Submission No 17

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

Organisation: Department of Defence

The Hon Warren Snowdon MP

Minister for Veterans' Affairs
Minister for Defence Science and Personnel
Minister for Indigenous Health
Minister Assisting the Prime Minister on the Centenary of Anzac

Senator Mark Furner
Chair
Joint Standing Committee on Foreign Affairs,
Defence and Trade – Defence Sub Committee
Parliament House
CANBERRA ACT 2600

22 AUG 2012

Dear Senator Furner Mark,

Thank you for your letter of 27 June 2012 inviting the Department of Defence to make a submission to the Joint Standing Committee on Foreign Affairs, Defence and Trade on the inquiry into the care of Australian Defence Force personnel wounded and injured on operations.

I have enclosed a submission prepared by Defence, which addresses the terms of reference, providing the Committee with information relating to Defence's efforts to care for Australian Defence Force personnel wounded and injured on operations.

I trust that this submission will be of assistance to the Committee in preparing its report.

Yours sincerely

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Encl

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JOINT STANDING COMMITTEE ON FOREIGN AFFAIRS, DEFENCE AND TRADE

DEFENCE SUB-COMMITTEE

INQUIRY INTO THE CARE OF ADF PERSONNEL WOUNDED AND INJURED ON OPERATIONS

DEPARTMENT OF DEFENCE WRITTEN SUBMISSION REGARDING THE INQUIRY TERMS OF REFERENCE

AUGUST 2012

Service in the Australian Defence Force (ADF) is demanding and unique. Defence Members may be required to work long hours, shift work and irregular hours under harsh environmental conditions. As well as facing the possibility of service in hostile areas, Defence Members participate in other forms of operational activities where a degree of personal risk still exists.

Whilst the health and welfare of members is a command responsibility, which ultimately rests with the Chief of each Service regardless of where the ADF member may be posted, the Surgeon General Australian Defence Force/ Commander Joint Health is responsible for the technical control[1] of ADF health services. This includes all personnel involved in the provision of health care (which includes psychology services) within the ADF, the provision of specialist health advice, development of policy on health issues and delivery of all garrison health care.

Joint Health Command is responsible for the Defence health care system which is designed to prevent and minimise the impact of operational, environmental and occupational health threats and to treat ill, wounded and injured members. The provision of health care to ADF personnel does not start when an individual is wounded or injured and the Defence health care system provides a continuum of care from enlistment through to transition from the ADF and during all phases of an operation. Components of this health care system include all routine and emergency health care within Australia, health promotion activities, predeployment fitness assessments, first aid and advanced first aid training for non health personnel, operational health support in theatre, a tiered medical evacuation system and post deployment assessment and care, physical and occupational rehabilitation and mental health support.

Joint Health Command provides the standard of health care required in order to ensure the operational readiness of the ADF and enable all personnel to perform their military duties. Defence has a commitment to managing the health consequences of operational service as well as providing health treatment to wounded and injured personnel.

Joint Health Command is required to provide to members of the Permanent Forces such health care as is deemed necessary to detect, cure, remove, prevent or reduce the likelihood of disease or infirmity which affects, or is likely to affect:

- the efficiency of the member in the performance of their duties; or
- endangers the health of any other member; or
- assists to rehabilitate the member for civilian life; and
- restores the member, so far as is practicable, to optimal health in the ADF context.

Equity with *Medicare* under the provisions of the *Health Insurance Act 1973* underpins the basic entitlement to the range of medical services provided to members of the Permanent Forces. Usually the range of, and ease of access to, health care provided to such members will exceed that available through the public health care system because of the requirement to meet and maintain operational readiness. However, from time to time the Surgeon General Australian Defence Force will issue policy which may exclude or limit the provision of

[1] Technical control is defined as the specialised or professional guidance and direction exercised in technical (professional) matters. Technical control may be used where necessary to designate specialised and professional operating procedures essential for the proper management and operation of the forces. Technical control advice may not be modified but may be rejected in part or in total by the commander in consideration of operational factors.

certain medical or dental treatment on the grounds that such treatment is contra-indicated or unnecessary for operational readiness

Reservists serving on Continuous Full Time Service are provided with the same level of health services as Permanent Force Members. When wounded, injured or suffering an illness resulting from Defence service, health care for that injury or illness will be continued after the Reserve Member ceases to be on continuous full time service and resumes part-time service.

Reservists serving on other than Continuous Full Time Service receive health care for injury or illness resulting from their Defence service until the transfer of the member into the military compensation system, administered by the Department of Veterans' Affairs (DVA), is completed.

