Royal Commission Update – Townsville Day 39 – 29 June 2022

RSL References

Positive:
NA

Negative:
NA

9:00am – 10:30pm – Hon. Leonard Roberts-Smith RFD QC continued

Inquiry into abuse at ADFA

- 50 complaints of abuse – high % were sexual abuse – mostly regarding 1990s – broken down by gender there is a large bias towards complainants having been female – cadet-on-cadet abuse largely, groups of males - Trainee hierarchy – used to perpetuate abuse
- ADFA has outsize cultural influence role – once graduated, next day they go out and start their officer roles
- Physical abuse included hazing rituals – 'woofering' – harassment and bullying
- Reasons for underreporting abuse – culture, lack of reporting mechanisms, stigma, threats of reprisal, lack of confidence in staff at ADFA
- Lack of effective reporting mechanisms – those who did report were subject to stigma and shame – no culture of reporting – lack of confidence in members of staff – staff also involved – no response or inadequate response
    - This lack of reporting was extended to people who were in positions of support i.e. medical staff
- Punished for reporting, particularly for women who were sexually assaulted – threat of being charged with fraternisation – chain of command was sending a message that reporting was not acceptable – abuser saw they could act with impunity, dissuading reporting and encouraging future abuse
- Evidence of bystander behaviour or other actions that should have been addressed by chain of command
- Contributory factors to assaults – alcohol, power disparity between perpetrator and victim (senior male cadet perpetrator), gender issues, staffing, security
- Still-serving alleged abusers – identified at least 60 individuals between 1980s and 2000s who were still serving – additional 10 who were on inactive reserve
- By end of tenure, was unaware of any action being taken by anyone who was still serving
- Recommended Royal Commission be held into ADFA abuse because no response was being taken to these historical cases – examining Defence mismanagement and culture
- Long-term effects on those who suffered abuse at ADFA – some left Service, evidence of suicidality

Abuse in Defence

- For the first time ever, some of those who were abused were able to speak up – hard to decade-by-decade analysis
- Profile of abuse changed over time – sexual abuse charted decline since a peak in the 70s – still prevalent in the Navy in the 2000s – Navy was the highest proportion of abuse complaints – harassment and bullying didn't change much over time – historically high in the Army
- Had ongoing, informal contact with the Defence Force at multiple levels, including CDF
- Abuse perpetuates an impairment of the capability of Defence
- Sexual abuse of males was an exercise in power and hierarchy – assaults on women were more sexually-oriented or abuse of power, not hazing
- Factors contributing to abuse – authority and hierarchy – difference between official and unofficial power – rank, institutional unofficial power, individuals who exercise power without holding significant organisational power
- Senior NCOs will be defining culture on a day-to-day basis – need to keep an eye on the culture of officers at the small group level and the closed small environment – if there is abuse in this setting, then the abuse will continue – needs a circuit breaker
    - Suggested giving this role to the Defence Ombudsman
- Had similar complaints from the Apprentice Schools as about the other training institutions (ADFA) – fundamental failure by Defence to protect these young people
- Aftermath of DART – individuals who committed serious offences, but were never held to account – some were referred to the Police – doesn't recall seeing results
- Difficulty in locating DART Taskforce reports – should be widely available to help to learn lessons

10:45am – 12:15pm – Rachel Baker, Area Manager, Defence Member and Family Support – Captain Glenn Kerr, RAN Provost Marshal, Australian Defence Force Group – Captain Karen Breaden, Director of Personnel, Headquarters Joint Operations Command – Lieutenant Colonel Glyn Llanwarne OAM, Staff Officer Grade 1, Fatalities, Army Headquarters

Mental health support

- Mental health support – incl. psychologists – will be deployed with a larger force – risk is also taken into account – there will always be a psychological element on standby, ready to move within 48 hours – if there is an incident overseas, we are ready to move people almost immediately
    - Deployed commander is responsible for mental health and wellbeing in the field – may not be trained in this
    - If deployed personnel want to access mental health services, they do not have to go through their commander, but this is encouraged – email, phone, senior NCO – if they take up this support, is the commander notified? – not always – does not always need consent for command to be notified
    - Is accessing mental support i.e. via Skype visible to the members' colleagues – could be due to close nature of the environment – unlikely that no one else would know – highly visible
    - Capacity for routine mental health care to continue when deployed?
- Psychoeducation before deployment to family members – could be a conversation, through the helpline, presentation, referral to social worker
- Chaplain can provide emotional support – circumstances where a member can call home is location/circumstance-based
- Capacity for members to build routines on deployment – exercise, social, training – facilitates connection

