Submission No 6

Inquiry into the Care of ADF Personnel Wounded and Injured on Operations

Name: **Withheld**

Submission to Joint Standing Committee on Foreign Affairs, Defence and Trade for the Inquiry into the Care of ADF Personnel Wounded and Injured on Operations

My submission is with respect to the care and management of personnel post operations and, specifically, the administrative support given to me during my diagnosis and treatment for PTSD with an associated Adjustment Disorder.

I am a in the RAAF and I deployed to Kandahar, Afghanistan for the period I did not come into direct contact with the enemy, but was subjected to indirect rocket attacks on a very regular basis (3-4 times a week, normally between 0430 and 0500). I believe that the stresses were greater on me as I was the isolated on one side to the runway at Kandahar (14,000 NATO personnel were on the other side of the airfield). I was also newly promoted and deployed within four months of taking command.

My symptoms (PTSD) were identified during both the Return to Australia and the Post Operations Psychological Screening but very little coping advice and no treatment was given at that time and I was advised that the symptoms would fade with time.

In April 2008, I commenced a new job in Canberra which, due to a 2002 decision to live 115kms NW of Canberra, entailed driving about 2½ to 3 hours per day to/from work. Whilst I was happy to do this journey in 2002 before I had PTSD, in 2008 I found the journey excessively fatiguing when combined with the insomnia and disturbed sleep patterns caused by PTSD. In the first week of April 2008 I had a car accident where I drove into the rear of a stationary bus within 500m of work. Whilst I was not physically injured, I was concerned enough to see a Medical Officer (MO) who clinically diagnosed me as suffering from mild/moderate PTSD and expressed concern about my fatigue levels and the distance that I was travelling.

Whilst I did have a certain amount of denial about having PTSD, I followed the MOs advice and requested service assisted relocation closer to Canberra. Not only was I told that I was not eligible for relocation, I was accused, in writing to my superior, of being inappropriate and unethical by obtaining medical support for my request. I experienced another car accident in June 2008, again between work and home where I drove into a stationary vehicle. My Psychiatrist has stated that my condition and specifically fatigue played a major part in both car accidents. The situation, in terms of distance between home and work, was exacerbated when my unit relocated to HQJOC at Bungendore in early 2009.

Despite support from my immediate superiors who repeatedly quoted the failing in the ADF's duty of care, ADF administrators refused to interpret PACMAN in my favour or even acknowledge that my medical condition could be a factor in any administrative decision. This situation has continued throughout the last four years despite the submission and processing of a Redress of Grievance (ROG) and the involvement of the Defence Force Ombudsman. The processing of my ROG was flawed in that investigations by Complaints Resolution deliberately ignored my medical condition biasing briefs to senior officers only on housing entitlement.

It was only following a Formal Complaint to CDF in 2011 that CDF used his discretion and I was granted a removal at service expense. However, this took four years to obtain and subjected my wife and I to additional unnecessary stress during a period when I should have been recovering. This stress has led to the aggravation of my conditions, resulting in an early discharge MUFS and the loss to the ADF of my expertise in Network Centric Warfare.

The reasoning behind the ADFs lack of support has been a continued interpretation of PACMAN that medical conditions are irrelevant to an administrative decision. However, PACMAN contains numerous clauses that contain the phrase "*the health and welfare of the member and his dependants*" which would allow CDF or his delegate to make a decision taking into account a medical condition…. otherwise there

would be no reason for PACMAN to even mention health and welfare. The Defence Force Ombudsman (DFO) has disagreed with Defence's interpretation, both in meetings with Defence and in writing to me for subsequent use in a CDDA claim. He has also criticised Defences lack of adherence to DI(G)PERS 34-1 *(ROG procedures)*, in that Defence failed to examine alternative solutions to my ROG. However, DFO has declined to take the matter any further as CDF, acting in my favour, has resolved the ROG. Despite CDF overturning the 2008 decision against a removal (only due to a formal complaint not due process) and DFOs criticism of Defence's interpretation of PACMAN and processing shortcomings, Defence (DCAF) maintains that the system is robust and fair.

Throughout this time I have consistently requested rehabilitation back into the workforce and ultimately had to force the ADF in attempting it. The ADF are not willing to interpret the progressive nature of the Joint Health Policy goals (**in priority order**):

1. Fit for duty in the pre injury/illness work environment;
2. Fit for alternative duty in the ADF; and
3. Transition out of the ADF.

The ADF have jumped straight to Goal 3 for transition out of the ADF paying only lip service to goal 1 or 2. The MECRB decision maintains my MEC at J43 to attempt rehabilitation, but states intent to make me MEC J51, presupposing a negative rehabilitation outcome.

The result of my dispute with the ADF has:

- been far more costly to Defence than the initial approval of a removal would have been,
- been the cause of not only my dissatisfaction with the ADFs support of members returning from operations but also of every one of my colleagues who know about my condition, and
- directly resulted in the exacerbation of my condition, the eventual MUFS discharge and the loss of my skillset to the ADF at a time where the ADF is seeking enhanced capability in this area.

I believe that the ADF has allowed flawed and distorted interpretations of PACMAN to drive decisions away from the logical and compassionate support of a member returning from operations with a service derived mental condition. In making these interpretations, they have not taken the effort to openly analyse the Defence Determinations or accompanying Explanatory Statements behind PACMAN and have allowed more comfortable peacetime assumptions to sway their determinations towards blinkered decisions. I strongly suspect that I am not alone in being the recipient of this distortion of government intentions.

By contrast the medical support provided by the ADF and my subsequent interactions with DVA has been very positive, although the volume of information provided by DVA has left me confused about my future post-transition financial prospects – a fact that is still very unsettling.