Royal Commission Update – Adelaide – 18 July 2023 - Day 2

RSL References

Positive:

Negative:
Limited resources;

General:
1990s – Qld State RSL organised Warie Days:
RSL Life Care cannot apply for funding as they are not-member based.

Timeline:
9:35am – In session
9:37am – Introduction to William Kearney OAM
9:37-9:45am – Commission's live stream failing
10:00am – ALERT: *"We are aware there are ongoing issues with the livestream and are working to fix the problem"*
10:43-10:50am – livestream cut.
10:52am – adjournment for morning tea
11:22am – In Session
11:23am – Affirmation of Witnesses
11:25am – Questioning by Leonid Sheetooha KC
12:05pm – Theme 1: Veterans SA and the work they do in SA – concluded
12:06pm – Theme 2: Department of Health and Veterans SA – in session
1:25pm – Lunch Adjournment
2:10pm – Adjourned extended until 2:20pm
2:20pm: In Session
2:29pm: Witnesses sworn in
2:37pm: The hearing has been muted for privacy reasons.
2:38pm: Unmuted.
4:15pm: Adjourned.
4:38pm: In Session.
5:40pm: Adjourned.

General summary

- Need to improve medical health frameworks;
- Primary prevention needs to be improved;
- "It's a travesty" - Dr. Peggy Brown, Commissioner;
- Reporting ought to separate near-misses and actual injury;
- SA Health aiming to introduce voluntary paperwork in schools and hospitals to help Veterans and their children;
- Recommendations to improve transition through improved health care and monitoring during recovery;
- Require software to monitor and manage health reports in Defence – new software required: industrial strength;
- Data management needs to communicate with other Departments and systems – prevents duplication;
- ADF should have duty of care to minimise injuries (Prof. Orr).

Witness List:

Time	Witness	Description
9:30-11:00am	William Kearney OAM	Lived Experience
11:00am-11:15am	Short Adjournment	
11:15am-1:15pm	**Chantelle Bohan** Director, Veterans SA **Adam Monkhouse** Acting Director of Health Services Programs SA Health	Professional Experience
1:15pm-2:15pm	Lunch Adjournment	
2:15-4:15pm	**Professor Rodney Pope** Professor of Physiotherapy **Dr. Stephan Rudski AM** Professor of Physiotherapy and Director of the Tactical Research Unit, Bond University **Profesor Rob Orr** Sports Physician and Fellow of the College of Sport and Exercise Physicians	Professional Experience
4:15pm-4:30pm	Panel Continued	Professional Experience

Counsel Assisting Opening Address

- Peter Singleton – Counsel Assisting
- Leonid Shetooha – Counsel Assisting
- Introduction of Commonwealth and South Australian Counsel
- Absences noted
- Introduction to Witness William Kearney – lived experiences
    - Entitlements from DVA and processes to assist Veterans
    - Advocacy issues to be at the forefront of William Kearney's evidence

9:30am – 11:00am: William Kearny OAM:

Spinal problems around thirteen-years post-service; received a knee replacement – spinal injuries and doctors.

Compensation claims made to CommCare – degenerative lumbar disease – injuries still unresolved.

Primary form claims – up to ninety minutes;

Lifestyle questionnaire forms – undertaken by Mrs. Kearney or partners: often more aware than Veterans.
Most cases resolved at primary level – or at external review; 15-20 cases taken by Kearney to AAT;

Evidence tendered:

Document	Paragraph	Body
[Redacted]	WIK-0000-900001-005	I opted for discharge in Townsville as I had family connections and service history in Townsville. The only transition support I received was a three-day course on superannuation. There was some discussion on Veterans' Affairs but nothing substantive.
[Redacted]	WIK-0000-900001-05	2010s period: Lack of support for Veterans – holistic lack of support from DVA, through to transition processes and post-service.
Witness: William Kearney OAM	Verbal Evidence	Advocates were unprepared, or underprepared, for Afghan-Iraq and East Timor Veterans, did not have adequate training. The development of modern warfare and conflict made it more difficult for past Veterans to assist modern Veterans. Warie Days: Involvement of Veterans who had been active in conflict – new beginning of female Veterans into armed conflict. Photographic and physical evidence aided DVA in processing claims; DVA unaware of the physical toll service had on Veterans.
Witness: William Kearney OAM	Verbal Evidence	Lack of consistent processes between DVA, DoD and other agencies which saw paperwork misaligned.
Witness: William Kearney OAM	Verbal Evidence	Conversation with other advocates and my own experience led me to believe that we needed to develop a training program for medical students who may go on to work with Veterans. I discussed with [REDACTED], who was the [REDACTED] Repatriation Medical Authority. He was also the [REDACTED] in Medicine at the UoQ. He totally supported the concept as did the Deputy Commissioner in Queensland. The State Chair of TIP opposed it most aggressively. The idea did not proceed.
Witness: William Kearney OAM	Verbal Evidence	GPs often do not know the difference between White Card and Gold Cards.

