information to respond to questioning. The illness to be feigned he said was PTSD. He had not seen any implementation of the plan before the motor accident, but thereafter he “sort of started going a bit funny in the head”, though that lasted for only a few days.

247. The behaviour that led to him moving out he said had commenced before SQNLDR Hughes was hospitalised in the New Farm Clinic in 2007 and
extended for some months after that. The particular incident that led to him leaving: ‘was SQNLDR Hughes’s obtaining medication on Mr Wright’s Medicare card, a practice that had existed from the start of their relationship, his constant drunkenness, disturbances disrupting his sleep and the necessity to be concerned not to upset SQNLDR Hughes with some inconsequential action. Their relationship he said had changed to one where he was simply babysitting SQNLDR Hughes. Mr Wright said that the relationship had been fine when SQNLDR Hughes initially returned to Brisbane from Tindal "and then obviously when he started taking prescription drugs or whatever, that’s when it started going downhill." In elaboration Mr Wright said that the behaviour occasioning the rift involved him finding on return to their apartment a representative of the body corporate “because she found him running around the apartment complex virtually in his underwear.” SQNLDR Hughes was he said prescribing medications for himself and was very moody. Minor incidents he said were accorded inappropriate significance until a stage was reached when he, Mr Wright, left the apartment they shared in

248. He made the decision to leave on an occasion when they were to go grocery shopping. SQNLDR Hughes was drunk and got into Mr Wright’s car, at which Mr Wright told him to get out and left, not returning save to collect his belongings. He had he said been invited to join SQNLDR Hughes, his mother and his sister in Christmas 2007, but had declined. Several boxes of his belongings are still in Mrs Hughes’s possession.

249. The relationship had continued to some extent after he had left the apartment and he had seen SQNLDR Hughes in January 2008.

250. The Inquiry saw evidence that Dr Hughes had obtained prescription drugs by writing prescriptions for himself. Though Kristian Hughes claimed that the two empty Panadeine Forte pills packets and the Serapax tablets in SQNLDR
Hughes's apartment were his, left behind accidentally on Saturday 19 January, he had taken none himself. Empty containers of a number of other prescription drugs were present in Dr Hughes's apartment, labelled in his own name. It is inescapable that Dr Hughes had developed dependency upon prescription drugs and obtained access to those drugs by writing prescriptions for himself, prevailing on other medicos to write prescriptions, and probably, availing himself of prescriptions written for others. He had unsupervised access to the pharmacy at Tindal and appears to have taken drugs without creating any record.

Kristian Hughes.

251. Kristian Hughes knew Adam Hughes throughout his life, having spent the first 13 years of his own life in Tasmania. He remained in regular contact with SQNLDR Hughes in the years after he moved to Queensland and they saw each other on an occasional but regular basis after Adam Hughes joined the RAAF. They shared a mutual enthusiasm for motor vehicles and spoke to each other of their respective problems.

252. Of SQNLDR Hughes Kristian Hughes said that he was aware that Adam was homosexual and that he had problems with his father, from whom he was seeking acceptance of his sexuality which he asserted he did not receive. He said that SQNLDR Hughes was not proud of his sexuality as evidenced by his failure to declare it. He said "he never really came out" He said that Adam Hughes's father knew of his homosexuality and it strained the relationship between himself and his son.

253. Kristian Hughes was aware also of the animosity that Adam Hughes had against his aunt Heather Hagan, whom he blamed for raising his homosexuality with his father, a matter that he regarded as his to resolve. He was aware that Adam Hughes had been hounding his aunt over the matter. He
agreed that Adam Hughes rang him when he was depressed on occasion, which depression he said had extended over the previous six months. His evidence of his contact with SQNLDR Hughes on the Saturday prior to his death has already been recorded.

Finding - Family Relationships and Sexual Orientation.

254. The impact of SQNLDR Hughes's homosexuality on his life was a recurring theme throughout the Inquiry. The break-up of his relationship with the younger Justin Wright was plainly a major factor in SQNLDR Hughes's depression through the last months of 2007, as witnessed by his references to the subject during the last conversations with his Tasmanian relatives and his irrational harassment of Mrs Hagan. A copy of a letter to Mr Wright found amongst his papers confirms the impact upon him of the termination of the relationship.

255. I find that the major factors in the state of mind that brought about the suicide of SQNLDR Hughes were engendered by the problems that he perceived to flow from his sexuality, and from the drug dependency that may well itself have been a cause and effect of his unhappiness.
PART B.

The events following SGNLDR Hughes's death.

256. Mark Hughes stated that he had learned that his son was dead on Tuesday 22 January 2008, the information having come through Mrs Adams from Mrs Gail Hughes, who reported that their son had overdosed. Mr Hughes thereafter embarked upon a series of fruitless phone calls in an endeavour to determine the details surrounding his son's funeral. He telephoned a number that he understood to be a 24-hour ADF response number dealing with such enquiries, but found it to be an automated service of some kind.

257. Mark Hughes was disturbed that nobody including the Defence Force had told him before Tuesday of his son's death. He surmised that his brother Peter in Brisbane would have prevailed upon Gail Hughes to make him aware of his son's death, in consequence of which Gail Hughes rang Vivian Adams, to tell him to break the news but to ensure that he was not in a position to "see me up there". It is not clear whether Mr Hughes had reasoned to this scenario or whether he had been told, but in either event it seems an entirely probable account of what actually occurred. He understood that Gail Hughes had advised Mr Adams that his son had overdosed and had stated that she had been on suicide watch.

258. Mr Hughes telephoned a local funeral director to try to ascertain how to find out where the funeral service would be, and subsequently telephoned a number of funeral homes in Brisbane, including the firm handling the funeral, but did not learn anything. He subsequently rang his sister who lives in to enlist her assistance. That too was unproductive. Telephone calls to the Defence Call Centre elicited no information, so he determined to travel on Thursday afternoon to Brisbane via .to meet up with his
sister. Whilst waiting in Melbourne he saw a friend of Mrs Gail Hughes. He guessed that she would contact her half sister Hughes in Queensland to alert them that he was on his way. In the event his brother and his wife were at airport to meet as was to meet him. He did not speak to his brother and party.

259. On Thursday evening 24 January he rang Hughes to see if she would give him any information; she confirmed that they were going to the funeral, stating that they were to be picked up and did not know anything beyond that. Thinking that the funeral might take place in a chapel on RAAF base Amberley, he drove to Brisbane from the following morning, after checking fruitlessly with the Coroner’s Office to seek information. They parked outside Amberley and made a number of telephone calls to various RAAF and Defence numbers, receiving no information from any. When he stated his business to security at the gates of Amberley, they were taken by security police into a room, where they were joined by Padre Paget and WOFF Holland, who were “nice about it all but they just would not tell me anything”. The padre he said stated that he was acting in accordance with the wishes of the member that he be told nothing. They were escorted off base, and took up a position down the road a little away from the base in the hope of seeing a hearse heading into the base. Further phone calls were made to Defence. It was whilst they were in that location that they received a telephone call from WGCDR Walker, who invited them to return to the gate. Other evidence establishes that that phone call was in fact made by Mrs Black, and that WGCDR Walker’s involvement with this aspect of the matter did not commence until Mrs Black encountered resistance to Mr Hughes coming on base after he and his sister returned to the security area. Nothing turns on this slip of recollection.
260. This Mr Hughes said marked a complete change in the manner in which he was being treated. The matters until that time denied to him, seeing his son’s body and attending the funeral were thereafter arranged. Appropriate transport for Mr Hughes and his sister was organised, and they were driven to and from Albany Creek where the funeral was to be held.

261. WGCDDR Walker subsequently contacted Mr Hughes to hand over to him photographs and medals (or duplicates) that had belonged to SQNLDR Hughes.

262. Mr Hughes reported “From then on they were very helpful. They did all they could for us. They got us all the information we wanted – Janelle Black was going to take us to Brisbane to the funeral. There was a lot of phone calls... to fix things up, sort things out.” Mr Hughes’s account from that point accords with that of Mrs Black, and in respect of subsequent assistance, that of WGCDDR Walker and WOFF Holland.

263. Invited to identify areas of dissatisfaction, Mr Hughes said that he should have been informed about his son’s death, he was unhappy that the padre was prepared to tell him nothing, that his ex-wife appeared to have control over everything, and that he had not been informed of his son’s psychiatric problems during his life-time. He had no complaints at all of Defence actions from the time that Mrs Black made contact to recall him to the base gates.

The Notification Process.

264. The body of SQNLDR Hughes had been discovered by his mother in his apartment at about 1030 on 21 January 2008. At about 1700 that day Dr Castrisos received a telephone call from Dr Carter of the Clinic, who advised him of Dr Hughes’s death. Dr Carter had learnt of the death from Mrs Hughes by telephone. Dr Castrisos telephoned WGCDDR Walker, CO of
1ATHS Squadron at 1710 that evening to inform her of SQNLDR Hughes’s death. At 1730 WGCDR Walker received a telephone call from Mrs Hughes.

265. During the course of her conversation with Mrs Hughes WGCDR Walker made enquiries relating to Mrs Hughes’s wellbeing and that of her daughter Peta. Mrs Hughes did not want to see anybody that evening, but agreed to WGCDR Walker telephoning the following day. During this conversation WGCDR Walker enquired and was advised that “the family” were all aware of SQNLDR Hughes’s death, and was told that no notification was necessary.

266. In the course of preparing a Hot Issues brief that evening, WGCDR Walker accessed the PMKeyS, noting that it recorded SQNLDR Hughes’s PEC as Vivian Adams at a Tasmanian address. Mr Adams was not noted in PMKeyS as SQLDR Hughes’s NOK. WGCDR Walker thought that entry to be of some antiquity. She initiated a FATALCAS... and spoke to Padre Knight, agreeing with him that Padre Paget would join a BST to be formed.

267. On Tuesday 22 January WGCDR Walker telephoned Mrs Hughes, who agreed to meet her and Padre Paget at 1400 that day. WGCDR Walker spoke to Frances Croft and MAJ Bancroft of DCO. Mrs Croft thought it too confronting for more than two people to visit initially and WGCDR Walker undertook to brief them further following the 1400 meeting. WGCDR Walker also advised Mrs Croft that she had decided not to speak to Mr Adams herself in deference to Mrs Hughes’s wishes. This is confirmed by the DCO FATALCAS SITREP of 22 January.

268. WGCDR Walker did not see the situation as one in which notification was any longer relevant: she saw her role as one of assisting in the provision of support. WGCDR Walker and Chaplain Paget saw Mrs Hughes as arranged.
After initial antipathy to the concept of a funeral in which Defence played any part, Mrs Hughes indicated that she would think about the situation further. General support for her was discussed. Mrs Hughes was asked directly for a contact for Mr Mark Hughes, there being no reference to him contained in the PMKeYS. Mrs Hughes made plain her view that Mark Hughes should have no part to play in any funeral arrangements and declined to provide a contact.

SQNLDR Robert Paget.

269. SQNLDR Paget is a Chaplain Division II with rank equivalent of SQNLDR. Chaplain Paget was identified by the inquiry as a person at risk of adverse comment, and was represented by Major Douglas Campbell SC. The matters of concern to the Inquiry related to Chaplain Paget’s role in preventing Mark Hughes from obtaining information concerning his son’s funeral.

270. Chaplain Paget served at RAAF Tindal in 2004 and 2005, a posting that coincided in part with that of SQNLDR Hughes. He had no further contact with SQNLDR Hughes but was asked to provide pastoral care to Mrs Hughes following SQNLDR Hughes’s death.

271. Chaplain Paget visited Mrs Hughes on Tuesday 22 January 2008 with WGCGR Walker, at which time Mrs Hughes did not intend to have a funeral by reason of her interpretation of a conversation she had had with her son at the funeral of a relative. Chaplain Paget persuaded Mrs Hughes to consider the matter from a different viewpoint, and Mrs Hughes agreed to do so. Chaplain Paget learned that Mrs Hughes was totally opposed to her former husband having involvement with any aspect of the situation. From general conversation with Mrs Hughes directed to identification of those who needed to be told Chaplain Paget drew an understanding that Mark Hughes had learned of the death of his son, and that SQNLDR Hughes was estranged from his father.
272. Chaplain Paget said he had contacted Father Barker in consequence of his own concern at the precise state of Mark Hughes’s knowledge. He had he said asked Fr. Barker to be on stand-by in case a notification was required.