Garrison Health Care

Joint Health Command is responsible for the ongoing health care of all ADF personnel when they are not operationally deployed. This includes specific health care needs such as routine health care, regular health checks, comprehensive vaccination programs, pre and post deployment screening and health care to manage the physical, mental and social wellbeing of the fighting force to ensure they remain "fit to fight". Joint Health Command staff also maintains strong communication pathways with units and Commanders to ensure that the welfare and health needs of individuals are coordinated, comprehensive and well managed.

This suite of preventative and primary health services is delivered through five Regional Health Services across Australia. Each Regional Health Service has a number of Health Centres and Clinics which deliver healthcare and support to ADF personnel and Commanders to ensure continued operational capacity and capability of ADF personnel. Current health services delivered include primary health care, preventive health care, diagnostic testing, pharmaceutical supply, physiotherapy services, dental services, mental health and psychology services, access to specialist medical care, access to tertiary level inpatient services within the civilian local hospital/healthcare network, and rehabilitation services including specialised case management.

Joint Health Command services are delivered by a wide range of practitioners including;

- uniformed doctors, nurses, dentists, medics and allied health professionals from all three Services;
- Australian Public Service health practitioners within health centres and clinics;
- contracted health providers who assist in the provision of many clinical roles;
- Reserve health practitioners who provide clinical services and specialist care; and
- civilian specialist health providers who provide advice and support to Joint Health Command practitioners while also providing specialist health care for ADF personnel.

Joint Health Command does not provide health support in the operational setting. This is the domain of the single Services, however, Joint Health Command supports the generation of ADF operational capability. Joint Health Command provides ADF health personnel with access to training which ensures that they can deliver health care while in the field, air and at sea during operational and training activities or when in the garrison health facilities. This training covers a number of areas including combat first aid, care of battle

casualties, emergency/trauma care and mental health care and support. Commander Joint Health in her role as Surgeon General of the ADF also has technical responsibility for health care in the deployed environment, and exercises this responsibility through the development of policy and doctrine and management of operational health capability requirements. This work is undertaken with input from the single Services.

Defence is responsible for the health care of serving members and the provision of all ancillary support services resulting from a health issue. The DVA will provide compensation and other support for a work related wound, injury or illness but not health care or rehabilitation until the agreed point of transition from the ADF.

Pre Deployment

The Australian Government is committed to protecting the lives and welfare of Defence personnel deployed on operations. A key component of this commitment is the provision of health support to deployed forces. This support ensures that a force deploys at optimal fitness with adequate preventive health measures.

All ADF members who deploy on operations must be assessed as being medically, dentally and psychologically fit for the tasking and are pre briefed on local health threats and appropriate individual health precautionary actions.

Health threats to Defence members may be operational, environmental, psychological and/or occupational. Operational health threats are those posed to Defence members by weapons systems, which may include non-conventional weapons. Environmental health threats include communicable diseases and environmental hazards. Psychological threats include an assessment of threat to self, exposure to trauma and operational stress. Occupational health threats are those posed to Defence members by our own weapon systems, platforms and/or work environments. Briefs addressing these specific health risks are developed and where possible appropriate measures to mitigate the threats are advised. Predeployment psychological preparation briefs are given and cover topics such as separation, cultural adaptation, operational tempo, fatigue, stress management and homecoming.

All members' medical employment classifications are reviewed between four and eight weeks prior to deployment to ensure that they are fit to deploy and all required vaccinations have been administered. A further check is undertaken within seven days of departure to ensure no additional medical conditions have occurred. For the Middle East Area of Operations baseline cognitive testing (COGSTATE© Sport) is undertaken and is mandatory for all members of the Special Operations Task Group and attached elements, all combat engineers and explosive ordnance device technicians and all mentoring task fore personnel engaged in outside the wire duties. COGSTATE © Sport tests reaction times, concentration, memory and decision making and it is employed as a tool to assist clinicians making decisions about when to return a member to duty after a concussive injury (e.g. from an improvised explosive device strike). Baseline testing allows comparisons to be made with a repeat test after a concussive injury.

Training

The initial response at the point of injury is crucial. The provision of bleeding and airway control for the most seriously injured must take place within 10 minutes of injury. To provide this, combat personnel (non-health personnel) are trained and competent to deliver enhanced first aid, principally to stop bleeding and secure the airway.