Witness: William Kearney OAM	Verbal Evidence	Ralph Review sought to introduce competency-based training – ATDP: strong resistance due to lengthy complexities.
[Redacted]	Document [Redacted]	My suggestion, for discussion, was to look at the feasibility of offering an 'Advocacy Training Package' to current serving members who had reached the seating rank and who may consider separating into an advocacy position. This would expose these people to the option of a career change of direction, salary on discharge (currently, Queensland RSL employs around 70 advocates) and an opportunity for a career where their military skills would be highly regarded. Further, I thought that these people, after some experience, could have the opportunity to then apply to be Service Members on the VRB or even, with further study, the AAT as a Tribunal Member.
Witness: William Kearney OAM	Verbal evidence	Proposal to retain VRB – allows review of case and submission for success of case. Abolition would result in going straight to AAT, introduction of VRB saw introduction of ADR.

11:15am – 1:15pm: Chantel Bohan; Adam Monkhouse:

Three themes:

1. **Veterans SA and the work they do within the State;**
2. **Particular focus on Veteran health;**
3. **Relationship between SA and Commonwealth in relation to Veterans issues;**

THEME 1:

- Sharing information: Veteran Health and Ministerial Advice and to the SA Government;
- Distributing grant funds and Secretariat support for the Veteran Advisory Council;
- Dedicated team of five people – SA Department – local networks and public health services (wellbeing and innovation)
- Prior to 2021: Census gaps for Veterans – poorly understood and recorded;
- Difficulty in data overcome by ABS 2021 Census;

SA Health is attempting to introduce Veteran identifying checkboxes for Veterans;

- Making mandatory will make it troublesome due to some wishes of Veterans to choose to not identify;

- Systems are being rolled out to encourage identification and assistance;

- Some Veterans do not want to be associated with their Service – or may decide later on to identify;

- Unpleasant experiences and wanting to move on – may not resonate with former personnel as an identity;

- Request for deidentified data to improve services to address complex needs promptly;

Primary challenges faced by Veterans in South Australia:

1. Seeking services;
2. Access of appropriate services;
3. Regional and mental health barriers;
4. Wait times and DVA fee scheduling;

Funding:

1. $2.1M funding allocated for Veteran Community Framework, from 1 July 2023;
2. Funding prior in Grants and Commemoration – anything for funding other than, required application;
3. Community Outreach Programme – will guide projects that are aimed for community and Veterans;
4. Will be guided by forums, Regional Outreach and Roundtables;

Community Policy:

1. Four Pillar Programme: *came about to support everything SA Health want to deliver.*
    a. *Honouring Service*
    b. *Data Informed Policy*
    c. *Community Inclusion*
    d. *Empowering Community*
2. Wanting to work with SA Department of Education to improve support to children of Serving Families;

3. Eight ladies completed the Course – three people found employment; biggest outcome was social connection – CoWork, CoPlay form in the pilot programme will be something SA Veterans wants to introduce into the Security Framework. Consultation will verify the need for widespread introduction.