273. WGCDDR Walker stated that she believed Chaplain Paget had undertaken to have his colleague initiate enquiries to locate Mark Hughes. Father Barker had earlier given evidence to the Inquiry in Tasmania but any issue relating to this aspect had not arisen and Fr. Barker was not asked about it.

274. It is entirely possible that Mrs Hughes having stated that Mark Hughes was aware of the death at the meeting with WGCDDR Walker and himself, Chaplain Paget interpreted the position as one where he needed only to ascertain Father Barker’s availability should a decision be made that more formal notification was necessary.

275. After SQNLDR Hughes’s death, WOFF Holland had met WGCDDR Walker, DCO representative Frances Croft and Padre Robert Paget on 22 January, it being his duty to attend to ceremonial aspects of the funeral of service members. WOFF Holland confirmed the decision that should Mark Hughes turn up, he was not to be told what the arrangements were regarding the funeral, which arrangement he sourced to his meetings with the DCO team. It was his understanding that Mark Hughes was listed neither as an emergency contact, nor as next of kin in SQNLDR Hughes’s PMKeyS record, and that the funeral was to be a private funeral arranged by Mrs Hughes through DCO.
WGCDR Michelle Catherine Walker.

276. WGCDR Walker is the commanding officer of I ATHS, RAAF base Amberley, and was so in 2007 and 2008. As such WGCDR Walker had overall charge of the notification process to be followed following the death of SQNLDR Hughes on 21 January 2008.

277. WGCDR Walker learned of the death on Monday evening 21 January 2008, at about 1710, when so informed by Dr Castrisos in her office. Shortly afterwards, WGCDR Walker received a telephone call from Mrs Hughes, who confirmed the death. WGCDR Walker offered to visit Mrs Hughes that evening with the Padre, which offer was declined. An arrangement that she and the Padre would visit her the next day was made. WGCDR Walker raised the question of family awareness and notification; Mrs Hughes responded that the family were aware of the death. With the information at her disposal at that time WGCDR Walker dictated a Hot Issues Brief and accessed the PMKeyS to obtain details of emergency contacts for notification purposes and the preparation of a FATALCAS signal. To gain access to the PMKeyS WGCDR Walker recalled her ADMINO who returned to the base some time after Mrs Hughes’s telephone call.

278. On Tuesday 22 January 2008 WGCDR Walker addressed her staff, and invited them to seek support. WGCDR Walker spoke to Mrs Croft of DCO, indicating that she would speak to her further following the 1400 visit to Mrs Hughes. She advised also that she was taking a cautious approach to the notification as Mrs Hughes had advised her that everyone had been notified. WGCDR Walker had consciously decided to take the matter no further at that time in order to avoid adding to the grief of SQNLDR Hughes’s mother. WGCDR Walker was emotionally shocked herself; she had spoken to WGCDR Wadsworth on the Monday evening when he came to see that she was alright.
279. At 1400 she and Padre Paget visited Mrs Hughes to offer support. During this visit they discussed DCO support and the assistance available in connection with a funeral. WGCDDR Walker sought contact details for SQNLDR Hughes’s father, but that information was not forthcoming. Mrs Hughes raised a number of issues where she regarded the RAAF to have some responsibility for SQNLDR Hughes’s death, and initially rejected any assistance in connection with the funeral. The atmosphere inhibited WGCDDR Walker’s willingness to pursue the question of contact details for Mark Hughes. On her raising the question of the PEC Vivian Adams, Mrs Hughes stated that she would contact him herself. An arrangement was made for DCO personnel to visit Mrs Hughes. WGCDDR Walker was given a copy of an email sent to her by SQNLDR Hughes that had been misaddressed.

280. WGCDDR Walker had enjoyed a professional and cordial relationship with SQNLDR Hughes. She was aware that Mrs Hughes held the RAAF to blame for the erratic behaviour of SQNLDR Hughes and had held that attitude at least since SQNLDR Hughes had been confined in the New Farm Clinic in early 2007. She had said no reason to distrust Mrs Hughes who had stated that she would herself contact Mr Adams, whom she described as “a family friend”.

281. WGCDDR Walker said that she wanted the question of support for the father to be looked into, and discussed with Padre Paget how contact might be established with Mark Hughes for that purpose; Padre Paget undertook to ring Chaplain Barker in to have him make contact with Mark Hughes. WGCDDR Walker did not attempt to make contact with the PEC, Mr Adams, as she regarded the family issues as sensitive and Mrs Hughes had stated that she preferred to contact Mr Adams herself.
282. Early the following day, Wednesday 23 January 2008, WGCDDR Walker flew to Townsville to meet obligations there, returning home to Brisbane about 2130 on Thursday 24 January. During Thursday she spoke to AVM Austin by phone, during which call she explained the rationale that was leading her to prefer a cautious approach to questions of notification. During Thursday WGCDDR Walker was advised of the arrangement of the funeral for the following day. She wasn't expecting the funeral to occur that quickly.

MAJ Lindsay Bancroft (by telephone).

283. MAJ Bancroft was posted to the DCO between 2001 and early 2009. He has been a member of the Australian Army since 26 February 1974.

284. During his period with DCO he gained considerable experience in connection with the system of notification of service deaths and post-death arrangements. Notification teams he said are trained by DCO nationwide and along with a Chaplain make up the notification team within units. The single service has the backing of the DCO in Canberra should there be an inability for the single service to conduct a notification.

285. As to the recipients of notification, MAJ Bancroft drew attention to DI(G) paragraph 14, that identifies the obligation to make personal contact with the primary emergency contact. The primary emergency contact and the secondary emergency contact he said are normally recorded in a member's PMKeyS record.

286. MAJ Bancroft added that “there are always issues with PMKeyS and its currency for that information”. Of the NWCC database MAJ Bancroft stated that it was a backup source of information where the PMKeyS record was
inadequate. In practice MAJ Bancroft said a senior officer may well perform
the duties of a notification officer, with the notification team present,
particularly in the case of an operational fatality.

287. The military support area within DCO he said was available to provide advice
to facilitate a notification.

288. Invited to offer a view on change that might resolve the shortcomings of
PMKeyS data, out of date information and the ambiguity of the next of kin
concept, MAJ Bancroft said that his personal view was that a single
notification policy for the ADF was needed. What is meant by the phrase
"next of kin" he said was a matter that came up for discussion often when he
was at DCOHQ. He said that some system whereby those who would be
ominated are identified by Defence, after consideration of any expressed
preference by individual members could remove ambiguity. He gave an
example where Defence decision-making of a discretionary nature had avoided
a public relations disaster for Defence.

289. MAJ Bancroft said that it was now a requirement for members to nominate a
next of kin on PMKeyS. That had not happened in the case of SQNLDR
Hughes. He said there was no policy on next of kin.

290. MAJ Bancroft was uncertain whether next of kin was to be ascertained by
legal analysis of whether it was the right of a member to nominate
whomsoever they wished. He accepted that the present PMKeyS provided no
opportunity for the recording of a member's wishes on questions of
notification. Where the nominated PEC appeared to have little relevance to the
member, he observed that opportunity should be afforded the member to
nominate additional contacts. That he said happened in practice quite often.
291. MAJ Bancroft saw merit in considering introduction of a policy pursuant to which certain categories of person would be automatically notified of a fatality by Defence after taking into account any views on the subject recorded by the deceased member and such other discretionary matters as arose in the particular case. Invited to comment on the practicality or otherwise of a recommendation by this Inquiry along those lines, MAJ Bancroft said "I think it would be helpful for Command to have something like that, that they could default to, so that it's a little clearer...we've got to have something." He agreed that a system along those lines would introduce some certainty into the routine.

292. On the question of any will, MAJ Bancroft confirmed that it was unassociated with the notification process; it was he said something for the BST to be aware of. Of the situation that had arisen in the case of SQNLDR Hughes's will, he said that the bereavement team would await direction and legal advice from HQDCO.

293. MAJ Bancroft said that he understood in the present matter that Mrs Hughes was negotiating through her solicitor to obtain the will and seek letters of administration or the executorship. That legal process was not completed until some time after the funeral.

294. MAJ Bancroft said that where there is an executor, that person or entity will be dealt with by Defence for estate management. He added that members were encouraged to make a will but it was not mandatory.

295. Of SQNLDR Hughes's case, he noted that the time between the death and the funeral was not long. As the relevant MSO, he had recognised the need to resolve the question of offering support to the deceased Tasmanian relatives, and observed that it was open to appoint a second team to support Mark
Hughes. It was he said his understanding that that was to happen; he had discussed it with Mrs Thomson, then DPPDCO, and the person in charge of case management after DGDCO. He had he said discussed the matter more than once with Mrs Croft.

296. He had become aware at some stage that Mr Hughes had contacted the DSC at Cowra and that he had been told that SQNLDR Hughes had stated that he did not want his father at the funeral. On Friday 25th of January, he had been in Brisbane, and not privy to the events of that day.

The Decisions Relating to Mark Hughes – Monday to Thursday.

297. Whilst reference to the question of support for anyone other than Mrs Hughes and Peta Hughes has centred almost exclusively on the position of Mark Hughes, it is to be recognised that SQNLDR Hughes had a significant number of close relatives living in and around Tasmania. SQNLDR Hughes had in fact spent a significant part of his life as a child and as a young man as a de facto member of the family of Vivian and Gwendolyn Adams at their home outside and was in close touch with them until the time of his death. His relationship with Karen Hughes was close, and he had a young half-sister. He had a number of aunts who cared for him.

298. In recording the course of consideration of support for Mark Hughes, and by extension other relatives in Tasmania, it is to be remembered that funeral arrangements were first discussed on Tuesday the 22nd of January; the funeral was set for the following Friday, either that day or on the Wednesday. It was not until that day that a decision was made to support Mark Hughes.

299. Following confirmation by Mr Hughes of earlier evidence suggesting that concerted action had been taken to prevent him attending his son’s funeral, the Inquiry gave PAP notices to DGDCO, Mrs Thomson DPPDCO of the time, to
SQNLDR Chaplain Paget and to WGCDR Walker. Each was advised that the Inquiry was interested in:

i. The decision to withhold from Mark Hughes details of his son’s funeral.

ii. The absence of any decision before Friday 25 January 2008 on the question of provision of support to Mark Hughes and his family.

Frances Therese Croft.

300. Mrs Croft is a DSW with DCO at Amberley. She was the case manager for the BST appointed by HQDCO to support Mrs Gail Hughes and her daughter Peta. Mrs Croft was one of a number of witnesses who spoke of the failure of individual members to keep the PMKeyS up to date.

301. Mrs Croft told the Inquiry that formulation of BSTs was determined by DCO headquarters in Canberra, in this case, Lizabeth Thomson. DCO she said is alerted to a death of a Service member by the circulation of a FATALCAS signal given pursuant to DG(P) PERS 11-2. In accordance with that protocol, a BST was formulated, consisting of a DSW, an MSO and an area manager.

302. The PMKeyS Mrs Croft said was inoperative on the morning of 22 January, and accordingly she consulted the NWCC register, which contained two entries. The first of those entries nominates Mrs Hughes as the PEC and Mark Hughes as SEC. The later entry removes Mrs Hughes as PEC, substituting SQNLDR Hughes’s sister Peta as the PEC. Additional detail has been added to the entry relating to contact numbers for Mark Hughes. Those details Mrs Croft said were conveyed to HQDCO (she thought to Mrs Thomson) on the
morning of 22 January 2008. The question of the funeral arrangements Mrs Croft said was a matter for discussion “between Defence and the family”.

303. Mrs Gail Hughes had advised WGCDDR Walker of her son’s death about 1730 on Monday 21 January – Mrs Croft learned of it the next morning, when she was appointed the case manager to lead a team consisting of herself, MAJ Bancroft as MSO, Mrs Janelle Black the Area Manager/Supervisor, and administrative staff. Where family circumstances so dictated it may be necessary for more than one team to be created.

