Royal Commission Update – Sydney Day 12 – 15 February 2022

RSL References

Positive:
NA

Negative:
NA

General Summary

- Lived experience of exclusion and mental health issues caused by anti-LGBTQI discrimination
- Insufficient support for families before, during and after a death by suicide
- Insufficiency of current coronial systems for dealing with death by suicide of ADF members and veterans, and their relations with families
- Possible 'quick fixes' to improve these coronial systems

10:00am – Ms Glenda Weston – Mother of Bradley Carr – died by suicide 2019

- Mr Carr was an outstanding soldier who deployed to Afghanistan for 8 months
- Different immediately on return – angry, eyes glazed, increased aggression, anxiety
- Debriefing in Dubai was ineffective – tickbox exercise to return home – believes should be debriefed a home and retaught how to become a civilian
- Mr Carr suffered in silence – Army knew he was suffering – diagnosed with PTSD and accepted injuries
- This led to overmedication, which continued after discharge with DVA doctors
- Lost sleep due to flashbacks
- Understanding and support was needed from ADF – instead, he was medically discharged
- Suicide attempted before and after discharge – family reached out for help, but ADF said 'not our responsibility' – no support offered
- During discharge and transition, ADF brought 'trumped up' charges against Mr Carr – form of additional punishment to make an example of Mr Carr
- Entered Greenslopes repatriation centre, but was released
- Mr Carr had physical injuries requiring multiple operations – 6-year battle to get Gold Card with DVA – only had first operation after 6 years – received constant on off physical and mental health treatment
- DVA cannot keep changing goalposts – destroys the drive and will of veterans

- Early intervention is required – ADF need to notice and deal with PTSD, not ignore and punish

11:45am – Mr Danny Liversidge - RAAF

- RAD tech training – lagged training after family accident – remustered to Transport – RAAF provided some emotional support, but essentially forced career change
- 4 years into service, anonymous complaint made – told to present for military interview and to source legal representation – told Padre would be provided if legal rep couldn't be found – not told what the interview was to be about - Legal rep waiver was signed before told what interview was regarding
- Formally and publicly marched, isolated – sat in room with two MPs, bade commander and flight commander on other side of table
- Presented with picture of LGBTQI bar – first realised it was about sexuality – had been under surveillance – a 'safe' space had become unsafe
- 'I wanted to crawl under a rock and die' – shaming and humiliating – first said out loud that he was a homosexual man
- Dates and times were presented and Mr Liversidge interrogated – 100+ questions, 2 hours – extremely personal and graphic questions Asked about others on the base – interrogation became aggressive with bullying – Mr Liversidge became terrified, hating himself, humiliated in front of superior officer
- 'Homosexuality is incompatible with military service' – career was ended – job performance was not an issue at all – considered the best in his team – these rules changed a year later
- Given three options: Leave (apparently honourably), dishonourable discharge following an investigation (with training papers withheld), if he was to fight and was successful, career would be stuck in stasis – chose to leave, having to make the decision straight away
- Following interview, told to return to work and not say anything – discharge process begins – not allowed to say goodbye to anyone – returned all uniforms and insignia
- No transition support – escorted off base with $1500 to his name – hadn't told family because of shame, so had nowhere to go and therefore slept in his car – in the space of 2 weeks jobless, careerless, homeless and sleeping in his car – close to suicide
- Following years – self-hate, lack of self-worth, didn't tell family – 'a wounded person' – felt labelled and led to getting into bad relationships
- 2016 – Andrews Government in Victoria apologises for discriminatory criminalising of homosexuality in Victoria, and has convictions expunged – inspired Mr Liversidge to share story on Facebook, eventually receiving a reply from Mr Andrews
- Met Yvonne Sillvett (see Day 11 summary) and contributed to *Serving in Silence*
- No support from Defence or DVA – took external support to know he was entitled to White Card and Mental Health Treatment – should be proactive reaching out from Defence and DVA, information provided to all serving personnel
- Apology from ADF would be huge – some sense that a wrong had occurred, where his sexuality had been made to feel wrong

2:00pm – Panel discussion – Expert Witnesses – Coronial systems

The Hon. Jennifer Coate AO (Judge, Family Court of Australia, State Coroner of Victoria), Dr Ian Freckelton AO QC , Mr Hugh Dillon (former Deputy State Coroner NSW)

Urgent measures to be implemented – Coroners:

- Mandatory consultation with families and colleagues
- Mandatory consideration and response to families of questions
- Recommended not to require inquest if family requests it
- Embed similar models to the Family Violence Death Review model currently in State bodies for deaths of current and ex-serving members of the ADF
- Coroner's Prevention Unit – teams who monitor deaths each day to identify trends and clusters of similar deaths, and determine if further investigation is necessary
- Require publication of Coroner's investigations and government responses to recommendations and findings
- Resource these teams appropriately as in Victoria – 28 researchers, multiple solicitors, investigators etc. Cost of approx. $20 million per year

Coronial systems:

- Need to make systems less legalistic and administrative, more human, with a human rights focus
- Initial investigation is important – conducted by police, so results can be variable – often veterans are not identified in these initial reports, and this should change
- Epidemiological approach to coronial investigations encouraged –
- The National Coronial Information System (NCIS) is the world's first national Internet-based database of coronial information. It was established in Australia following the recognition by coroners that their mandate for public health and safety could be improved if they could identify previous similar deaths.
- Federal Coroner not realistic at this stage – may be a long-term option, which requires the approval of all possibly involved Federal agencies and reform of the constitution

Coronial systems necessary elements:

- Fact finding function
- Minimisation of preventable deaths
- Therapeutic and restorative elements for loved ones
- Protection of life
- Public health

Notion of Suicide:

- Complex issue – intention of the person who has died is difficult to decipher
- Facts of deaths do not always allow for determination of single word outcome i.e. suicide – for example, in the case of single vehicle accidents
- Need to move beyond single word definition – suicide – and towards reflection upon intention, capacity, timing, and actions
- As this is not yet the case, the actual number of deaths by suicide may be underrepresented