4. Looking at overcoming widespread geographical issues faced by Veterans across SA;

5. Quarterly sessions between community organisations to share information and improve services to Veterans;

THEME 2 & 3: Particular focus on Veteran health; State-Commonwealth Relationship:

- Ongoing complexities within the Department of Health;
- No one-size-fits-all due to widespread requirements by Veterans;
- Higher risk factors for dependency, financial instability, housing requirements;
- Challenges around seeking help – mental health stigma, and rehabilitation requirements;
- Caretaker Mode prohibited any effective meetings throughout 2022 – HealthSA observed – no action;

- No practical outcomes from any meetings arising over the past couple of years – confirmed by Chantelle Bohan;

- Veteran Incarceration: Veteran SA does not know incarceration rate. For Department of Corrective Justice
    - Pilot Programme: knowledge of the programme and aim to achieve broadly
        - Aim: addressing unique needs of those incarcerated and prevent recidivism;

- Four-to-six meetings: Raised disparity of concessions; employment; commemoration; incarceration
    - Employment: finer details not known
        - No on the ground change – still develop
        - Implementation required from State to Commonwealth
        - No practical outcomes – Commonwealth cannot deliver services

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Currently enacting a *Learning Module – to learn about Veterans needs and the ways in which they require treatment;*

- Module is currently **not mandatory:** reporting can be made mandatory; training access data can be found;
- SA Office for Data Analytics – Discussion Paper by Veterans SA
    - *Consent Driven Model for Data Sharing*
        - *Induction Model – discussed with PM&C, endorsed and forwarded to Digital Transformation Authority (Cth)*

SA and Victoria to discuss Victoria's implementation success of new Veteran card – will be followed up by Commission.

Funding:

- $5M Grants across six identified Veteran Wellbeing Centres;
- Agreements between State and Commonwealth;
- Operational costs funded by State government;
- Jamie Larcombe Centre has been funded by SA Government – commissioned as a Health Service
    - Service provided – commissioning process looks at data and community need;
    - Yearly process in line with Budget and need of Local Health Networks;

- Lives Lived Well – to develop business case to establish Hub in North Adelaide;
- Existing services interact with new Hub to ensure consistency

Policies:

- Success formally recorded through quantitative and qualitative data sets;
- Data demonstrates Veterans in the centre – being helped, sourced through feedback;
- Need to improve sustainability and build upon community of practice – attract new people to it;

ESOs:

- Plympton Veteran Centre;

- Russel Veteran Living Centre
    - Homeless as ongoing issue
    - No data retained – Housing SA will need to provide data
    - Not raised by Veterans SA – not a key issue that has not been raised in discussions
        - Homelessness to be raised by Chantelle Bohan, Dire

- Jamie Larcombe Centre – Mental Health Precinct;
    - 24 bed acute mental health unit – provides for transition to recovery;
    - Proposed treatment plans and provides stability for transition to community;
    - Provides ambulatory programmes and community visits to Veterans;
    - Trauma recovery programme and range of things like mindfulness and yoga;

- Partnerships Hub
    - In conjunction with Jamie Larcombe Centre – resource sharing: has been successful.

Tendered Evidence by Leonid Sheptooha:

Document	Para.	Body
SAG-001-001-005 [Title Redacted]	.005	3.2% (47,852) of SA's population aged 15 years and over identified as current or previous serving members of the ADF. 32.8% of all Veterans in SA – the unemployment rate for previous serving members in SA was 4.3% compared to the national equivalent of 3.9%.
Strategic Aims Outcomes 2023	14.	Continue to participate in the Veterans Wellbeing Taskforce and Commonwealth State and Territory Committee (CSTC) ad any working groups that develop from these.
WAJ-0001 [Further Redacted]	Cost and Delivery	DVA delivery of grants direct to community groups without reference to State Government has resulted in several second order effects, these being: - Confusing service provider environment for veterans and their families - A sense of competition between service providers; - Encourages the establishment of single issue providers with unsustainable operating models - Duplication of services - Inefficiencies created for service providers having to seek funding from multiple sources The response provided under Subparagraph [2.f.ii] is a positive step forward in identifying these matters and developing a collaborative response to address these concerns.
WAJ.0001.0001 [Further Redacted]	.0003	Better access to Commonwealth deidentified data (The Department of Defence and DVA) with the acknowledgment that requests are solely for the purposes of enabling better outcomes for Veterans and their families and that data will not be inappropriately used.