304. Mrs Croft was advised that WGCDDR Walker and Chaplain Paget were to meet Mrs Hughes at 1430 on Tuesday 22 January 2008. Mrs Croft detailed her communications with WGCDDR Walker, Chaplain Paget, Mrs Hughes and Peta, which communications resulted in an arrangement for her to see Mrs Hughes on Wednesday 23 January 2008.

305. From an early stage of her contact with Mrs Hughes Mrs Croft became aware of Mrs Hughes’s determination that her former husband should have no part to play in the funeral arrangements for SQNLDR Hughes, and her wish that Mr Mark Hughes should remain ignorant of information generally. For this reason, Mrs Croft recorded the desirability of HQDCO considering appointment of separate representatives and making contact with Mr Mark Hughes in Chaplain Paget: she said suggested he might make contact with Padre Barker in . This recommendation was discussed by her with Lizabeth Thomson and Marion Smyth in Canberra who agreed on the need for that question to be resolved.

306. Mrs Croft continued her task of providing support to Mrs Hughes, and agreed with her on the nature of the funeral arrangements. The funeral was to take
place on Friday 25 January. It was to be small and private in nature with limited military overtones, to be followed by cremation.

307. The question of support for Mark Hughes had been recognised both by WGCDDR Walker and by Mrs Croft on Tuesday 22 January. A SITREP raised by Mrs Croft to MAJ Rasmussen at HQDCO of 23 January drew attention to the circumstance that no direct contact had been made with Mark Hughes. That SITREP came to the attention of the then DPPDCO during the morning of Thursday 24 January, and by email of 1143 of that day Mrs Thomson advised DCO personnel associated with the matter including DGDCO that the matter did indeed require the making of a decision as to whether to provide support to Mark Hughes. Mrs Thomson frankly admitted that she had not followed the matter up that day; there is no evidence that the matter received any attention at DCO that day. Detail of the arrangements for the funeral the following day was agreed in a meeting that afternoon.

308. On Thursday 24 January, Mrs Croft learned from the funeral director appointed to arrange the service that Mark Hughes had been telephoning funeral firms around Brisbane in an attempt to gain information about the arrangements for his son’s funeral. The funeral director stated that he had not given out any information as he regarded Mrs Hughes as his client. Following this discussion, Mrs Croft spoke by telephone to Marion Smyth in Canberra.

309. Mrs Croft also learned that Mark Hughes had called Amberley DCO seeking to learn the funeral arrangements. She contacted Mrs Thomson by telephone in Canberra seeking instructions. In response to my direct question, she said that she would have expected Canberra to put in a second team to support Mark Hughes.

310. By the end of Thursday, Mark Hughes had flown to Brisbane on the same plane as to whom an invitation to attend the funeral had been
extended by Mrs Hughes. That coincidence resulted in Mrs Hughes and through her DCO personnel being made aware of Mr Hughes's arrival.

311. She received no further instructions until Friday 25 January.

Janelle Black.

312. Mrs Black confirmed that Chaplain Paget had stated on Wednesday 23 January that he would have Padre Barker contact Mark Hughes in Tasmania. WGCDFR Walker left for Townsville that day and was not to return until Thursday evening.

313. On Thursday 24 January, she had met SMO O'Toole and WOOF Holland to make arrangements in respect of a flag, medals and photographs. She was aware that Mrs Croft had raised the question of a second BST to support SQNLDR Hughes's family in Tasmania, and she had herself spoken to either Marion Smyth or Liz Thomson of HQDCO by phone about involving the Hobart office of DCO. The matter was left as one to be resolved. She said that two teams were often appointed in circumstances of a fractured family, and that it was a matter to be determined by HQDCO. In response to a question she said that the terms of any will were relevant only to questions of beneficiaries. She was not herself told that the mother was thought to have authority as an executor.

314. An email from Canberra that day referred to the need to manage the father's expectation around the funeral arrangements and also look at another DSW to support the father. Mrs Black said that it was only that day that DCO had any contact details for Mark Hughes. Mrs Black agreed that contact details were recorded in the NWCC database; nobody had tried them. She agreed that
the email suggested a fairly relaxed approach by Canberra to the question of a second DSW team.

SQNLDR Paget.

315. Chaplain Paget had visited Mrs Hughes with WGCDR Walker on Tuesday 22 January. He attended a meeting on Thursday 24 January with WOFF Holland, SMO O'Toole and Mrs Black, by which time Mrs Hughes had agreed to a funeral with limited Defence participation, and arrangements were to be finalised for the ceremony the following day. By that time it was known that Mark Hughes was on route from Tasmania to Brisbane.

316. Chaplain Paget said that as details of the funeral were discussed, it had become apparent that it was a requirement of Mrs Hughes that SQNLDR Hughes's father not be told about it. The decision not to pass information to Mr Hughes was one agreed to at that DCO coordination meeting. It was he agreed an acceptance of a risk of the kind that came to pass. He agreed that the consequence of the agreement that the father not attend was to preclude the BST from any discussion with Mark Hughes, who would have been very likely to commence any discussion with an assertion of his wish to be present at the funeral. When the risk materialised it was resolved by DGDCO appointing Mrs Black to look after Mark Hughes; to take him to the funeral. Mrs Croft was to placate Mrs Hughes as best that could be done. The situation would have been thrown into considerable confusion had Mrs Hughes, relying on the agreement reached refused to accept the presence of Mark Hughes at the funeral.

317. Chaplain Paget said that the acceptance of Mrs Hughes's stated condition in this regard was her condition for Defence participation in the funeral ceremony. The agreement he said was that it would be a private funeral with
Defence's involvement limited to the conduct of the ceremony by Chaplain Paget, the attendance of WOFF Holland not in uniform, with Defence meeting the cost. The Hughes family were to be represented only by Mrs Hughes, her daughter Peta and one friend from Tasmania. Chaplain Paget's view is that a funeral should take place as an integral part of the grieving process, and he had assisted in persuading Mrs Hughes to hold a funeral. He said "it was clear that she wanted no involvement from him". He said and others confirmed that Mrs Hughes would simply not entertain any discussion on the involvement of Mark Hughes. Chaplain Paget added that the understanding of the existence of an estrangement between SQNLDR Hughes and his father may have led to the belief that it was unlikely that Mark Hughes would wish to attend.

318. SQNLDR Paget said it had been accepted that Mrs Hughes's assertions that Mark Hughes would be likely to create a scene and disrupt the funeral service should be believed. Consistent with that decision Padre Paget said he had informed personnel at DSC in Cooma that information concerning SQNLDR Hughes's funeral was not to be given to Mr Hughes. In addition he had informed the employees of the civilian contractor providing security at the gates to Amberley Base that should Mr Hughes arrive there he was not to be admitted, but he should be alerted to his presence. He did not intend those contacts to be construed as orders as he did not have any executive authority to give them. At that time Chaplain Paget was under the impression that Mrs Hughes was both the next of kin and the executor of SQNLDR Hughes's will.

319. I am comfortably satisfied that SQNLDR Paget in contacting both the Defence call centre at Cooma and the security at Amberley was implementing an agreement with Mrs Hughes entered into at least in part in order to persuade her to agree to a funeral that may otherwise not have taken place. It is faintly ironic that at the time that he was acting in what he thought to be an agreement to which all were committed in the best interests of Mrs Hughes and in
accordance with the wishes of the deceased, reconsideration of the issue was taking place in Canberra that resulted, perhaps predictably in reversing that decision permitting Mark Hughes to attend the funeral.

320. He was not kept apprised of developments by DCO and was unaware of the change of position on Mark Hughes until he appeared at the funeral. He was unaware that the decision-making process in Canberra directed to support for the Tasmanian relatives had temporarily halted. I am left with difficulty accepting that the decision to deny information to Mark Hughes was made on Thursday, when Mark Hughes's presence in Brisbane was known, without any apparent thought about how the matter of his presence was to be handled.

Lizabeth Thomson.

321. In evidence, Mrs. Thomson DPPDCO at the relevant time said that she understood that the executor of a will had the right to determine matters such as the funeral of the deceased and matters associated with the disposal of his remains. She believed that in the present case the executor nominated in SQNLDR Hughes’s will had “transferred” the executorship to Mrs Hughes, in consequence of which actions Mrs Hughes was entitled to determine how the funeral was to be conducted. That understanding she said followed receipt of an email from MAJ Rasmussen on Thursday 24 January 2008.

322. Mrs. Thomson received a SITREP from Mrs Croft dated Wednesday 23 January 2008, but which as it arrived after hours, was not seen by her until Thursday morning. That SITREP had occasioned Mrs Thomson to email Mrs Croft expressing concerns as to the position of Mark Hughes. That email foreshadowed a consideration of support for Mark Hughes and concluded:
"...therefore we need to make every effort to find the father, to contact him and to work with the mother/family to facilitate his involvement."

323. That email was sent at 1143 on Thursday 24 January. It was neither followed up nor was it the subject of a response. 

324. Mrs Thomson said that responsibility for extracting issues of importance from SITREPs lay with MAJ Rasmussen then A/DMS, and Marion Smyth. 

325. Mrs Thomson accepted that the question of Mark Hughes's knowledge of his son's death had been raised by MAJ Bancroft in a memorandum of Tuesday 22 January 2008. Mrs Thomson expected Frances Croft as the case manager to follow-up on her email of Thursday 24 January. She had said no authority to contact the father, because he was not registered on PMKeyS. DCO practice she said was not to make contact with persons not nominated on PMKeyS. The NWCC database she said is regarded as a separate database, kept for the purposes of deployment. 

326. Mrs Thomson said that she had expected that the response to her email of Thursday 24 was that Mrs Croft would speak to Mrs Hughes, would revert to her, and that another DSW would be appointed to look after Mark Hughes if appropriate. That she said was what ultimately occurred. The process she said could occur quite quickly; it had not occurred before Friday in this case because there had been no involvement with Mark Hughes to that point. It was not she said DCO's role to inform the father and the PMKeyS is the single source of information for DCO. Her role she said was to work through the mother to facilitate his involvement, notwithstanding Mrs Hughes's antipathy.
As to the lack of follow-up to her email, her expectation she said was that the supervising area manager would have done that.

327. Mrs Thomson accepted that some conflict existed between DI(G) 42-6 and DI(G) 11-2, the former at least envisaging communication between DCO and the next of kin.

328. Mrs Thomson drew attention to the CDF Directive (exhibit 18), which provides that the DCO will task and co-ordinate notification teams but that “DCOORD Air Force will identify the responsible unit and ensure that commanding officer is aware of the casualty. The responsible unit CO will then co-ordinate process, with DCO’s advice and support.” This quotation appears to me to confirm that the thrust of the requirements as to notification is to be found in various instructions, that whilst not entirely consistent plainly envisage a co-operative role between Command and DCO.

329. Mrs Thomson acknowledged that she had been told by the SITREP she saw on Thursday 24 January that Mrs Hughes was not the executor, a role to which DCO attached some importance, but thought that the statement by Maj Bancroft updated that advice by conveying that the trustee had relinquished the role; that gave DCO “the green light to engage with Gail Hughes”. Mrs Thomson acknowledged that Mark Hughes had an entitlement to attend the funeral, irrespective of arrangements relating to payment.

330. I do not think that that position can be drawn from the communications then available, which appear to me to foreshadow a course of action proposed to be followed rather than one that had already taken place.
331. Mrs Thomson gave evidence as to the manner in which an additional DSW might be appointed to aid the BST. That process consists of discussion between herself, Mrs Smyth and MAJ Rasmussen, who form the requisite view and determine the availability of personnel, following which in appropriate circumstances DGDCO is approached, advised of the situation, and makes a decision as to whether or not a DSW will be added to the BST.

**Friday 25 January.**

DGDCO.

332. During Friday morning DGDCO had become involved in the deteriorating situation, and had sought legal advice. With Mr Hughes at the gates of Amberley DGDCO decided the best solution was to extend the help necessary to get him and his sister to the funeral and to prevail on Mrs Hughes to accept that development. I infer from later evidence that that decision was provisional in nature. Mrs Black was so informed.