Critical incidents

- Critical incidents are managed on a case-by-case basis and they are subjective – commanders have responsibility for this management

    - Have different criteria for reporting depending on the type of incident
- How do you identify a critical incident? Very broad – What about a number of soldiers being distressed? This would trigger an investigation
- Process adopted by Army when there is a critical incident on deployment – response to incident is not at discretion of the commander, but within a framework of responses – junior soldier probably doesn't have the ability to go to chain of command – hierarchical process
- Psychological critical incidents – commanders do not have training to respond to the incident, but will trigger the response process – this is left to the health professionals
- Debriefing processes following critical incidents – usually group debrief, followed by opportunity for individuals to come forward to support team – usually occurs within 24 hours – framework for debrief is at the discretion of the commander – voluntary for those involved in the incident, but highly taken up
    - This process is led by commander and Critical Incident Support Coordinator, padres and Allied Health
    - Everyone has the chance to be heard, but often not taken up – not about individuals to speak about what occurred to them – commander will present facts of what occurred – want people to understand the process of what will happen
    - Process aimed at assisting members to normalise their emotions - factual overview of the event to stop speculation – helps to identify where they can go for support – records are kept of the debrief, which is not intended to be part of the investigative process
    - Tension between toughening up emotionally during training and then embracing your emotion during this process – there can be coexistence
- Critical Incident Mental Health support is the responsibility of the Critical Incident Response Manager – can make referrals to see other supports
    - Can include psychoeducation, and other structured interventions and rituals
- Screening done by Army Psychologist after critical incident
- After action reports can be provided to chain of command after a critical incident – step-by-step summary by commanders
- Are there assessments undertaken of the level of support available after critical incidents? Not aware of anything specific – not sure if this works
- No significant difference between how an incident is dealt with on deployment v. at home

<u>Chain of command</u>

- Welfare of soldiers is at the heart of Officer training from day one
- This is part of leadership training at RMC Duntroon for example – there is not specific mental health training
- Much of this has to do with monitoring the wellbeing of their soldiers – in terms of response, it is mostly process – not mental health clinical responses

1:15pm – 3:15pm – Dr Darrell Duncan, Director of Strategic Clinical Assurance & Ethics, Joint Health Command – Commander Samantha Juckel, Deputy Director, Navy Career Management/Military Employment Classification Review Board – Lieutenant Colonel Scott Foster, Staff Officer Grade One - Separations, Career Management (Army)

<u>Military Employment Classification System (MEC)</u>

- Complex bureaucratic system – who guides them independent of the organisation? – sits with Commanding Officer – JTA is oversight – no independent advice
- Difference between employable and deployable – employable means being able to be deployed in work group, with deployable being able to undertake operations in Australia or overseas – employment restrictions are how we can employ a member i.e. the duties they can carry out

    - May be limitations to access to certain areas of support or limitations about being able to get health care
    - Full employable and deployable – no restrictions, with some supports required
- Medical assessments can be done by nurse practitioners, but usually by Military Health Officer
    - Requirement to do military-specific training for these professionals – not always an occupational physician, could be any specialist – taught by teachers who have done this role
    - Functions as a risk-assessment/balancing act
- If a member is classified as being unable to perform their duties, they can be transferred to another suitable trade – they have 12 months to get up to speed once they've joined their new unit, to become deployable – every member must have a trade
- Where a member might not be deployable, they can be employed elsewhere if they can contribute to capability and remain employable – Member is employed at Service discretion
    - This is part of the Career Management Agency's role to decide – duty to find the right place for deployment – this is a five year maximum classification
    - This review is to ensure medical condition is compatible with role and force capability
- MEC Review Boards (RBs) often coincide with posting cycles – has to do with ADF retention
- Deployability is not a requirement across the whole force because of the skills some members may have that contribute to capability – overall, you are assessing someone's ability to go to war, but there is some grey area
- Treatment and management of conditions has improved to the point where people can deploy with a medical condition – there is a threshold of likeliness when considering whether medical assistance will be available overseas
- Duration of extended rehab is up to two years before being referred to MECRB again, including for pregnancy, when there is a return to work – but this is frequently handled at Medical Centre-level – doesn't automatically impact their career at all