2:15pm-4:15pm: Professor Rodney Pope, Dr. Stephan Rudski AM, Professor Rob Orr:

- Counsel Assisting: Garbiella Rubagotti
- Poor post-care leads to lower social health outcomes, mental ailments and physical disability;
- Link between disabilities, poor mental health and suicide behaviours;
- Poor physical health results in poor mental health and suicidality;
- 11 deaths; 19% saw illness, chronic pain and suicidal tendencies;
- Relationship breakdowns and poor social connection relationships;
- Injuries often seen mostly during recruitment.
- Introducing barrier testing to prohibit recruits with poor health;
- Applicant pool small – may ignore health and fail tests to meet quotas;
- Physical training = 12% of all physical training: 88% training comes from marching; drills; weapons etc
- Training control: reduce up to 60% of injury rates and/or severity of injuries;
- Tables [redacted], shown to Commissioners and Witnesses regarding spinal and musculoskeletal conditions;
- DIPP was seen as overburdened and admin-heavy: ineffective in achieving its objectives and aims;

Tendered Evidence by Garbiella Rubagotti:

Document	Para.	Body
DEF.1151-0005-0179 [Title Redacted]	Table 6.28	Number of work health and safety incidents and number of people involved 2019-20 to 2021-22.
DEF.0001.0001.4178	.4346	[REDACTED]
Military Classifications System	[REDACTED]	[REDACTED]
DEF999.999.095	[REDACTED]	[REDACTED] General: suicide and suicidality.
DEF.1167.0004.0138	.0168	Serving and ex-serving Australian Defence Force members who have served since 1985: suicide monitoring 1997-2020.
DEF.1237.0001.0183	[REDACTED]	Defence Injury Program: The Defence Injury Prevention Program has been implemented to reduce the non-combat injury rate among ADF personnel. The purpose of the program is to: - Improve retention of ADF personnel; - Reduce non-combat injuries among ADF personnel; - Improve individual readiness; - Reduce the direct medical cost of injuries;

		- Reduce the demand for rehabilitation; - Reduce the level of compensation costs; Outlay; $3.262M; benefits of almost $42M expected due to decreased medical, military rehabilitation, compensation and pension costs and working days lost.
DEF.1237.0001.0164		Effectiveness of the Defence Injury Prevention Program: *Portfolio Evaluation Report*
[REDACTED]	[REDACTED]	The Evaluation Team recommends that the DIPP be retained as Defence's structured approach to injury prevention for the ADF, and that its implementation be re-invigorated by a full review to ensure DIPP is effectively managed and fully supported to achieve its intended objectives. Accordingly, the following actions, together with proposed responsibility and implementation timings, are recommended for Chief of Defence Force and Secretary endorsement.