333. DGDCO sought legal advice on Mr Hughes's expressed wish to see his son's body, having been told by the funeral director that he would be acting only in accord with Mrs Hughes's wishes. DGDCO decided that as Defence was meeting the costs of the funeral it was in his discretion to direct the funeral director to permit Mark Hughes to view his son's body, and he did so. Mr Hughes viewed his son's body after the ceremony when Mrs Hughes had departed.

Lizbeth Thomson.

334. On Friday morning, Marion Smyth rang DPPDCO to advise that no transfer of executorship had occurred. DGDCO and Mrs Thomson directed Mrs Smyth to get legal advice. It seems that the position as lunchtime approached on the
Friday was that the decision not to inform Mr Hughes remained on foot pending that advice. Mr Hughes was known by all to be in Brisbane.

335. Mrs Thomson confirmed that the DGDCO had on Friday morning determined that Mrs Black should find Mark Hughes at Amberley, offer him support and arrange for him to attend the funeral. Burials she accepted may well take place within a week of the death. Should the executor not be available or decline to take out probate, she said that DCO would seek legal advice where to go from there. When I suggested that the advice she might get from Defence Legal may entail an application to the Court which would take at least several weeks, she confessed herself at a loss to know what DCO would do.

336. Mrs Thomson said that she had not known before Friday that Mark Hughes was being excluded from the funeral arrangements. I accept her account.

Frances Croft.

337. On Friday 25 January 2008 Mrs Croft learned from her office that Mark Hughes had travelled to Brisbane. Later that morning she saw Chaplain Paget in her office dealing with some administrative matter, but they had not spoken.

338. On Friday afternoon she commenced the drive to the funeral venue at Albany Creek, still uninstructed as to the HQDCO position on Mark Hughes's presence. During the drive she maintained telephone contact with her office, and was in due course informed that she was to break it to Mrs Hughes that Mark Hughes would be attending the funeral. This instruction came within the hour prior to the conduct of the funeral. Mrs Croft contacted Mrs Hughes by telephone and advised her that her former husband would be present, advice
that predictably was not well received. In the event, the funeral was conducted with appropriate decorum, with no direct contact between Mark Hughes and his former wife.

Jauelle Black.

339. Mrs Black is currently the Area Manager of DCO at RAAF Amberley. Her involvement in the team assigned to provide support to Gail Hughes was she said peripheral until Friday 25 January, the day of the funeral. Prior to that she had met WGCDDR Walker, Frances Croft and Chaplain Paget on Tuesday morning following the death, and she was aware that Mrs Croft proposed to visit Mrs Hughes later that day, after Mrs Hughes had been visited by WGCDDR Walker and the Chaplain. She understood from WGCDDR Walker that SQNLDR Hughes was estranged from his family and Mrs Hughes was anti-military.

340. On Friday morning 25 January she had met with WGCDDR Walker, who told her Mr Hughes was in Brisbane. Mrs Black said that funeral arrangements were discussed. She conceded that the question of Mr Hughes was a bit of an elephant in the room, adding that she had advised Marion Smyth of Mr Hughes’s arrival in Brisbane. She learned when she returned to her office that Mark Hughes had made contact with DSC and that DSC had received instructions from Chaplain Paget that were Mark Hughes to ring the Centre no information was to be given out about his son’s funeral. She said that the Chaplain had been in the DCO office earlier that morning but had not spoken to her at that time. When she heard from DSC that Chaplain Paget had instructed that Mr Hughes was to be told nothing, she had wondered about his authority to take that action and had telephoned HQDCO. Mrs Black’s perception was that Chaplain Paget had probably stepped out of his Chaplain’s
role, probably acting in good faith as Adam's friend, not as a Defence Chaplain.

341. She was subsequently called by Mrs Thomson who had spoken by phone to Mark Hughes who was at the Amberley gates and had been there all morning. This was about 1300. She was told to find Mr Hughes at the gate and provide support. Mrs Black had become the support officer for Mark Hughes, about one hour before the funeral was to take place.

342. Mrs Black accordingly made her way off Amberley Base and located Mark Hughes and his sister whom she endeavoured to bring onto the base. Security declined to admit Mr Hughes consistently with the instruction from Padre Paget; the sole reason she was given was "We've been given our instructions". Mrs Black, understandably annoyed, sought to use the security office phone to make contact with WGCDDR Walker but was initially denied use of the phone. She did not have her own mobile with her; she was directed to a public phone which did not work. This did not assist to calm her frame of mind. She was at the second attempt permitted to use the security office phone. There was no response: Mrs Black rang the DCO office and arranged for staff to contact WGCDDR Walker. She remonstrated with the pass office staff, who stated "we've been given our instructions not to let Mr Hughes onto the base." Those instructions they said were received from Chaplain Paget.

343. After endeavouring to speak to Padre Paget, WGCDDR Walker spoke to security and after some initial resistance Mrs Black was permitted to bring Mr Hughes and his sister onto base, where WGCDDR Walker joined them. Appropriate courtesies were extended. At this time Mrs Black learned of the manner in which Mr Hughes had spent his morning, including his visit with Chaplain Paget and WOFF Holland. The history she said shocked her.
344. In the DCO office tea and sandwiches were organised; WGCDDR Walker visited. Mrs Black was informed of the relationship between Mr Hughes and his son from his perspective for the first time. Mrs Black left the room in order to ring DGDCO from Mrs Croft's telephone. She spoke to Mr Callan and Mrs Thomson, who were on speaker-phone. Mr Callan was of the opinion that Mr Hughes should go to the funeral and should be permitted to see his son's body at the undertaker's. A number of telephone calls between Mrs Black and Mr Callan followed, both in the DOC office and whilst Mrs Black was driving to Albany Creek one hour away. Mr Hughes's request to view his son's body at the undertaker's was unresolved at the time that Mrs Black commenced driving Mr Hughes and his sister towards Albany Creek. Whilst en route to Albany Creek, Mr Callan contacted Mrs Black to advise her that he had arranged for Mr Hughes to view SQNLDR Hughes's body after the funeral. Mrs Croft was to inform Mrs Hughes of that arrangement. In the event her party reached Albany Creek before Mrs Hughes and Peta, and arrangements were made in conjunction with Mrs Croft as to the manner in which the matter of seating might best be addressed.

345. The service took place without incident, and Mr Hughes and were subsequently taken by the funeral director, Chaplain Paget and WOFF Holland to view SQNLDR Hughes's body. Mrs Black drove Mr Hughes and back to the base via Ashgrove, where she purchased a late lunch for them. Questions of a presentation flag, photographs, a DVD of the funeral, medal replicas and other items were raised during that afternoon and were subsequently organised to Mr Hughes's satisfaction. Reimbursement of airfares was arranged. In the ensuing weeks Mr Hughes was provided with mementos and material relevant to SQNLDR Hughes. Mr Hughes said that he appreciated the support that he received following the decision to provide it, and made no complaints respecting his earlier treatment.
346. Mrs Black said that whilst changes had been made in recent times, they related solely to the means of appointment of the bereavement team. Mrs Black attached no apparent importance to the terms of any will in respect of DCO operations, was unclear whether the next of kin was a legal or social concept so far as DCO was concerned, and repeated that any question of a second team was a matter for HQDCO.

347. Both the problem of support for the father and his relatives and the manner in which his appearance at the gates of Amberley was handled were she believed matters for reference to HQDCO for guidance.

Chaplain Paget.

348. Chaplain Paget confirmed the accounts the inquiry had already heard of the meeting with Mark Hughes and his sister following their arrival at the gates of RAAF Amberley on Friday morning. This occasioned me to ask the question "whether or not it is wise, or even appropriate, to agree to a service funeral in one form or another, where one party has made it a condition that another part of the family should be kept out of it altogether."

349. Invited to comment on that question Chaplain Paget said that the greater concern on the Friday was that Mark Hughes may have acted in the way that Mrs Hughes said that he would, a greater concern than the manner in which Mrs Hughes would react to the presence of Mark Hughes. He said he discovered on Friday morning that Mark Hughes was not as confrontational as Mrs Hughes had suggested. That circumstance had led to additional angst in explaining to him that no information could be given, and prompted him to suggest to Mark Hughes that he seek legal advice from DCOORD. He had he said endeavoured to contact WGCDDR Walker to determine how to proceed.
but his attempts to contact her on Friday morning had not been successful —
"and I just decided at that stage that I had to face the music".

350. Chaplain Paget agreed that he had telephoned the Defence switchboard at
Cooma on Friday morning 25 January, in consequence of his learning that
Mark Hughes was endeavouring to gain information about the funeral. He was
he said implementing the "general agreement" that that information was not to
be passed on and he wanted to ensure that information was not passed on
inadvertently. Chaplain Paget agreed that he had telephoned the main gate at
Amberley to alert them to the possibility that Mark Hughes might arrive there,
leaving an instruction that they should ring him should that occur. He accepted
that he had no executive authority to give orders; he was he said simply
seeking to avoid the possibility that the gate might admit Mr Hughes and direct
him to some office inside the base, as occasionally happened.

351. Mrs Hughes's description of Mr Hughes's character had been present to his
mind when he spoke to security at the Amberley gates. He agreed that it
would have been helpful to know DCO's position at the time he saw Mark
Hughes at the base, particularly if they were trying to find him. Chaplain Paget
accepted that the decision made in the DCO office not to provide Mark Hughes
with funeral details was not known to WGCDR Walker before the Friday
morning and that WGCDR Walker had been unaware of his meeting with
Mark Hughes that morning. He agreed that DCO did not contact him to alert
him to the abandonment of the original agreement — a matter he first learned
when Mark Hughes and his sister arrived at the funeral chapel that afternoon.

352. I have no hesitation in accepting his account.
WOFF Holland.

353. On Friday 25 January 2008, WOFF Holland saw Chaplain Paget and at his request accompanied him to the SECFOL area of RAAF Amberley, where Mr Hughes then was. He confirmed that at the meeting which followed, Mark Hughes was refused detail of the funeral arrangements. His own limited involvement appears to have been one of support for Chaplain Paget, and advice to Mark Hughes that he might make contact with DCOORD. After parting from Mark Hughes and his sister he next saw them at the funeral that afternoon.

354. He confirmed that Mark Hughes was told by Chaplain Paget that Mark Hughes could not be told where the funeral was to take place as there was no authority to tell him because he wasn’t listed on PMKeyS. Invited to comment as to how a similar matter might be handled in the future, WOFF Holland responded that he would get the manager of DCO involved at the earliest moment with a view to having someone appointed to look after each party.

WGCDR Walker.

355. On Friday morning 25 January 2008, WGCDR Walker was briefed by the SMO that the funeral was to have little service character, and that she was not expected to attend. She became engaged in other issues. At 0900 she met with Mrs Croft and MAJ Bancroft to receive detail of the funeral arrangements formally. During that meeting they alerted her to the circumstance that Mr Hughes was believed to be in Brisbane seeking to attend the funeral, in consequence of which DCO were obtaining legal advice. WGCDR Walker raised the issue with Commander CSG at a 1000 meeting, providing him with such detail as she herself had.
356. WGCDR Walker was not to attend the funeral, and the problem posed by Mark Hughes's presence was under consideration by DCOHQ. WGCDR Walker went about her other pressing business. Her next significant involvement occurred after noon when she received a phone call from Janelle Black who was calling from SECPOL at the Amberley gates. SECPOL was declining to allow Mark Hughes to enter the base in accordance with what they regarded as instructions given by Chaplain Paget. WGCDR Walker endeavoured to contact either the Padre or WOFF Holland without success. She telephoned SECPOL and after some discussion WGCDR Walker countermanded the directions given by SQNLDR Paget and Mark Hughes and his sister entered the base with Mrs Black, and proceeded to the DCO area where WGCDR Walker joined them. Refreshments were provided for Mark Hughes and his sister, WGCDR Walker apologised for the inconvenience to which they had been put whilst she was unaware of their presence. She explained that she did not have his contact details and had been in the process of trying to get them. During that meeting Mrs Black made contact by phone with Canberra from another room, the outcome of which discussion was advice to Mark Hughes that he seemed likely that he could attend the funeral but final confirmation was required. Given the time frame Mr Hughes and his sister departed shortly thereafter to change into clothing appropriate to the funeral that they had in their car. They were accompanied by Mrs Black who remained in contact with Canberra by telephone from time to time thereafter.