Every member of the ADF routinely receives training in first aid with an emphasis on the skills required in a military environment. Selected members are provided with advanced first aid skills tailored to their Service environment. These include the Minor War Vessel Medical Care Provider Course and the Combat First Aid Course and Patrol Advanced First Aiders Course. These skills are periodically refreshed as part of the normal training cycle.

Based on the risk associated with the operational deployment there is further tailored refresher and skills extension training conducted at all levels of the first aid and emergency medical response. For forces deploying into Afghanistan the pre-deployment training is conducted under the Exercise Primary Survey framework. All members are trained and assessed in Care of the Battle Casualty with significant resources being utilised to create realistic combat scenarios where the skills in management of combat injuries are developed and assessed by experienced medical observers. Combat First Aiders, Patrol Advanced First Aiders and deploying health staff conduct additional high fidelity training focused on comprehensive pre-hospital treatment and evacuation. The training is overseen by both military and civilian trauma specialists and adapted to reflect current best practice and scenarios are based on the experiences of health staff that have recently returned from Afghanistan. The final component of the exercise series targets the health staff, refreshing and enhancing their trauma skills. It involves live tissue training and challenging simulated resuscitation drills overseen by military trauma specialists.

During Reception Staging Onward Movement and Integration (RSO&I) in Al Minhad Air Base all members deploying into Afghanistan receive further high fidelity refresher training in Care of the Battle Casualty. This training is delivered by a contractor utilising ex-serving, combat experienced medics and overseen by ADF health staff. It involves a combination of lectures, individual skill refresher stations with an emphasis on control of massive haemorrhage and extraction of casualties resulting from an improvised explosive device strike. The training culminates in an assessment of all skills within a realistic simulated battlefield environment.

Whilst deployed, members receive ongoing refresher training that is often conducted in conjunction with range practices and focused on maintaining currency in the application of the Combat- Application-Tourniquet (CAT) and production of the NATO medical evacuation request. This is a message that is transmitted quickly to request an urgent medical evacuation and contains information that includes: the condition; number and nationality of the casualties; their location; what special equipment will be required; and the conditions on the ground that might inhibit their extraction. Combat First Aiders and health staff maintain their skills by routinely participating in the Role 2E trauma roster and augmenting during multiple casualty incidents. The currency and competency of first aiders and health staff are regularly tested with real time trauma patients. Our coalition partners have consistently observed that the quality and responsiveness of our first aiders and health staff in trauma cases is first class.

Specialist health personnel are qualified, current and competent in their clinical and operational skills and must meet the credentialing requirements of Australia and coalition partners.

Operational Health Support

Health support also ensures that appropriate treatment and evacuation capabilities exist to maximise the early return to duty of casualties.

The ADF provides comprehensive health services in permissive, uncertain and hostile environments. Health elements are capable of responding to diverse incidents in a range of environments. In addition to caring for Defence personnel, ADF health elements may provide humanitarian health care in higher threat environments until the situation has sufficiently stabilised for handover to civilian providers.

Military health support is commensurate with force strength and assessed health risks. Support starts before deployment and expands as the force strength expands and risks increase. It focuses on both battle casualties as well as disease and non-battle injuries. Health support has a surge capacity to support peak casualty periods. This health support may be required by either day or night and under any climatic or topographic conditions.

When ADF personnel are injured or become ill, there is an expectation that they will receive prompt and effective health care. ADF health care meets contemporary professional Australian standards except when the exigencies of military operations dictate otherwise.

The operational health care system provides for the continuum of care from initial first aid, and via a dedicated evacuation chain to increasing levels of specialist health care delivery. This system is organised into roles of health care, which range from first aid through to definitive health care and rehabilitation. Roles of health care extend from the point of injury or illness providing continuous care to casualties. Each tier has increasingly sophisticated treatment capabilities and each casualty is treated at the most appropriate role of health care. This may involve either movement through the care continuum or casualty evacuation to the most appropriate health facility.

A Role 1 health facility provides primary health care, triage and basic resuscitation and stabilisation. A Role 2 health facility provides enhanced clinical support based on formed health teams and is capable of advanced resuscitation and treatment of casualties prior to evacuation. A Role 2 enhanced (Role 2E) health facility provides secondary health care built around primary surgery, intensive care and nursed beds and treats and prepares casualties for evacuation to a Role 3 health facility or directly out of theatre. A Role 3 health facility provides comprehensive secondary health care including primary and specialist surgery, major medical and nursing services and casualty holding for treatment and return to duty. A Role 4 health facility offers the full spectrum of definitive care and is provided from or within the national support base.

