Royal Commission Update – Wagga Wagga Day 3 – 30 November 2022

Kylie Reynolds – Lived Experience Statement - Army

- Was sexually assaulted by superior – had to keep mouth shut
- As a female private, was the lowest of the low
- Eventually excelled in the Army
- Assisted a friend in the Army not to commit suicide – was harassed following this intervention
    - Mental health began to decline – could not make everyday decisions
- Transition was incredibly difficult – felt lost – needed support of partner and service dog to get her through
- Poor dealings with DVA – no timely reimbursements, decline of payment without explanation, lack of understanding of medical conditions, lack of clarity around legislation, difficulties around use of MyGov
- Medically discharged

9:00am – 12:15pm – Colonel Simon Dowse – Conduct After Capture (CAC) Training

Conduct After Capture

- Directed at preparing some members of the ADF for the possibility of being captured in adverse circumstances – includes theoretical and practical training
    - Withstanding rigours of capture, resist exploitation by opposing force, maintain dignity, maintain safety as much as possible
- 3 levels – Level A (education), Level B (exposure), Level C (experience)
- Survival, Evasion, Resistance, Escape (SERE) is the type of training
- CAC and Resistance to Exploitation are essentially the same
- Has acted as Conducting Officer (direct responsibility for practical activity) for running recent CAC courses – control and monitor training, without being involved in the training – safety, effectiveness
- Aim for training is to build efficacy, faith, skills that they can respond to being captured and questions
- There is the possibility of injury during CAC training – taking advice from a range of ADF health professionals- includes staffing during the training
- Worst thing that can happen to anyone who is captured is to be unprepared – this can be part of operational readiness
    - It is part of duty of care to service personnel – allows them to survive what can be a very traumatic experience in the most possibly safe way
    - Can also be about the protection of information and security
    - It is about the person first, not the public affairs effect

- Can also protect against 'innocuous' questioning during the course of normal travel – broad spectrum of 'foreign government detention' – this was an additional benefit of the training

Studies

- No formal study quantifying the risk of capture
- No formal study demonstrating effectiveness of CAC training
- Every individual case where someone has been captured is examined – but there is no broader academic study
- Do 'lessons learned' but unsure if this is kept in a log
- Has there been any study of possible adverse effects of CAC training – ADF is conscious of this, particularly Level 3 CAC training
    - ADF consults with mental health experts about CAC training
    - There is no reference to outside mental health professionals for analysis

CAC Training Activity

- Level C in particular is well supervised – Conducting Officer, other layers of command, ADF medical technicians, at least 2 psychologists, 2 neutral Officers to keep dispassionate eye and maintain safety if they feel anything untoward may occur
    - Every aspect of a Level C activity is captured and monitored on CCTV systems, and if this isn't running, the activity is stopped – for reasons of privacy, can only be watched by resistance trainer, senior trainers, psychologists, neutral officers and Conducting Officer
    - Screens are a two-minute walk from the actual site
    - Video recordings are retained and held in suitably secure Intelligence site
- Medical technicians are present as activity is being conducted – if staff observe medical issues, they can let the med tech know
    - Learners can indicate medical issue to staff without fear of detriment – learner can then be attended outside the training location
- Each Level C activity is accompanied by a risk assessment
- Need for the training is greater than the risk to the participants
    - Determination of which personnel require Level B & C training, is done by deployment capability elements of the ADF, following broad determination of which personnel would benefit most from the training
    - Following identification, is psychological screening done to ensure those who are subjected in the training can handle it – unsure- must meet certain ADF medical standard (MECJ1/J2)
    - Pre-training screening may delve into past traumas – can help to design different training
        - There is risk trainees will omit any issues they may be facing
    - At start of Level C, process where Conducting Officer, accompanied by medic, receives learner in neutral environment – need to ensure the learner remains a volunteer
        - Medic will then go through questions re. the current medical state of the learner
- May be perception that there may be some negative impact on a member's career if they do not complete the CAC
    - Also benefits for deployment i.e. renumeration
- There are many factors that would encourage a member to engage in the CAC training
- Most of those who go through Level C CAC training know that this course lay in the course of their career when they chose their career path
    - Pre-briefing says that CAC is a requirement – may cause some confusion
- Very few withdraw from CAC Level 3 training – can pause the training and get some support to carry on, but this is a very small number