357. WGCDR Walker regarded the decision making process generated by the circumstances to fall fully within the province of DCO. She had been engaged on her other duties.

358. In the period after the funeral, WGCDR Walker wrote a condolence letter, ensured mementos of portraits, plaques, medals, photo album and the like were put together, and made arrangements to present these to Mark Hughes, flying
to Tasmania in mid October to present to him a set of mementos similar to that that had been presented to Mrs Hughes.

359. In response to questioning directed to lessons to be learned from the Hughes experience WGCDR Walker responded:

Notification – Command notification of the PEC had not been effected directly as a discretionary decision had been made by her as CO to rely upon the mother’s indication that she would herself contact the PEC.

Support for the deceased’s father – The process of tracking down Mark Hughes to establish whether he and other family members in Tasmania would benefit from support had been initiated via Chaplain Paget, who was to obtain a contact point through Chaplain Barker in That process had been overtaken by the funeral before contact was established. In general both Command and DCO should work in concert to keep all involved informed the whole time.

Fractured Families – The present situation illustrates the need to educate service people better in respect of the importance of PMKeyS, and the need to adjust PMKeyS itself to permit better involvement by service people in the process.” WGCDR Walker did not think that a commander has the expertise to deal with a fractured family where questions of special support and legal support may arise. The command role in that area she thought involved facilitating such matters as fell within the commander’s province, at the request of DCO for example.

360. WGCDR Walker’s attention was drawn to the Terms of DI(G) PERS 11-2; and in particular to the provisions of paragraphs 3(e) and 3(a). WGCDR
Walker agreed that SQNLDR Hughes did not meet the definition of "member" in 3(e), as he was not performing full-time continuous service at the time of his death. She thought also that it was doubtful that he was a "casualty" within the meaning of 3(a), as he was not a member who had been killed, but one who had died. Whilst WGCDR Walker had not turned her mind to these definitions at the time, she believed herself to have been discharging obligations under the DI, and said she undertook the obligations of notification in circumstances where a serving member passed away from natural causes. WGCDR Walker's advice on these questions she said she obtained from senior administrative staff experienced in interpreting orders.

361. WGCDR Walker denied: that she had made any assessment that support was to go to Mrs Hughes rather than Mark Hughes, as DGDCO had asserted. She stated that she had raised the question of contact with Mark Hughes both with DCO through Frances Croft and with Chaplain Paget. The matter was also adverted to in her initial Hot Issues brief. WGCDR Walker agreed that an opportunity to ensure that serving members PEC and NOK information in PMKeyS is up to date is presented at the time of posting it.

362. WGCDR Walker stated that the NWCC forms completed at the time of deployment require signing off by her, providing some confidence in the accuracy in the information. She does not know why that information is not entered directly onto PMKeyS rather than the NWCC database. Access to DRN terminals was she said part of the problem: she agreed the information in PMKeyS relating to SQNLDR Hughes appeared to be several years old. SQNLDR Hughes had bypassed normal posting and induction systems.
A number of questions were drafted by Mrs Hughes and put to her by Counsel for SQNLDR Hughes. I record these and her responses.

*When SQNLDR Hughes became ill how did the Air Force assist?*
WGCDR Walker responded that at the time SQNLDR Hughes was admitted to New Farm Clinic, following his telephone call to her on 18 or 19 March 2007, she arranged for somebody to stay with him whilst she sorted out medical support; she put in place a plan to assist him with his GP training, a matter of concern to him, quarantining him from anything else until he'd completed it.

*What was arranged in respect of psychological or social worker support?*
WGCDR Walker responded that she had referred him to the base psychologist (WGCDR John Kelley) when issues were raised. She offered all services to him, and he was aware of them himself. She offered to support him and arranged for him to come under medical care.

*What was the extent of contact during his illness?* WGCDR Walker said that she was in very regular contact notwithstanding the difficulty of so doing because SQNLDR Hughes changed his contact details and his email addresses from time to time.

*Did you encourage contact with his colleagues and friends?* WGCDR Walker said that during SQNLDR Hughes's illness he saw his colleagues. When in the New Farm Clinic he did not want his colleagues to know he was ill so she restricted information given to his work colleagues, passed on their comments and their queries and left it to SQNLDR Hughes to contact them if so minded. When out of the clinic, he came into the unit on a regular basis and saw his colleagues at that time.
Did you see a need to give him special attention as a PTSD sufferer? WGCNR Walker said that she was not aware of him being diagnosed with PTSD until late, if in fact he was. She said that she provided as much support for him as she could.

Do you think you did as much as you possibly could have done? WGCNR Walker said she thought that she had, that there was no area that she could have improved on what she did. She gave instances. WGCNR Walker believes that Defence and RAAF had responded adequately to the issues raised by SQNLDR Hughes's mental health condition.

364. Whilst it is possible with the benefit of hindsight to recognise that had WGCNR Walker communicated with Mr Adams herself she would have been given a telephone number for Mark Hughes, I do not see this as a matter of criticism. Mark Hughes was in fact informed of SQNLDR Hughes's death by Mr Adams on advice from Mrs Hughes. No criticism of WGCNR Walker's judgement call on the matter is warranted. WGCNR Walker raised the question of support for Mark Hughes with Padre Paget after the initial meeting with Mrs Hughes, as Padre Paget confirms. She was entitled to assume that her instruction would be followed up and action taken if appropriate.

365. Submissions were made on behalf of WGCNR Walker on 22 May 2009. Those submissions are highly critical of DGDCO, and the position he enunciated for DCO in the course of his evidence. That evidence she submitted "warrants clear comment by the CDF COI, and should now be brought to the attention of CDF as an issue of some concern...the understanding of the roles and responsibilities of DCO with respect service deaths - as...formally expressed in the evidence of Mr Michael Callon...is greatly disturbing. It reflects a position that can only be categorised as inimical to the best interests of Command; the ADF in general; and in particular the needs and expectations of ordinary defence force families...the position...is rigid and
...inflexible and most unhelpful to Command...Mr Callan's sentiments suggest that there may be a need to reorient DCO”.

366. This is strong criticism indeed. I have however decided that Mr Callan has not acted in any way that ought attract personal criticism. I have commented in some detail on the difficulty that Mr Callan’s evidence has occasioned me and I have made recommendations that are directed to clarification of the meaning of a number of ADF documents upon which Mr Callan relied for the views he expressed.

DGDCO Michael John Callan.

367. Mr Michael Callan was the Director General of the DCO based in Canberra at the time of SQNLDR Hughes’s death, and still holds that position. He provided two statements to the Inquiry and gave evidence. A number of systemic matters were discussed.

368. He was on 22 April 2009 identified by the Inquiry as a person who was potentially at risk of adverse comment, and was so notified by letter in accordance with Regulation 121 of the Inquiry Regulations. That letter identified two issues of interest to the Inquiry, namely the decision not to advise Mark Hughes of the details of his son’s funeral and the failure to make a decision as to the entitlement to support of Mark Hughes and the Tasmanian members of SQNLDR Hughes’s family before the events of Friday 25 January 2008.

369. Mr Callan echoed the problems associated with inadequate and out of date information commonly encountered when reference needs to be made to the PMKeyS database. He readily accepted that information on NOKs and PECs was often absent, inappropriate or out of date. Whilst aware of the NWCC
database, he regarded PMKeyS as the sole databank from which information relevant to notification could be drawn, a position that in my view is at variance with Annex B of CDF’s Directive 29/2006, exhibit 18.

370. Notification he said was an essential precursor to provision of support services, since DCO was reactive to requests for support. It followed that absent a request for support no steps would be taken by DCO to assist the father of a deceased member who was not nominated in PMKeyS. In the present case, this response was he said appropriate because Command had told DCO to support the mother and had not asked that the father be supported. He read paragraph 18 in DG(G) PERS 20-5 as providing DCO with a discretion as to whether it would meet the costs of transporting a person falling within the terms of paragraph 3 to the funeral of a deceased member, pointing to the word “may”. Mr Callan is not a lawyer and was unaware that in particular contexts the word “may” is a word of empowerment not signalling discretion, so that in specified circumstances it requires the specified action to be taken.

371. Mr Callan accepted that he was a party to the decision not to inform Mark Hughes of the details of the funeral, though it was not a formal decision made by him. On invitation to identify the factors that justified that decision, Mr Callan identified the following:

- The PMKeyS did not record either the father or the mother as the next of kin.

- The PEC and the SEC were the conduit of information until such time as the PEC stands aside or otherwise directs.
- The PMKeyS is the member’s statement of whom he wants involved.

Mr Callan’s position rests on the entries on PMKeyS and DCO practice rather than on any factors peculiar to the individual case and is thus a matter of system.

372. Commenting on the circumstance that those considerations would have required the same decisions to be made in respect of the mother, Mr Callan stated that the difference lay in that the mother was the executor of the will with the right to make a decision on the disposal of the body. This proposition he amended to state that the actual executor of the will was proposing to "hand over" responsibility to the mother. Mr Callan stated that his understanding was that the actual executor was entitled to hand over the powers of executor to the mother.

373. That understanding led me to query whether legal advice had or ought to have been obtained to which Mr Callan responded that "that is what we normally do". That question led to the second: given that the legal response will be that it can be done or it can’t be done, was it not appropriate to determine that matter in order to know whose instructions are to be followed? Mr Callan stated that if they followed the appropriate notification process through the PEC information comes out that allows managing of the tension around responsibility for disposal of the body and appropriate funeral arrangements. The particular case arose he thought, because of the short period between DCO engagement with the Brisbane family which he put at Wednesday the 23rd of January, and the agreed day for the funeral, Friday 25 January. In those
circumstances he said legal advice was sought by his staff. The evidence before the Inquiry of Marion Smyth was that no legal advice was obtained before Friday.

374. Mr Callan accepted the likelihood that DCO will on occasion be confronted with the circumstance that a nominated executor will not wish (or be unable) to accept the obligations of an executor, engendering a delay whilst a court appoints an administrator. In response to the question of whether it would be helpful to have a clear legal opinion to guide DCO should such factual circumstances arise, Mr Callan said that the indication of the nominated executor in SQNLDR Hughes’s will that it was not proposing to make any decisions left him in a very invidious position.

375. Mr Callan went on to say that he had had subsequent discussions with legal counsel and DCO had “a far more mature approach to it than we had at that time”. Taken back to the question of instructions should an executor renounce or be unable to take appointment and invited to comment on a formula for decision making that had led to acceptance of one party calling the shots to the exclusion of another, Mr Callan responded that the variety of problems that might arise requires “inherent flexibility in the way that we approach these things”. The proposition that when following a particular line in order to determine from whom instructions ought to be taken made desirable the existence of a mechanism that permitted timely decisions should an executor not propose (or be unable) to accept executorship was accepted by Mr Callan to be correct, but was not the subject of further elaboration.

376. These responses appear to me to support the need for a clear legal opinion to be available in advance.
377. The critical issue Mr Callan identified as the need to allow the family to regain control as a death takes control away from the family. That approach in the present matter seemed to me to raise the problem that where there are two families each may wish to have that control.

378. It is my view that whilst the occasions on which such a situation may arise may be few it is appropriate that the manner in which the problems inherent in that situation are to be resolved should be efficacious and predetermined. I have addressed that topic within the Recommendations section of this report.

379. Mr Callan agreed that the wording of DI(G) PERS 20-5, Funerals, Graves and Associated Matters, in its provision that the MSO should be the case manager, was at variance with practice where in truth the DSW acted as case manager. That he agreed ought to be redrafted.

380. Mr Callan agreed that SQNLDR Hughes’s PEC Mr Adams would have been entitled to support from DCO to attend the funeral in accordance with PERS 20-5. That he said would have been a discretionary decision. It would be said have been funded by DCO had Mr Adams asked to attend the funeral. DCO made no contact with Mr Adams.