The ADF is responsible for the provision of Role 1 health support to ADF elements in the Middle East Area of Operations. Role 2 support is provided at the ADF health facility at Al Minhad Air Base and Role 2E support is provided at the US led International Security Assistance Force (ISAF) facility in Tarin Kot. Role 3 health support is provided to ADF members at the Multinational US led ISAF facility at Kandahar. Role 4 health support is provided from either the US Landstuhl Regional Medical Center in Germany or from Australian tertiary civilian hospital facilities.

The ADF also has embedded health staff and fly in specialist teams to provide psychological and critical incident stress management support in the area of operation.

Evacuation

The objective of casualty evacuation is the safe and efficient movement of casualties, with the provision of en route medical care, from point of injury or illness to the appropriate health facility as soon as possible. Evacuation comprises both surface evacuation and aeromedical evacuation.

The evacuation system evacuates casualties 24 hours a day, in all weather, over all terrain and in any operational scenario. The system provides clinical sustainment of the casualty throughout the journey, using appropriately trained clinical staff and accurately tracks patients and equipment throughout the evacuation. Casualties are evacuated to the most appropriate facility in the shortest time while applying appropriate clinical processes. This approach enables forward deployment of health elements and concentrates resource-intensive casualty care in more secure areas where health facilities are not required to move with changing tactical situations. Casualty regulation directs the casualty to the health facility that is best able to manage the condition in terms of nature and availability of required treatment. Regulation ensures proper routing of patient to health facilities and minimises casualty handling and transfer. In the Middle East Area of Operations aeromedical evacuation of a patient from the scene of injury or illness to the initial treatment facility and evacuation of a patient between health facilities within the area of operation is the responsibility of our coalition partners.

Australians serving in Uruzgan rely on a team of highly skilled US and Australian trauma and medical staff working in a well equipped International Security Assistance Force Role 2E health facility in Tarin Kot. This facility performs the initial trauma management similar to that provided by the emergency department of a civilian hospital and if required, the facility can also undertake emergency surgery to treat the wounded or injured.

Not everyone who is wounded or injured requires evacuation and those ADF members who suffer only minor physical impairment are treated and, once fit, return to duty.

Casualties that require more specialist care than can be provided at the Role 2E at Tarin Kot are evacuated to the Kandahar Role 3 Multinational Medical Unit. Depending upon the treatment required casualties may receive further surgery, be clinically stabilised, and/or provided supportive care. The facility is predominately staffed by US health specialists but is currently being augmented by ADF specialist reserve staff. The ADF currently has a general surgeon, anaesthetist, orthopaedic surgeon, two perioperative nurses and two intensive care nurses embedded in this facility.

Once stabilised, seriously wounded or injured personnel will be returned to Australia for additional treatment and rehabilitation which is managed by Joint Health Command.

ADF Aviation Medical Officers, located at Kandahar Air Field, are responsible for coordinating the aeromedical evacuation of ADF casualties by either ADF aircraft, or the US aeromedical evacuation system. Casualties evacuated by ADF aircraft are provided medical care in the air by Australian Air Force personnel. Patients requiring transfer to the US Role 4 Landstuhl Regional Medical Center are evacuated by the US aeromedical evacuation system. They are cared for by US medical personnel, and supported by a dedicated ADF aeromedical evacuation trained Air Force nursing officer throughout the conduct of their aeromedical evacuation (AME).

As at 10 August 2012 the US aeromedical evacuation system has facilitated the movement of four Australian casualties in 2012. These personnel transited through Landstuhl Regional Medical Center for a period of approximately seven days, before their evacuation to Australia. Their medical care at Landstuhl included surgery, multiple investigations, wound care, and intensive and general nursing care. Care in Landstuhl is directed towards improving casualty outcomes and expediting their return to Australia. While at Landstuhl casualties are supported by Air Force health personnel and commonly members from their Unit.

Post Deployment

All members receive a Return to Australia medical brief from medical staff prior to leaving the area of operation. Personnel are briefed on the actions required during the post-deployment period and issued with a post-deployment information card. A post deployment health screen is conducted by a medical officer and includes a targeted physical examination guided by a general health questionnaire. Members are advised on any health eradication regimes (e.g. for malaria and helminths) at this time and provided with the appropriate medication. This applies to all personnel, including those injured and undergoing rehabilitation.

A post deployment health assessment is then conducted three months post deployment to review any health issues that may have arisen since the deployment and includes testing for blood borne diseases and audiometry (hearing testing) for those on land based deployments.