<u>Negative mental health effects of the MEC system</u>

- Issues leading to thew MEC can also often cause mental health issues
- No study of outcomes of the system
- The certainty provided by the determination of MEC RB can be beneficial – worked hard to ensure process flows as quickly and efficiently as possible
- The MECRB process can be overwhelming for members with mental conditions, but the feedback said that Joint Health Command and commanders were generally supportive
- Worked on the MEC process to make it the best possible – education, greater engagement, aligning the three MECRB determinations, reducing the bureaucracy from the determinations so it's clear to the individual, plans to better educate Cos, created commander's guides and members' guides
    - Have been getting a lot of feedback from Army

<u>Procedure</u>

- Who initiates MECRB process – via the Medical Officer, CO, or MECRB
- In-session or desk review – Chair MECRB will determine whether it will be an in-session meeting
- Person may be downgraded if they haven't been able to recover during a rehabilitation process – would need to take into account a few factors – provided evidence can be conflicting
- If a decision is about to be made, what information is available to the decision maker? Members' health statement, workplace capacity report from the unit commander, medical officer is involved
- MECRB Chair makes the decision on classification – Board assists and provides opinion and advice – everyone on the Board gets a say
- There are steps for the member to disagree if they want to – once CO has received determination, info is passed to member – member can then seek other medical advice – workplace capacity report is seen by member before it is submitted
- Why can't a member attend MECRB? Potentially there is no harm, but there can also be stressors on the

member – could be up to 20 senior people at a MECRB, and this could be stressful during the assessment and then decision talking about potential separation
    - Not always to assist the member – decision is to get to change in MEC for the member
    - There is some discretion to allow members in, but would not be looking to do that – how could this be determined?
- MECRB session length depends on the case and its complexity – takes as long as needed to reach a decision – discuss each case on average for 15-20 mins
- Advice of the treating doctors is sometimes gone against – when advice of MEC Reviewers is contrary – if there is any doubt, benefit of doubt Is given to the patient

Transition
- Where there is a complex transition, there is a lot of support from JHU and Career Management

3:30pm – 4:30pm – Kim Mills, Acting Director, Transition and Coaching Directorate, Defence Member and Family Support Branch – Lieutenant Colonel Kenneth Golder, Commanding Officer, 3rd Combat Engineer Regiment – Lieutenant Colonel Stewart Holmes-Brown Senior Medical Officer, Australian Defence Force

Medical transition
- 18% of discharges across the ADF are medical discharges – it affects capability, but it is manageable
- Medical discharge - struggle where choice has been taken away from the – a decision they haven't been able to control
    - Where individuals are still ready and willing and passionate about serving, this can be difficult – needs better explanation and time to make this happen
- People in the Service are there for service – they know what they like to do – central purpose that they achieve with their teams and their mates
- Process of that transition is significant – there are many services available for support – encourage strongly members accessing these services – want to get the people locked in to those services – member is at centre of all services available to them, and it is opt-in
    - Doesn't know about opt-out system, think it is about education – otherwise it may strip away autonomy
    - Transitioning through Defence Member and Family Support Branch is mandatory

Transition support
- Encourage members to engage with transition coaches at any point in the career
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Mental health support
- Family life challenges are picked up first at lower levels of command – may notice a difference in behaviour, character in workplace, or put their hand up for a chat
    - Then pushed through chain of command for referral to available services

Psychiatric support services
- Could be better psychiatric support available, but is still quicker than civilian system – heavy utilisation of triage services
- Difficulty in getting members to report these types of issues

Wellbeing at barracks

- Major area improvement in the ADF Rehabilitation program – since going to BUPA there has been significant staff turnover - difficult to fill these rehabilitation consultant position

- Turnover when new consultant start and then leave – vacant position not being filled with long-term positions, but short-term fill
- Impacts through lack of continuity as single rehab coordinator cannot be assigned to a unit – constant handover, retelling of consultant, building relationships with chain of command
- Difficult position to recruit across all health positions in Australia
- No physicians with specialist rehabilitation qualifications at Lavarack – could be accessed externally, but no one in a uniformed capacity
- Having an occupational physician available could be valuable for complex injuries or for reports to DVA for claims

Welfare Boards

- Unit welfare boards run quarterly for members of the unit medically engaged and to gauge progress on rehabilitation – who attends is at discretion of the member – outcome is about helping the individual – told to the member when they are present
- Individual welfare boards will occur as result of event or incident within 14 days – small, distinct group – limited to three people depending on members' consent
    - Support officer is normally available to the member, along with family support, padre, mental health officer etc.

Corps transfer when medically downgraded

- Movement due to medical downgrade – uptake on this is often low, although it works
- Could they take lesser roles within the unit – challenge for officers to find non-deployable, compared to deployable roles in a unit
- MEC system tells chain of command about a members' employability at a point in time