381. Invited to comment on the uncertain meaning of “next of kin” Mr Callan stated that he retained “far more flexibility to deal with some of these cases when I don’t have a clearly defined next of kin...” which flexibility he said had worked well over the last 15 months. Mr Callan seemed to have in mind the terms of DI(G) PERS 42-6 par (5) that provides “the next of kin is that person whom the Director-General determines”. 
382. This provision Mr Callan said had enabled him to give directions in other matters "not to sell the father anything about the funeral...to keep them away from the family." This he said allowed the case management team to work with the family to the point that "the father's been allowed to attend." He attributed the failure to have that happen in the Hughes matter to the lack of available time.

383. I do not see this provision as a carte blanche providing unfettered discretion. Whilst I accept the need for flexibility I do not think that the provision would provide clear protection for the holder of a public officer should the father of a deceased member take umbrage at a decision to deny him knowledge of the member's funeral. Here too I see a need for legal advice.

384. Mr Callan was aware that WGCDR Walker had agreed to Mrs Hughes's request that she contact the PEC and understood that she had in fact done so. Mr Callan said that the notification team should have gone directly to the PEC. By submission of 22 May 2009 DGDCO submits "that the PEC/SEC should have been informed of the death on the Monday evening" and that process in this case was not followed. But the provision in PERS 11-2 in that regard is discretionary, providing that the relevant CO shall arrange for notification.

385. He said that the case management team would be organised in respect of "that element of the family that Command has suggested that we should go, or directed..." WGCDR Walker does not accept that she directed that only Mrs Hughes's segment of the family should be supported; her position, which the documentation of the time supports is that she set in motion the mechanisms for determining a contact for Mark Hughes through SQNLDR Paget with the intent that DCO should explore his need for support.
Mr Callan stated that access to the DCO support system may well have filtered to Mark Hughes had the PEC been directly contacted by a notification team and observed that "subsequent events indicated at least the father was not informed of the funeral". But the reason Mark Hughes was not informed of the funeral was not a consequence of any breakdown in communications; rather it was a consequence of a deliberate decision that the best means of implementing Mrs Hughes's wishes in the matter lay in denying him information he had directly requested. It seems likely that this decision had been made by DCO personnel when they saw Mrs Hughes on Wednesday 23 January.

387. Questions directed to Mr Callan about the prima facie entitlement of the father and mother to attend the funeral contained in Dl(G) PERS 20-5 paragraphs 3(c)(iii), 18 and 21, established that Mr Callan read the definition section in paragraph 3 as a default section to be followed where no NOK is nominated and recorded. The PEC he said was not the next of kin, "so it's up to the family therefore, or the person who has carriage of the funeral to decide who attends the funeral, not DCO".

388. That assessment to my mind begs the question. Which family? Who is the person who has carriage of the funeral, and how is that person to be determined? Mr Callan went on "...so it would be the responsibility in this case, because that responsibility was given to the mother to determine who was going to attend and invite them to the funeral."

389. The conclusion that application of that approach results in the mother making the relevant decisions does not logically follow. The proposition appeared to me to be sustainable only on the basis that the executor had power to give directions and had transferred that power to Mrs Hughes. I know of no method
whereby that could have been done outside the provisions of the Wills Act 1992 (Tas.) 'I have assumed that that Act provided that Letters of Administration may be granted where the executor for whatever reason does not take out probate, consistently with all other Australian jurisdictions.

390. Mr Callan said that he was acting in the belief that the mother had been nominated as the next of kin by the executor. The other key issue was the funeral director had advised him that in Queensland whoever recovers the body first has the absolute discretion to the disposal of the body. "She who gets to the body first wins". That advice he said had subsequently proved incorrect. I cannot accept that any holder of public office would act on such advice. He added that they do not make those assumptions anymore but seek legal advice on issues of probate on a state by state basis if there is no clear line of succession to inform him as to who has responsibility.

391. Returning to DI(G) PERS 20-5, paragraph 3(c), Mr Callan said that in the absence of any nominated next of kin the provision had no effect, and DCO has no statutory responsibilities pursuant to that Defence Instruction. It followed he accepted that fathers and mothers not recorded in PMKeyS could be turned away as a matter of course. Mr Callan's view that in the absence of a nominated next of kin, neither the father nor the mother of a deceased member has any entitlement to assistance to attend the funeral appears to overlook the provisions of paragraph 21. Taken to DI(G) PERS 20-5, Mr Callan said that until such time as a PEC has been notified DCO do not start to operate. That is not what happened in the present case. Mr Callan's construction of the DI(G) appears to me to be at variance with accepted canons of statutory construction.
392. Mr Callan accepted that DCO had accessed the NWCC database following the death of SQNLDR Hughes and that that database reveals the existence of Mr Hughes and his contact address. He did not accept that it would have been advisable in hindsight to feed that information back to Command, because *NWCC is not an official database*. That response sat oddly with his evidence that after accessing the NWCC database the information gleaned from it was "passed back to the bereavement support team to actually talk to Command about... once I made it clear that the father was there... we then directed them to take action". Mr Callan stated that should Command enquire whether DCO had information beyond PMKeyS, "we would point them to the NWCC database and say, 'in the absence of anything else'".

393. Taken to the CDF Directive and in particular to paragraph 4(b) which, dealing with the notification team states "the composition of the team will be activated by DCO headquarters" Mr Callan stated that Navy declined to comply with that Directive, whilst Army and Air Force complied.

394. Mr Callan expressed the view that the notification process required did not occur or at least did not follow the procedures in place at the time... As communication along the lines that Mrs Hughes said would occur in fact occurred I invited Mr Callan to comment on why that methodology, against the background of discretion and avoidance of multiple notifications did not constitute adequate notification. Mr Callan responded that DCO accepted that notification to the PEC had occurred but he was uncertain whether that was sufficient; he queried whether DCO should have raised a notification team and sent it in to talk to Mr Adams, because he thought that was "germane to the way the rest of the week fell out". He would he said have preferred the notification team to go down and actually talk to the PEC. Mr Callan said "in
Mr Callan accepted that whichever way one approached the problem in the present matter, it led to reliance on the nominated executor, with such problems as followed should the executor refuse or be unable to accept the nomination.

Mr Callan made reference to the SITREP raised by Mrs Thomson in which she expressed concerns with respect to Mark Hughes, concluding “we can obviously also look at another DSW to support the father...”. Mr Callan said that that was not done because he had not determined Mark Hughes to be the next of kin, and the PEC had not indicated the need for any family support in Tasmania. That basis seems to me to be insufficient where the PEC has not been consulted.

Mr Callan stated that he would not have denied the information to Mark Hughes on the basis of a possible scene at the funeral but because he was not a PEC recorded on PMKeyS. The same reasoning was not applied in the case of Mrs Hughes because she was thought to be the executor of SQNLDR Hughes’s will. He was he said endeavouring to “manage the serving members wishes, as expressed on PMKeyS". As Mrs Hughes is not mentioned on PMKeyS I interpret this as a reference to the views held about the ability to transfer executorship.

Mr Callan stated that “this was the first time but not the last time I made a decision not to provide support to a fractured family member or – not give them details of the funeral because we had essentially worked with the family to get them to make the decision to allow that person to attend. That’s the best outcome.” Mr Callan stated that whilst there was a recognised risk, which I
take to be the possibility of Mark Hughes endeavouring to attend the funeral, he was not minded to appoint an additional social worker to deal with a potential risk. "I accept the risk and move on":

398. Mr Callan pointed out that some actions were taken on Thursday the 24th January to work with Mrs Hughes during which she rejected any attempt to engage the father. It was known by then that Mark Hughes was trying to learn where the funeral was to be held. The decision he said was changed when he became aware on the Friday morning that Mark Hughes was in Brisbane.

399. Mrs Thomson having conceded frankly to the inquiry that she had received no response from Mrs Croft and had not herself followed the matter up Mr Callan was asked to direct attention to the source of his understanding that actions had been taken in respect of Mrs Thomson's memorandum. Mr Callan directed attention to the SITREP report prepared by Mrs Croft on Thursday 24 January, following a meeting that had occurred with Mrs Hughes and others, not including Mrs Thomson, at 1100 that day. That SITREP included the passage “Mr Drury advised Ms Hughes that her ex husband Mark Hughes had been in contact and was seeking details with regard to Adam's funeral. Ms Hughes stated that under no circumstances was any detail to be provided to Mr Hughes. Mr Drury indicated that it was company policy to only deal with Ms Hughes and that privacy would be respected (risk has already been identified in CM.SITREP with HQ Ack, "). Mr Callan accepted that that document had misled him, and there had been no DCO follow-up of Mrs Thomson's concerns.

400. Asked about a fall-back plan to avoid repetition of the events that had occurred in the present matter, Mr Callan stated that DCO carefully worked with the family to develop a connection to the father, to work with the family rather than try direct access to the father, in order to act in accordance with
the interpretation of the member's views as determined by reference to PMKeYS.

401. Taken to his statement, "in this case the commanding officer and her team determined that no support was to be given to the father..."  Mr Callan said that whilst he accepted the distinction between directing support to Mrs Hughes and directing that no support be extended to Mark Hughes that was his understanding of the situation at that time.

402. The CO had not made any such statement, and had drawn to attention the necessity to consider the father's position. After some jousting around the subject Mr Callan stated that he would still hold to his position, but might amend it slightly. When pressed on the proposition that no support was afforded to Mark Hughes before Friday on the basis of information supplied by Mrs Hughes, Mr Callan rejected the proposition. Mr Callan added that if a request to support the father had come from him, he would probably have taken a different view earlier. When it was put to him that he had earlier stated he would not have provided support to Mark Hughes because he didn't appear on PMKeYS Mr Callan responded "I wouldn't have - I would not have contacted the father. I probably wouldn't have provided any support to him and changed my actions. I would have (sic) given him information on the funeral, but I may well have given him some form of support if he'd come to us, but what I wouldn't have done prior to Friday is provide him information on the funeral."

403. Mr Callan accepted that Command had not suggested that DCO should support Mrs Hughes to the exclusion of all others and had asked DCO whether or not the father should be supported. Nonetheless that the bereavement support stage had been reached he said Command retained primary carriage of
events. He accepted that functional responsibility for DI(G) PERS 20-5 and PERS 42-6 rested on DCO. Command's responsibility to manage the bereavement process he said was to be found in the CAF or the CDF Directive.

404. He said that he did not believe he had said that DCO would give Mark Hughes no support, though his statement records "DCO was following the wishes of the family and command by not providing any support to the father". He accepted that the CO's report said "the mother clearly does require some DCO support and further enquiries have to be made to ascertain the needs of the father". Of the CO's drawing attention to the need for investigation of the father's position, he said "the father is not a nominated next of kin, so therefore I will not chase down the father, I won't chase down the PEC to find the father, because even if I knew where the father was and I could contact him, I wouldn't do it". The information about the father contained in DCO SITREP's he said was highlighting a potential risk. There are no circumstances he said where he would contact the father if he is not nominated in the PMKeyS as a next of kin.

405. He was then asked "Are there no circumstances in which you would make contact with the father of a deceased member other than those that you've mentioned, i.e. if they're nominated as a next of kin or a nominated next of kin says 'please provide some support'?" To this he responded "In the situation where the member clearly hadn't filled out any of the information available to us that we could probably then step back into some legal advice and seek how best to then resolve that situation": Asked if the references in the NWCC database to Mark Hughes as SEC were a discretionary factor for him to take
into account, he asserted that he would "remain with the PMKeyS data...I would not contact the father in those circumstances."

406. Mr Callan appeared to accept that in readily imaginable circumstances it would be inappropriate to proceed by a rigid adherence to the routines he had identified saying "it would depend on what information – every case is different. It'd have to be on a case by case basis" which led him to accept that if other information were available it may persuade him that it was appropriate to make contact with the father. Asked about accessing other information, he responded "but when it's absolutely clear cut, as it was in this case, you stick to the process".

407. I found this evidence to be confusing in its changing and contradictory positions.

408. Mr Callan in response to Counsel Assisting stated that DCO had engaged with Mrs Hughes as the person on the ground who on the advice that DCO had, had access to the body and was thus responsible for the funeral. Mr Callan agreed that one doesn't become the personal representative of an estate merely by being nominated in a will but added "unless you're nominated as the executor". He accepted that the question of acceptance of such a nomination as executor remained for determination.