Witness	**Comments**
Dr Rudzki AM	Injury is not the problem: it is the failure to accurately diagnose and locate issues. Mental distress leads to erratic behaviour. Defence has a committed work force however has a lack of practitioners who specialise in musculoskeletal conditions. Commonwealth relies on contracted GPs – not adequate expertise or training to manage these conditions. To consider structured return to work schemes. Huge number of injuries: particularly lower limb. Publicist literature; running distance and weekly kilometres were directly proportionate to risk of injury. Significant reduction of injury and lower limb injuries – eight of the first eleven finishes were those who had not run at all during twelve-week training trial. US has solid models in maintaining frameworks – Australia often loses them after a short while. ADF saw value in health programmes: didn't fund it – was seen as a priority for Health to fund and manage. Specific diagnostic kits should be introduced to analyse mechanisms of injury and rates of successful recovery. Accurate diagnoses are important in ensuring that health care needs are met and addressed promptly to improve success rates of healing and recovery. We can never eliminate injuries: we need to eliminate injuries that result in medical separation. Reporting has ramifications – entitlements, provision of healthcare post-discharge; leads to separation; normalisation of reporting needs to be established. Many injuries occur because of overload – military organisations hate the concept of *rest and recovery*. The ADF needs to look at data to be able to reprogramme efficiently and minimise injuries. <u>Defence Injury Management:</u> 10% of ADF personnel medically discharged; 29% in 2021 medical discharged. Inadequate treatment leading to medical discharge. Veterans seen are very badly injured. They have often managed the symptoms, not treated the cause. **Primary Prevention:** changing regimes to minimise risk. **Secondary Prevention:** screening to identify diseases in the earliest stages before the onset of signs and symptonms. **Tertiary Prevention:** surgery to prevent further deterioration of injury. Privacy issues with Doctors – concerned about cancellation of registration and ban from practice. Consent required to disclose relevant matters to Commanders. Concerns about opioid dependency developing. Every medical discharge is a financial loss; results in more expenses being distributed than through implementing health cost programmes. Duration and intensity = injury; needs to be balanced to ensure efficiency and effectiveness. Early treatment = better outcomes.
Professor Orr	The ADF key values of courage, teamwork and initiative. Conundrum where these key values conflict with consideration of rehabilitation and physical care. Removing troops from their Units to recover causes a disconnect and disturbs social connections. Australian Military Medical Association (2017/8): integrate the injured person and keep them with their unit during training, they saw improved recovery – integrated into the training continuum with specialised care. Meaningful duties; not menial duties. Active re-engagement seen in State law enforcement: PT and Psych Sessions and, Physio – aided in positive outcomes: suggested to be considered by Defence. Benchmark starting 7.5 on shuttle run: progression points to determine progress. A lot of variability between individuals. One-size-fits-no-one: less resources, inexpensive, cheap. Easy for people to lose fitness capabilities. Introduced manipulated varied exercises: all recruits do the same exercise – at their own level. Different variations of exercises. Saw that logistic changes with training schedule resulted in more injuries. Need to improve motor control and motor learning training; mechanics; ongoing professional development. Training for the ADF needs to be developed by the ADF. Biggest risk of injury is previous injury. No plan lasts two posting cycles – history of policy development needs to be recorded accurately. Minor injuries with the prospect of becoming larger problems need to be addressed before they [the injures] cause long-term damage. Specialists need to be introduced to accurately identify issues. Decrease in VO2 max; long-covid impacts not known; lack of gross motor skills capability.
Professor Pope	Pain catastrophising: increases the risk of suicide. The decision of suicide is not always from mental conditions; but the physical pain may result in suicide. Literary evidence highlights that physical pain results in suicide, noted in people who haven't had (identified) mental health conditions.

	Inherent requirements of fitness: need to be appropriate to the starting level of each individual level of the recruits. Fitness levels of themselves account for less than 2% of individual variability risk. Volume of the work = 50-60% of injuries; equal training volume = reduction 2-3% reduction. Can halve, further research. Diet relative deficiency – lack of energy to fulfil their requirements and workload expected to undertake; stress fractures; fatigue; further injury. Dieticians need to be readily accessible. Defence Injury Prevention Programme: Surveillance and resolution through countermeasures; came to the attention of the Director General of Defence Health Service who wanted it to be replicated across Defence. Scale up programme to be rolled out across three branches. Injury Surveillance System to provide data to safety structure and command within the local unit to ensure prevention became everybody's accountability. Point-of-Care: approach to separate injuries *and* near-misses to accurately identify injuries, severity, type and cause.

Questions by Commissioners and Counsel:

Witness	Commissioner	Question	Answer
William Kearney OAM	Commissioner Brown	*There was a lot of anger from Veterans – why? Was it before the claims, after, can you elaborate?*	Defence takes 17 year old boys how to be aggressive to survive on the battlefield – but there is no process to undo that – when they leave Defence, they still have that aggressiveness with them. The Civilian world doesn't like aggression, and can transform and further their anger. They don't understand why they don't fit back into this "system" and probably, that, fuels their anger. Advocates already see their anger when they first engage with them.
		"How do Advocates deal with this anger?"	You have to play it as you see it; let them rant and rave; and when they're finished, we need to focus on the end goal. Advocate roles are to "deal with the facts of the case" and aren't equipped to deal with emotional stress, too.
		"Do Advocates also deal with emotional stress?"	Yes; but in one case, a case of sexual assault was different in the emotional toll compared to a man who had RPGs fired at him.
		"Do we need lawyers and trained legal practitioners in these positions?"	Yes, we need Advocates who have some legislative knowledge. I think the system we have now, reliant on Volunteers, with minimal training, pitted against lawyers at the AAT, is a little bit unfair – I would see that higher up in the food chain that there would need to be lawyers to perhaps administer the system and take on those complex cases.
		"Is there a role for Volunteer Advocates?"	There's a difficulty in understanding why people would do Volunteer work when sitting next to people who are paid to do the same work.
		"Why did you become an Advocate?"	It gave me a sense of purpose. I was thrown on the scrap heap, saw Veterans who went through the same process. I didn't want others to go through that road, and I needed a purpose to be a role model to my children – we do it for different reasons, but I find it a difficult question to answer.
		"Have you seen issues with CommCare and the similar issues to you – similar concerns?"	DVA took over the contract for CommCare and administered the Safety and Rehabilitation Legislation. When CommCare worked out of DVA offices, there was some disharmony between both Departments. This was pre-DRCA.
William Kearney OAM	The Hon. James Douglas KC	*"The Volunteering between the Royal Canadian Forces and the Royal Canadian Legion – and the assistance of claims processing and an equivalent for review through their VRB – kicking in with the Pensions Advocate."*	It is important that the process sees competent Advocates – there are some oxygen thieves who are practicing too – and it is a big problem that sees a need for qualifications and better training.
Ms Chantelle Bohan	Bohan Commissioner Kaldas OAM	*1,100 Veterans are in SA detention – can this be confirmed?*	No confirmation – taken on notice to provide statistics.
Ms. Chantelle Bohan	Question by Counsel Sheptooha	*It seems that these forums are to identify issues but not raise solutions, would you agree?*	Yes.
		How would the Commonwealth and the State improve outcomes for Veterans?	State and Territory perspective have good relationships - once requirements are established; funding; the Commonwealth may not have service delivery within the States.
		"Why has Veterans SA not looked at these difficult issues such as homelessness? I understand Department's will look at specific issues, but with an area of focus – is there going to be a whole-of-government committee supporting Veterans to look at service delivery of widespread issues?"	No, Commissioner.

Ms. Chantelle Bohan	Commissioner, Dr. Peggy Brown	*"Is there a systematic way of looking at these issues?*	Three contemporary Veterans – one current serving; one male, one female former serving – presenting to the room, highlighting and challenging their perception of what a Veteran is, and within Local Government Councils, there was surprise and a want to reach out and help Veterans in their community to help develop the framework.
		In terms of your five FTE, is there a sense that this is sufficient to meet the need?	That will be a part of the planning process to understand if the resourcing we have, is adequate, and I hazard a guess to say that it is not.
		What is the population of South Australia, with the Veteran population being at 47,000-odd "	I'm not sure, Commissioner.
		What level of collaboration is between Veterans SA and DVA to know what services they are providing and you are not duplicating; and identifying gaps; and minimise confusion.	For Veterans SA, we have vastly expanded our connections so the State has no place in providing services to current service members as it is a Commonwealth constitutional responsibility. We are reaching out to families and patterns, then collating that information to reach out to other State government organisations.
		The US Veterans Affairs receives information the moment of discharge, and the Veteran can elect to have their home State government receive their details – pass them onto all Government Departments and local counties. Would that information be useful?	It would be [absolutely] amazing if we could do something like that – for my thought, when people join the ADF – an opt in upon enlistment, identifying want or need for post-service support through Local and State Government.
		Does Veterans SA and Health have options for crisis support?	In a broader context, we have Urgent Mental Health Care Centre, the emergency department, Lifeline. There is nothing specific that SA has.
Ms. Chantelle Bohan	Commissioner, The Hon. James Douglas KC	*The Covenant in the UK which has teeth as it is backed by Statute.* *The Covenant here does not give rise to obligations or is backed by Statute.*	This Charter was signed off by Cabinet in 2012. We have only just discussed within the Agency requesting a Review – no legislation – however, it is not something we have had considered; but can go onto our existing workload.
Ms. Chantelle Bohan	Commissioner, Nick Kaldas APM	*What were the numbers you were expecting from the Census?*	Considerably lower – around half of what we received.
Professor Pope	Gabriella Rubagotti	*Can any of our witnesses make comment on whether there is a higher rate of injury based on training or deployment?*	From my research – training – there is so much more stress on the system; deployment sees training, however, I have seen more injuries occur during training and on base.
Professor Pope	Comissioner, Dr. Brown AO	*It is a travesty – what you are mentioning today – shows the long-lasting impacts on the bodies of ADF personnel.*	No comment.
Professor Pope	Dr. Rudski AM	*Can you confirm that the ADF did not want to implement DIPP, and the reason for that?*	Yes, the ADF did not want fund it as it was seen as an issue for Health to follow up.