Members returning from operational deployments receive psychological screening both prior to returning to Australia (return to Australia psychological screen – RtAPS), and 3-6 months following their return (post operation psychological screen- POPS). This applies to all personnel, including those injured and undergoing rehabilitation. For those personnel requiring further mental health support and treatment, comprehensive counselling and treatment programs are available using a network of Defence mental health providers and external services.

ADF personnel are not to redeploy on any further operation until such time as any outstanding post deployment heath assessments and POPs screening has been undertaken.

Family Support

The ADF is committed to ensuring family members of those ADF personnel wounded or injured on operations are supported through the period from wounding or injury, acute treatment and rehabilitation to return to work or transition from the Service. The ADF, Services and DSG is sensitive to the requirements for family sensitive health care delivery and a number of supporting systems and programs have been or are being implemented to further address the needs of the family.

Supporting Systems

A number of systems, organisations and mechanisms exist within the ADF to provide support to ADF wounded and injured members and their families. These include the Defence Community Organisation, the Australians Dangerously Ill Scheme, the ADF Rehabilitation Program, the Support to the Wounded Ill and Injured Program and the Simpson Assistance Program. Descriptions of these supporting systems are detailed later in the brief.

Summary

Whilst the health and welfare of members is a command responsibility, which ultimately rests with the Chief of each Service regardless of where the ADF member may be posted, the Surgeon General Australian Defence Force/ Commander Joint Health is responsible for the technical control of ADF health services. The provision of health care to ADF personnel does not start when an individual is injured or wounded and the Defence health care system provides a continuum of care from enlistment through to transition from the ADF and during all phases of an operation – predeployment, provision of treatment and evacuation during deployment and post deployment. When ADF personnel are injured or wounded, there is an expectation that they will receive prompt and effective health care which meets contemporary Australian standards and this underpins the continuum of care that is provided to the men and women of the ADF.

Responses to the specific terms of reference are provided below:

(a) treatment of wounded and injured ADF personnel while in operational areas;

An ADF member who is serving in war-like conditions and is hurt during contact with the enemy is said to have been 'wounded' and is defined as a battle casualty. An ADF member who is hurt in an incident on operations that has not been the result of enemy action is said to have been 'injured' and is defined as a non-battle casualty. The management of our wounded and injured is the same regardless of cause and follows the same medical treatment system.

Acute psychological injury has not previously been included in the ADF definition of battle casualties. However whilst uncommon there are circumstances where acute psychological conditions arise as a result of direct contact with the enemy or as a result of direct exposure to the consequences of enemy action. Criteria have been developed to provide a framework to support classifying acute psychological casualties as battle casualties. The casualty must have a clear diagnosis of acute psychological illness, be unable to perform their duties on operations and require medical return to Australia for their condition within one month of exposure. Members who develop mental health conditions on deployment but not as a result of direct contact with the enemy or subsequent consequences of the contact or post deployment are not classified as battle casualties.

Management of the wounded and injured in Afghanistan will be used as an example of the treatment management system, although similar arrangements exist for other areas of operation. This is currently our most difficult area of operation for the provision of health care and the lessons learnt in this operation have been and are applied to other operations and exercises.

Roles and responsibilities for the welfare of ADF members

Defence is committed to supporting members, and their families, who are wounded or injured while serving in the ADF.

The welfare of members is a command responsibility, which ultimately rests with the Chief of each Service regardless of where the ADF member may be posted.

A Commander remains responsible for the support and welfare of ADF members within their command at all times. Where complex circumstances are present, the appointment of a

Member Support Coordinator provides a Commander with the additional skills and resources required to ensure the provision of the appropriate level of support.

Member Support Coordination

Defence is in the final stages of preparing a policy to confirm the Member Support Coordination arrangements. Completion is expected prior to the end of 2012. Once published, a copy of this policy can be provided to the Committee should it be of interest. Key elements from that policy are described in the following paragraphs.

Member Support Coordination is the overall coordination effort required to ensure that a member, whose circumstances meet the definition of complex, is effectively supported throughout their recovery, rehabilitation and either their return to duty or transition from the Australian Defence Force. Responsibility for the initiation and management of such coordination resides with the member's Commander.

