Royal Commission Update – Sydney Day 18 – 9 March 2022

RSL References

Positive:
NA

Negative:
NA

General Summary

- Coverage of DVA process, backlog, McKinsey report and ongoing reforms

9.00 – SY4 – Lived Experience - RAN

Much of the account was muted for privacy reasons

- Navy clearance diver who recounted instances of belittling punishments endured throughout service
- Experienced personal injury – perforated ear drum - as a result of punishment drill ordered to complete by superior
- Instructor advised that witness should say injury was incurred as part of an accident while diving, not as part of punishment. Waited outside doctor's room to check this was accounted to doctors. Instructor was the same person who inflicted punishment
- Highlighted use of self-administered medication like Sudafed (pseudoephedrine) to treat injuries and regular use among other personnel
- Talked of friend who experienced suicidal thoughts. Captain instructed that they didn't want him back. Didn't commit suicide but was believed to be close call.
- Was then suspended immediately without pay and only given 48 hours to respond following requests to leave service
- Was working with a barrister at the time to develop what I thought was a good response. Highlighted that all elements of the claim were false
- Applied for transfer to Perth Personnel unit. I put in a claim of bullying against them and put in a FOI claim. I did get this but 90% was redacted
- From there it was like I was fighting an unwinnable battle. It took 6 months and my career was basically over
- Very much impacted on mental health. Took it's toll on relationship and my family.

- FOI was submitted because felt bullied and harassed. Believed there were a lot of things being done and processes not followed correctly
- Symptoms throughout process included feeling on edge all the time, constant drinking to take the edge off. Was medicated by psychiatrist which helped reduce drinking
- Experienced an incident where Navy called the police on him which induced an anxiety attack. Was the point that gave up.
- Sent letter to divisional officer – very helpful man – to resign and leave the military.
- Psychiatrist pointed him toward lawyers to work with who have been very supportive
- Still battling physical injuries and slow process of recovery
- Outlined that if he was going through this again, he would have walked away straight away. Toll that it took was too much. Advice he said he'd give to anyone would be to use the 20 days notice to walk away and find another job.
- Emphasised the toll that the 6 month process will take on anyone personally
- Felt supported on the medical side. On divisional side, felt he was being lied to and manipulated and couldn't trust them. Believes they didn't think he would fight claims so much. Got support from a separate divisional officer.

10.20 – ABS Professional Witness - Mr James Eynstone-Hinkins & Ms Lauren Moran

Coding of deaths recorded:

- Explanation of coding of all deaths received and information sources used and explanation of coding on cause of death that is used.
- Presented two diagrams on coding of closed cases on NCIS (National Coronial Information System) to intentional harm.
- Coding of cause of death and possible intent is important in identifying and capturing suicide. Death by suicide is rare to see as a cause of death. Death by intentional self harm is used as a reference. Some coding – for example Accidental deaths – could 'conveniently hide' suicides
- Getting clear and consistent data on cause and intent of death can be difficult. Relies on coronial inquiries which can take time as well as police reports
- An individual isn't specifically identified or coded as part of the current process. ABS is not able to do this currently but there is theoretically possibilities for correlating across different data sets.

Coronial identification of suicides and sharing of data:

- ABS coding team looks at every coronial reviewed death. Suicide is very hard to determine but review contextual (notes left, medical notes etc.) elements as well as mechanism of death (how the death occurred).
- Benefits of all reports being available in making timely and accurate determinations and roll that can play in informing prevention focused efforts.
- NCIS is the source of all cause of death data. ABS is not able to undertake its own investigation
- There are differences in the system that impact timing – in South Australia toxicology and pathology reports are not shared. In Queensland, reports aren't shared until cases are closed. Coronial courts sometimes block very sensitive cases
- Statistics on intentional self-harm multiple – causes of death and ICD can be marked twice for each suicide case. Substance use, anxiety and stress related causes and mood disorders all have a high frequency in suicide cases. These factors alongside social contributors (financial stress, relationship breakdown) was all factored into report completed for Australian Institute of Health and Welfare (AIHW)

Timing of information sharing around deaths:

- Time gaps between when a death occurs and when it is registered. ABS only receives once registered. Doctor certified deaths take approx. two months to complete but can extend significantly. Coronial investigated deaths take much longer.
- Certification process of deaths and time lags, differences state to state and potential undercount this can create in counting deaths that occur due to suicide
- Differences between ABS and Suicide Registers and how they work – suicide register focused on rapid recording of suicide deaths based on police reports.
- Numbers of recorded deaths by intent and breakdown of how they are statistically recorded.

<u>Other:</u>

- Occupational indicators could be included but it would require linkages to service personnel data held by Defence. This doesn't currently take place, but could be done in future
- Number of coronial inquests each year sit at around 120 and not information comes from these inquests
- Information from coroner is important to assigning accurate codes to intent of death
- Death by suicide is rare to see as cause of death. Cause of death and intent of death are two different areas
- Preliminary coding is done at approximately 9 months after death. But this is often done before full coronial findings are available. Majority of final cases and entire investigation is received within one to two years
- Causes of death annual report, reports on all causes of death within a year and they are doctor and coroner certified
- Discussed possible categories in coding that could capture and hide suicide – for example accidental deaths

11.30 – AIHW Professional Witness – Ms Louise Gates & Mr Matthew James

<u>Defence and Veterans Death by Suicide Annual Report</u>

- Good data for deaths by suicide between 1 January 2001 and 31 December 2019
- Harder to provide linkages for data for deaths by suicide between 1 January 1985 and 31 December 2000
- Even more difficult providing and linking this data pre-1985
    - Number of people who have had 1 day service since 1985 – 373,000
    - Number of that cohort who have died – approx.15,500
    - Number who have died by suicide – 1273
    - Percentage of suicide deaths among total deaths – 8.21%

<u>National Suicide Register</u>

- Recommendation from *Constant Battle* (2016) report to establish National Veteran Suicide Regitser
- Work has not begun on this – funding is needed to understand what the Register should look like and then to develop – AIHW has only received money for annual Defence and Veteran Suicide report.
- Depends on what question we are trying to answer – do we want close to real-time data (i.e. State Suicide Registers) or a snapshot each year (i.e. Annual Report) – requires further discussion

<u>Data and funding from Defence and DVA</u>

- Ongoing funding from DVA has been halved between this year and last - $1million down from $2million, but negotiating for more funding
- No clear picture of who served before 1985 – estimated extra 300,000 veterans unaccounted for

- No Defence funding for any suicide work at this stage
- AIHW funding is 33% appropriation, 66% fee for service
- 7 months delay in receiving Defence personnel data – change of scope of work leads to restarting process – requires rigorous approvals
- Some information in PMKeys wasn't initially provided, and would be useful for AIHW work
- No way to get information re. families of Defence Members and Veterans who have died by suicide – at this stage
- Working with Defence, DVA and ESOs to determine number of veterans who served prior to 1985

2.00 – Professional Witness – Ms Fiona Dowsley & Ms Ally Watson – National Coronial Investigation Service (NCIS)

- Voluntary database summarising findings of coronial courts through Australia and New Zealand – coronial staff in each jurisdiction input data into NCIS database
- NCIS is funded by consortia of Australia State and Territory Government, New Zealand Ministry of Justice, and a number of Federal Departments and other organisation
- Idea of intent is crucial to coronial inquests – this coding is done through the Coronial courts
- Attachments in NCIS include Police Narrative, Toxiocol