409. Counsel Assisting posed a hypothetical situation where an unmarried member nominated persons as his PEC and SEC who were not his parents, and asked whether engagement between DCO and the parents would not occur, notwithstanding DI (G) PERS 20-5. Mr Callan said that was correct, adding that by working with the PEC and the SEC he would expect that DCO would engage with the hypothetical member's parents. He agreed that if the PEC and
SEC did not know where the parents were, Defence was in an awkward position."

410. Mr Callan shared the reservations expressed by others as to the accuracy and currency of material stored in PMKeyS. "Taken to his statement "Extant policy indicates that the PEC must be informed and if this had occurred, the information would have flowed to the next of kin" Mr Callan disagreed with the suggestion that reliance on PMKeyS to identify PEC was uncertain. In his experience he said the process does work quite effectively nine times out of ten, resulting in identification of the NOK. On this approach Mr Adams might have contacted Mark Hughes, but would he have been regarded as SQNLDR Hughes's next of kin? He was not on PMKeyS, a stated sine qua non for DCO's acceptance as an NOK.

411. Mr Callan repeated that he recognised the risk of Mark Hughes seeking to attend the funeral. His risk mitigation strategy was to attempt to have the family sort it out amongst themselves, intervening only if that failed. He recognised that that strategy may not have worked in the circumstance of the Hughes estrangements, and added that DCO probably didn't have the time to do it. He had he said waited until the last possible moment to make an intervention because he was hoping the family would sort it out. That strategy seems to me unlikely to succeed when the agreed approach was to deny all information to the father and the two major claimants do not speak to each other.

412. Mr Callan said that the references in the CDF Directive to PEC and NOK, coupled with references to PEC and/or NOK were productive of confusion and inconsistency. DCO he said were aware of that and were working through a process put in place by the system of Defence Instructions to try and resolve
the issue. DCO was he said engaged in the process so far as Dls relevant to DCO was concerned. Mr Callan did not agree with Counsel Assisting's interpretation of paragraph 3(c)(iii) of Dir(G) PERS 20-5, which paragraph defines next of kin in what appears to be a cascading manner, the last of which reads "in the case of a member without dependants, the father and the mother." Mr Callan interpreted that paragraph in a manner that meant that in the absence of any person nominated and recorded as the person's immediate family, the investigation ended there. Mr Callan stated that if PMKeyS contains no nomination of next of kin paragraph 3(c) has no operation. Taken to apparently contradictory provisions in the Guidelines for Bereavement Support,7 where next of kin are described in terms including "parents"; Mr Callan stated that that did not necessarily entitle parents to get travel and accommodation to attend a funeral at public expense. They could be refused, he said because the relevant terminology utilised the phrase "return travel and accommodation to attend may be provided..." that phrase he said was to be differentiated from "is to be provided" or "must be provided". I intervened at that point, as the debate had strayed a significant distance from legal reality.

413. I returned to the matter of concern in my own mind following what Mr Callan described as a formal submission... I identified aspects of the evidence occasioning me concern and said "The question that exercises my mind is that in fact nothing happened within the Department until the balloon went up the following day and Mr. Hughes was at the gates." That was a reference to the line in Mrs Thomson's email sent at 1143 Thursday 24 January to Mrs Croft that stated "We can obviously look at another DSW to support the father". I went on "Is there anything else that I should know about the period after Thursday after 1143?" Mr Callan responded that the process envisaged
by Mrs Thomson was exactly what he would expect his staff officers to do. There was little time to react to the email. He agreed that Mrs Thomson should have followed up with a phone call. His own view was that he would not act until it was the last safe moment because he did not wish to ride rough-shod over the case management team when they could be in the position of dealing with the issue. The failure to follow up he conceded was “one for our lessons book”. He did not think that given the time he would have acted any earlier than in fact he did. The team he said had to work their way through the matter and while a follow-up telephone call from Mrs Thomson might have hastened the particular process, he was uncertain whether it would have achieved the aim. Having heard Mrs Hughes on the subject, I share the DG’s doubt, but on the other hand, when it was presented to her as a fait accompli the following day, Mrs Hughes accepted the situation. I voiced the concern that the further line in Mrs Thomson’s email “therefore we need to make every effort to find the father, to contact him” seemed to me to require no more than picking up a phone and talking to Mark Hughes.

414. I have carefully read the submissions made on behalf of DGDCO of 22 May 2009. These commence with an assertion of a misconception “that a decision had been made at DCO HQ not to provide either details of the funeral arrangements or bereavement support to the deceased father. No such decision had been made.” This is an erroneous statement of the Inquiry’s interest, which turned on evidence that:

(1) DCO was party to a decision to deny to Mark Hughes details of his son’s funeral arrangements and

(2) that no decision on bereavement support to him had been made before the events of Friday 25 January.

I am comfortably satisfied that both those propositions are established.
415. The submissions next address notification of death and DCO appointment of a BST. Submission 8 asserts "the CO’s FATALCAS signal of Monday...nominated the mother as the NOK (Vol 02 03 p. 475-477) thus effectively cutting out the PEC/SEC/NOK nominated by the member in PMKeyS". Submission 10 asserts "the CO...override the deceased’s last nomination of his wishes in PMKeyS". Examination of the signal does not support submission 8. I do not accept submission 10.

416. Submission 14 submits “the notification of the PEC/SEC and then presumably the father should have occurred on the evening of Monday 21 January 08”. I have accepted that the CO had the discretion to “arrange notification”, and her reasons for acceding to Mrs Hughes’s wishes in this regard fell properly within her discretion.

417. I accept that the issue of notifying the PEC was raised by DCO on Tuesday 22 January as submitted in Submission 16. It is however the inescapable inference from the STREP 2 of Wednesday 23 January 2008 and the entail of Thursday 24 January 2008, both DCO documents, that the matter of determination of support for the Tasmanian relatives was not followed through before the events of Friday 25 January. Mrs Cril’s and Mrs Thomson’s evidence support that view. I do not accept the submission “there is no evidence of what precisely the CMT did as a result.”

418. Submission 17 says “Mr Hughes...on Wednesday 23 Jan...had not sought help from DCO, presumably because he had not been informed by Mrs Hughes, PEC/SEC of his ability to do so”. Whilst I have no doubt that none of Mrs Hughes, Vivian Adams and Mark Lees advised Mr Hughes of his ability to seek help from DCO I do not regard these persons as having any obligation or even knowledge in this regard. I attribute his lack of approach to DCO to his own ignorance of his entitlements. Mr Callan told the Inquiry that Mr Hughes had no entitlements, as he is not the NOK nominated in the PMKeyS.
419. Submission 24 addresses "the Will and the Executors" but does not address any of the problems identified in evidence.

420. Mr Callan submits "the PEC/SEC should have been informed of the death on the Monday evening. That would have at least given them the opportunity of giving Defence the father's details, and would have passed onto them the assistance available to them or relevant relatives". But the father's details had been located by DCO in the NWCC databank on Tuesday 22 January. The implication that PEC/SEC should have advised Mark Hughes of his entitlements is not a proposition readily apparent to me. I read the submission as a criticism of Command for failing to make personal contact with the SEC, with the implication that had that occurred the father would have sought help from DCO and a timely decision would have been made. I am not prepared to speculate on the likelihood that that chain of events would have occurred.

421. The issues raised by the notice given to Mr Callan were the decision to deny Mr Mark Hughes details of the arrangements for his son's funeral until Friday 25 January 2008 and the failure to consider and determine the question of support for the Tasmanian relatives of SQNLDR Hughes in a timely manner.

Findings:

The CO's Decision to Notify the Tasmanian Family through Mrs Hughes.

422. I see no criticism of WGCNR Walker in her implementation of the notification process. She accepted that both Mark Hughes and the PEC nominated on PMKeyS, Vivian Adams would be notified by Mrs Gail Hughes. Her judgment was vindicated; both men learned of the death on Tuesday 22 January 2008. WGCNR Walker gave directions to locate Mr Mark Hughes and expected that DCO would take up questions of support when contact was made. Chaplain Paget initiated that process but stopped short of asking Father Barker to make contact, perhaps because the matter though present in the
collective DCO mind was not at that time the subject of a decision to offer support.

423. I recognise that some confusion attends the interpretation of relevant D1(G)s, but I do not think that any confusion is relevant to the failure to make contact with Mr Hughes, Mr Adams and others in Tasmania to whom support might have been offered. Accordingly I do not see the failure to make contact with the Tasmanian relatives as a systemic failure.

The Decision to Deny Information.

424. As DGDCO Mr Callan bears the responsibility for the decisions made by DCO officers. The decision to deny information to Mr Hughes was one not made by Mr Callan but in which he had acquiesced. His basis he said was solely because of the absence of Mr Mark Hughes from PMKeyS. All other parties to the agreement were motivated by a belief that Mr Hughes was estranged from his son, that he bore the unfavourable character assigned to him by Mrs Gail Hughes and that there was a real prospect of him creating an unseemly scene should he attend the funeral. Whilst one may criticise the failure to look into the information that formed the underpinning for a serious decision that was plainly at variance with expectations surely shared by all parents, I do not see that any such criticism turns on any shortcoming of a systemic nature.

Consideration of Support for the Tasmanian Relatives.

425. The need to consider the position of Mark Hughes and by extension the Tasmanian relatives was present from the outset and was recognised by DCO in the SITREP sent by MAJ Bancroft at 1320 on Tuesday 22 January 2008.

426. The concept of fractured families is a familiar one, well known to Command and DCO. The need to consider and determine the desirability of a second
bereavement team, or an additional DSW dedicated to Mark Hughes and associated family members was raised several times, the last when it was raised by Mrs Croft in an email of Wednesday 23 January, which email occasioned Mrs Thomson to raise the matter for HQDCO determination by email sent at 1143 the following day. That email was not dealt with by its recipients and its author did not pursue the question further. By Friday 25 January the question was overtaken by events. A belated decision was made to support Mr Hughes and his sister and arrangements were put in place for them to be taken to SQNLDR Hughes’s funeral and to view his body.

427. No explanation as to why no decision was made before Friday 25 January was proffered. Nonetheless I do not characterise the failure to determine the question of support as a systemic problem. Whilst I do not accept that a funeral held four days after Command and three days after DCO learned of a death provides insufficient time for questions of support to be determined, the delay in the present case seems to me to reflect human rather than systemic failure.

428. I asked Mr Callan whether or not in the consideration of the events after they had occurred he had identified any systemic change that might assist in ensuring that a similar situation would be less likely to occur in the future. Mr Callan responded that the wash-up after the event had not identified to him anything that needed to be changed at DCO level and no change had been implemented. If indeed no change has been introduced I do not think that adequate thought has been given to the problems encountered in the present matter and the potential for negative publicity that might have followed.

429. Mr Callan was invited to make submissions “if you can see some way that it could be tightened up or precluded altogether from a recurrence then I would welcome such a submission.” Submissions were received on behalf of DGDCO dated 22 May 2009 in which the problems encountered are attributed
to a failure to follow the notification process. Mr Callan has not addressed any submission to the issues to which I drew his attention whilst he was giving evidence.

430. I found Mr Callan’s evidence to be confusing and internally contradictory. Some of his answers were at odds with the evidence of other witnesses and on occasion at variance with what I would have expected. I do not of course claim to be either experienced or expert in the operations of DCO. But much of what was discussed involved matters of legal interpretation and legal practice. I accept that the documents guiding action in the areas associated with the death of a serving member were productive of confusion amongst those charged with implementing the necessary actions, and there is in my view a strong case for having those documents considered and where appropriate revised to eradicate contradictions, ambiguities and directions that cannot be sensibly implemented in the same way in all Services.

431. I believe Mr Callan executed his role in respect of both the decision to deny information to Mr Hughes and to offer no support before Friday 25 January 2008 in accordance with DCO practice, his understanding of the relevant governing documents and such legal advice as he received. Such deficiencies as were demonstrated appear to me to be ingrained systemic shortcomings that require further consideration. I do not think that any criticism of his actions at a personal level is warranted.

I report accordingly.
PART C – Recommendations.

Integration of Medical Records.