    - ADF does not keep data on when people with draw or when they seek a pause – but Conducting Officer does keep a log
- CAC Level 3 is dangerous, complex and sensitive
    - Safety measures include attitudinal (these are our colleagues), documentary (exhaustive instructions and orders re. safety), application (trainees escorted under approved measures every step once they are unable to move under own steam)
    - Complete and pervasive safety overlay
    - Unauthorised behaviour is countered by constant observation and culture of discipline – has never seen a report or record of unauthorised behaviour during CAC Level 3 training
- Reporting regime attached to Level C is very extensive – does anyone examine these records for patterns and changes relating to the training – it is possible that these reviews happen
    - When they are done, there is correspondence within the system that would seek decisions from senior Officers
    - There is also a debrief after the activity

Suicide and suicidality

- 45 members who have undergone CAC training are suspected to have died by suicide
- Can be a difference between hallucination and self-care
- Cannot recall trainees becoming unconscious during CAC training
- Do trainers have protections following the training that the learners have? No, not to the same degree – but can have contact with other staff to help them understand
- Long debriefing phase – conducted by people who've been in the activity, including pretend adversary
    - Never been an issue for either party during debriefs

1:15pm – 2:50pm – Robert Worswick – Medical Officer Army – Regional Generalist - Clinician contracted to ADF through BUPA

Medical Officer (MO) experience

- Included stint in Joint Health Command – provided advice re. suitability for employment and deployment of ADF members
    - Then Senior Health Officer in Southern NSW region
- Unique nature of military medicine – need to take organisational perspective
    - First priority is to health and wellbeing of individual ADF member
    - Then must provide advice to ADF re. ADF members' fitness for service
    - Sometimes the treating MO can get lost in the conditions, but may lose the longer-term view of the ongoing treatment and employability of the member
- Medical Welfare Board – Army, Navy and less so in RAAF
    - Great tool for Defence, which by and large work well
    - This is a Command responsibility, not a medical one

Recruiting challenges in ADF

- Lowering of recruiting standards relating to fitness to increase pool of candidates – worried this will perpetuate rate of veteran suicide – this includes slightly higher psychological risk allowance – Physical Fitness Assessment is the greatest barrier to the Army's inflow
    - Young people aren't as fit as they were, which is reflected in ADF – DFR providing a less-stringent ADF-wide standard

- This has impact on physical fitness – attrition rates for training of recruits
    - Attrition rates of injury in training, particularly muscular-skeletal injuries, can be high
    - i.e. Beep test can be a strong predictor of attrition in training – Army has removed beep test as barrier to enlistment
    - Removal of certain activities during Recruit Training as risk mitigation strategy – no study to the flow-on effect of these changes – intent to move these types of training to further along the training continuum
    - 30% of people who commenced Army Pre-Conditioning Program (APCP) i.e. were below standard on beep test, did not complete recruit training
    - Mitigation may be the provision of increased health services at Initial Training Centres, such as Kapooka
    - Increasing throughput of recruits as ADF grows, with generally lower standard of physical fitness – has not been commensurate increase in provision of medical services to account for this increase
- Has also suggested that restrictions on certain conditions be relaxed, but this should not include Musculo-skeletal conditions and mental health conditions – these are concerning because they often result in medical or non-medical separation
    - More waivers are being applied for more conditions
- No way of tracking later in life whether there is a correlation between injury in recruit training and wellbeing later in life
- Challenge for clinicians at Kapooka is that ADF training can reveal pre-existing conditions – those with aspirations, but who cannot make it through training – this is a real issue for the clinicians who advise recruits of this unsuitability
    - Some recruits' medical separation is commenced as soon as they get off the bus
    - Some recruits require care before they begin training – this requires additional doctors
- It is not necessarily the ADF taking on the additional risk – there is a need for informed consent for the individual trainees i.e. knowing the risk as an individual of being injured, and being separated – especially where there are pre-existing conditions
    - Does not believe trainees coming to Kapooka with lower entry standard are being given correct advice, and therefore, informed consent
    - Feelings of stigma and shame with separation, both involuntary and voluntary

- Defence Force Recruiting (DFR) marches to the tune the Services have provided
    - Need for meeting between medical officers, DFR and command
- Need to do more to mitigate the risks presented by lowering recruiting standards, noting that risk will always be an element of service in the ADF

<u>Army Indigenous Development Program</u>

- Concerns over challenges and risks – must mitigate risks to ensure success of the program
    - Doesn't believe this has happened
- These risks include changes to candidate selection, expectations communicated properly to candidates, overreach and scope creep, resourcing – including for Joint Health Command tailored support