432. The Inquiry was told that SQLNDR Hughes’s psychological file was kept separate from both his unit medical record located at the Area Health Centre, and his central medical record kept in Defence records at Canberra. Records of pharmaceutical items dispensed, the Inquiry was told are kept on separate databases at each base and on a central pharmacy record. The base records are not transferred when a member is posted elsewhere or deployed and the databases are not set up to communicate with one another.

433. It follows that a psychiatrist to whom a member is referred may rely entirely upon the member’s account in respect both of prior psychiatric attention and the nature and extent of drugs to which the member has had access. A member who is abusing drugs is unlikely to disclose this fact and his/her account of earlier incidents may lack accuracy for many reasons. These lacunae are more likely to occur when the referring GP is a civilian as was the case here. Access to the member’s records may cast significant light on the member’s diagnosis.

434. The Inquiry was informed by a medico formerly with the RAAF that software programs that provide access to a databank containing patient histories and prescribed medication is in common use in civilian practice. It was beyond the scope of the Inquiry to determine how such systems operate and how issues such as privacy have been addressed. The importance of an accurate history and knowledge of current and past medication was acknowledged by all relevant witnesses.

435. Unless there be good reason not to do so it would seem sensible to consolidate medical records, psychological records and pharmaceutical records in a manner that permits access thereto in appropriate circumstances by doctors charged with diagnosis and treatment of service members. This may
necessitate the obtaining of member’s consent either in advance or when the need arises.

436. I recommend investigation of the viability of recording the medical histories and drugs obtained through ADF onto a central accessible database to include

- Records of consultations with medical practitioners by a member;
- Records of consultations with external medical practitioners;
- Records of results of medical investigations and testing;
- Records of the prescribing and dispensing of drugs obtained; and
- Records of consultations with psychologists.

The Use of PMKeyS and NWCC Databases.

437. All witnesses relevant to the subject agreed that the PMKeyS is notoriously out of date in respect of many members. WGCDR Walker knew SQNLDR Hughes’s PMKeyS entries to be incomplete. Mr Callan said that the DCO will have reference only to PMKeyS. By submission of 22 May 2009 DGDCO submits that “DGDCO supports any recommendation to get rid of the NWCC database.” DGDCO in evidence said the PEC and SEC ...(are) the only people... we had a responsibility to provide information to.” Mr Callan said also that a person must be recorded as NOK in PMKeyS in order to qualify as a next of kin.

438. Nobody seemed to accord the NWCC database any standing and its use to record the wishes of members about to be deployed has obvious potential to create a situation conflicting with that recorded in PMKeyS. Members who have updated or completed NWCC records may imagine there is no need to
update their PMKeyS. There seems no reason why members ought not to be required to update their PMKeyS entries on an annual basis.

439. WGC/DR Walker submits ‘members should be required to enter parental details in PMKeyS and that a default position should be established where both parents will automatically be notified of a casualty unless the member has advanced an acceptable reason for not doing so. This reflects a suggestion raised in evidence but I do not think I am in a position to offer a direct view as to how the unsatisfactory situation disclosed might best be addressed.

440. I recommend that the status of the two databases be clarified.

441. I recommend that where use of the terms NOK, PEC and SEC is appropriate, an explanation of the meaning and purpose of those persons be included.

442. I recommend that the obligations of members in respect thereto should be identified and attention given to the manner in which members’ compliance with their obligations may best be ensured.

Defence Instructions (General) and CDF Directives.

443. It is apparent from the evidence to the Inquiry that considerable confusion attends the status and practices associated with the use in the Df(G)s of the terms “next of kin”, “primary emergency contact” and “secondary emergency contact”. Similar confusion extends to the rights of a person named as an executor by a will, the mechanics and timeframe for renouncing an entitlement to take out probate and the role and rights of such a person should he or she take out probate of a serving member’s will. The Inquiry heard that for a time DCO were acting under the belief that the person physically in possession of a body had the legal right to dictate the means of its disposal.
444. DGDCO told the Inquiry that if no person is nominated NOK in PMKeyS, para 3(c) of Dl(G) PERS 20-5 has no operation and DCO has no statutory responsibilities pursuant to the Defence Instruction. He said that unless somebody is nominated and recorded there is nobody that answers the description in the definition and it follows that the father or mother of a deceased member not nominated in PMKeyS as an NOK has no entitlement to the assistance for which the DI provides. I cannot accept this construction.

445. Dl(G) PERS 11-2 as modified by CDF Directive of 29/2006 and CAF Directive 01/2007 provide the directions and policy guidance in force at the time of SQNLDR Hughes's death in January 2008. The interpretation of directions and policy placed on these documents differed considerably as between those charged with their implementation. Witnesses differed as to whether the Dl(G)s and Directives have any operation in the case of a suicide. This turns upon whether the word "casualty" is to be read as including a death that was not the consequence of some incident of service.

446. The Oxford English Dictionary defines "casualty" as:

1. Chance, accident (as a state of things).
2. A chance occurrence, an accident: esp. an unfortunate occurrence, a mishap: now generally, a fatal or serious accident or event, a disaster.
3. Milit. Used of the losses sustained by a body of men in the field or on service, by death, desertion, etc...

[Emphasis added.]

This suggests that the death of any serving member is a casualty in a military setting. But PERS 11-2 defines casualty as "A member who is killed...."
447. The definition of "member" in paragraph 3(e) of the same DI limits that category to persons performing full-time continuous service at the time of death. It is my view that a member on leave without pay does not meet that definition. It is not difficult to envisage other factual situations that would give rise to anxious concern as to the applicability of the Directive. There is a case for clarification of this aspect as well.

448. From a legal perspective there are arguments either way but this is not to the point. It is plainly desirable that those charged with implementation of the DI are in no doubt as to its application or lack of application. The relevant DI was re-issued in May 2008 but the interpretation problem remains.

449. In the present Inquiry it was not in issue that the father of SQNLDR Hughes had not been told of his death by the CO of his unit. Much was made of the accepted position that "notification is a matter for Command." The relevant Directive term requires the CO to "arrange notification", a phrase that conveys the existence of a discretion in the CO as to the how that might be best be done in individual circumstances. The intent could be made clearer.

450. DDCO stated that his concurrence with the decision not to inform SQNLDR Hughes's father of the details of his funeral was justified by the circumstance that the father does not appear on PMKeyS as NOK, PEC or SEC. Because the father is not a next of kin nominated in PMKeyS he said he would not make contact with him.

451. Taken to DI(G) PERS 20-5 he agreed that DCO would fund Mr Vivian Adams had he asked to attend the funeral. Mr Callan said that DCO does not start to operate until PEC has been notified. His view was that Command had not followed procedures of the notification process.
452. I did not read all the Di(G)s as did Mr Callan. Other witnesses too had different interpretations, not all of them consistent with each other. There is in my view a need to revise the terms of those Di(G)s that the Inquiry saw, both in form and in some instances substance.

453. The understanding or misunderstanding of the legal role of an executor, the absence of any legal power in a nominated executor before probate is granted, the need to apply to renounce executorship and the time frame for obtaining Letters of Administration thereafter are matters requiring elucidation amongst those called upon to deal with the aftermath of a death. The standing of a SEC and an SEC, if indeed it goes beyond mere nomination for notification purposes should be clarified and disseminated. Finally the term next of kin, which has a legal connotation, is defined in PERS 20-5, par. 3(c) and under (d) any uncertainty is dealt with only by referral to HQDCO. But by Di(G) PERS 42-6 par (5) the matter falls within the discretionary nomination of DGDCO. This is a situation of potential legal uncertainty.

454. Allied to this area is the confusion surrounding the role, status and legal rights of a person nominated as an executor of a will and the legal steps associated with grants of probate and renunciation of executorship. Whilst grants of probate are within state law there is little difference between the various state provisions. There is in my view a need for legal advice on these matters to be provided to those charged with dealing on short notice with problems of the kind thrown up before the Inquiry.

455. I recommend that the question of the interaction of the relevant Di(G)s and associated Directives be reviewed with a view to identifying and remediying any internal inconsistencies and ambiguities, ensuring that they reflect current policy settings and the legal rights of potentially affected parties.
RAAF Deployment Records.

456. The Inquiry heard hearsay accounts of a number of events said to have affected SQNLDR Hughes whilst on overseas deployment. Some of these events it was suggested and later submitted may have had a bearing on SQNLDR Hughes's medical condition and upon his decision to end his life.

457. Counsel Assisting the Inquiry report that considerable time was expended in endeavouring to locate records relevant to SQNLDR Hughes's deployments in the Solomon Islands, Iraq and Timor L'Este. They report that other than the reports of SQNLDR Hughes himself from Iraq—no records could readily be discovered. The unavailability of such records required investigation of the allegations by less reliable and more circumlocutionous means.

458. I recommend that attention be given to the adequacy of the existing system for creation and retention of records of members' service overseas.

Pharmaceutical Access at Tindal Base.

459. GPCAPT Leschinskas had been instrumental in putting forward SQNLDR Hughes to replace her in Canberra as the Director of Military Medicine in 2007, an offer that SQNLDR Hughes declined citing personal reasons.5

460. GPCAPT Leschinskas was asked about the circumstances at Tindal and confirmed the difficulty in obtaining civilian medical officers to go there. She referred to the problem posed by the spread of activity over many hours of the day.
461. In response to questioning on issues raised by FLTLT Clark, GPCAPT Leschinskas referred to the appointing of a nursing officer as the OIC of the facility and the manner in which that decision had assisted to some extent. She referred also to efforts to obtain civilian assistance and expressed the hope that that would reduce the present requirement for cyclical turnover.

462. After discussion of the limitations of an Inquiry such as that on which I was engaged GPCAPT Leschinskas said that she could identify no area where change could sensibly be recommended. She added as an afterthought the suggestion that perhaps I could add my voice to those seeking a greater allocation of funds to the area. I did not encourage her to think it likely that I would do that, which disappointment she bore bravely.

463. Evidence before the Inquiry established that recording of the dispensing of prescription level drugs occurs on both a national pharmaceutical database and on a database at RAAF Tindal. The national pharmaceutical database is intended to record the totality of the prescription drugs obtained by members from service sources. Both are reliant upon input from the various service bases. In the present matter reporting from Tindal was deficient in respect of a period of more than two years, apparently because those at Tindal were unaware of the requirement to pass on data generated at that base. The failure to forward data went un-noted for a considerable time. LEUT Clutterbuck submits "where an individual had a predilection to addiction, the system itself provided a smorgasbord of medication... which... was entirely or without doubt in a major way causative of his death".

464. The Inquiry considered SQNLDR Hughes's database records from his time at RAAF Tindal, and those from his time at RAAF Amberley, and heard evidence that established considerable laxity at least in the system at Tindal. The precise quantities of prescription medication including Schedule 8 drugs
to which SQNLDR Hughes had access could not be obtained with accuracy. What is clear is that he obtained drugs for his own use in various unrecorded ways, and he appeared to obtain access to drugs through Tindal after his posting to Amberley. FLTLT Clark said that there is no imprest cupboard for prescription drugs and access is unrestricted to medical staff in the absence of the civilian pharmacist.

465. The Inquiry was told of software programs that involved automatic alerts of unusual and dangerous patterns of prescription by the monitoring of a database. The Inquiry was told that the existing system did not permit the exchange of pharmaceutical information between Tindal and Amberley.

466. The ability to detect drug abuse would be greatly enhanced were such information to be more rigorously recorded and more readily accessed. That development would not deal with the possibility of abuse of the local system by the doctor in charge, a problem that may necessitate some form of audit. The shortcomings of the system at Tindal would in my view justify consideration of the existing system and its civil counterparts, and potential improvements to the former.

467. The problems at Tindal of which the Inquiry heard related to the period prior to 2008. Sensible recommendation would in my view require an inquiry specifically directed to its present shortcomings, if any.

468. I recommend that the significant irregularities in the conduct and practices associated with dispensing pharmaceuticals at Tindal between 2005 and 2008 be the subject of an investigation.

I recommend accordingly.
AUTHORISATION

I, Richard John Burbidge QC confirm the findings and recommendations presented in this Report into the death of SQNLDR ADAM LUKE HUGHES 8143873, CSC.

Richard Burbidge QC
President of the Commission of Inquiry
12 June 2009