Member Support Coordination is designed to ensure that:

a. the member:

   (1) remains the central focus of support;
   (2) is supported effectively;
   (3) has, in the Member Support Coordinator, a single point of contact with whom they may turn to for assistance, support and guidance (but not specialist advice);
   (4) understands the support and services available to them and their family;
   (5) receives coherent and coordinated support tailored to their needs,
   (6) understands their obligations during the period of support; and
   (7) is provided with all the information and specialist advice needed to make sound and timely judgements; and

b. the member's Commander is provided with the resources, support and access to the additional skills required to ensure the facilitation and coordination of all necessary support.

Member Support Coordination arrangements are established to support individual cases where there are complex circumstances and comprise:

a. the member and their family;
b. the member's Commander, who remains responsible to the relevant Chief of Service for the continued support and wellbeing of the member;
c. a Member Support Coordinator;
d. a Healthcare Coordinator; and
e. all health and administrative agencies and service providers, both within and external to Defence, who are engaged with, or support, the member.

ADF personnel wounded and injured

Since operations commenced in the Middle East in 2002, 249 ADF personnel have been wounded, of which 234 have been in Afghanistan. For the period January to March 2012, four personnel sustained an injury that required their medical repatriation back to Australia for further treatment and rehabilitation. In 2011, 36 ADF personnel sustained an injury that required medical repatriation.

The breakdown for wounded in Afghanistan by year for 2002 – 2012[2] is:

Year	Number of Wounded
2002-2004	4
2005	2
2006	10
2007	19
2008	26
2009	37
2010	65
2011	50
2012	21 (to date)

The types of wounds sustained can be broadly categorised as amputations, fractures, gun shot wounds, hearing loss, lacerations/contusions, concussion/traumatic brain injury, penetrating fragments and multiple severe injuries.

The casualty treatment process is layered to provide the best possible care for Australian troops. All Australian soldiers are trained in basic first aid and initially casualties are provided first aid or administer self aid with combat medical supplies they carry themselves, where possible, within ten minutes of being wounded. During force preparation training at Al Minhad Air Base, all personnel deploying into Afghanistan receive refresher training in first aid that includes the management of catastrophic haemorrhage and airway management. The care of battle casualties training is conducted in a simulated battlefield scenario providing personnel the opportunity to refresh their skills just prior to going into combat. In the event of battle casualties, personnel can correctly apply the life saving medical supplies provided to them.

During initial first aid, an assessment is made as to the severity of the wounds and injuries and if required, the soldiers will then call for additional medical support or an evacuation of the wounded or injured person.

Tactical units may also include combat first aid trained personnel who have received advanced training in the initial treatment of wounds likely to be encountered on a battlefield. Special Forces patrols often include a patrol first aider or advanced combat first aider. These soldiers are trained in advanced first aid procedures and are similar to paramedics in the civilian world.

[2] As at 10 Aug 2012

If required, the wounded or injured personnel will be evacuated to a medical facility for further treatment. This evacuation is conducted by the most suitable and expedient means and this is most usually by helicopter. Timings for aeromedical evacuation in Afghanistan are based on the severity of wounds or injuries and can be complicated by the tactical situation, particularly if troops are still engaged with the enemy. For life-threatening wounds or injuries the following timings are mandated by International Security Assistance Force and endorsed by Australia.

Evacuation assets aim to reach seriously wounded soldiers within one hour of wounding, and provide en-route care based on the clinical needs of the patient. This one hour guidance is not always possible when the tactical situation delays evacuation. All attempts are made to evacuate casualties to a medical facility able to provide surgery within two hours of wounding. This is the basis for the 10:1:2 rule – first aid within ten minutes, advanced resuscitation within one hour and surgery within two hours of wounding. For non-life threatening wounds the timings are extended, although in many cases the evacuation process is such that the same timings result.

Australians serving in Uruzgan rely on a team of highly skilled United States (US) and Australian trauma and medical staff working in a well equipped International Security Assistance Force Role 2E health facility in Tarin Kot. ADF health staff supporting this facility consists of three medical officers, two nursing officers and number of medics - usually about six in Tarin Kot and a number out at the Patrol Bases. These personnel are on-call for trauma two times a week providing emergency care and preparing the wounded for evacuation as required.

This facility performs the initial trauma management similar to that provided by the emergency department of a civilian hospital and if required, the facility can also undertake emergency surgery to treat the wounded or injured.

ADF members who are wounded or injured and suffer minor physical impairment are treated and, once fit, return to duty.

Casualties that require more specialist care than can be provided at the Role 2E at Tarin Kot are evacuated to the Kandahar Role 3 Multinational Medical Unit. Depending upon the treatment required casualties may receive further surgery, be clinically stabilised, and/or provided supportive care. The facility is predominately staffed by US health specialists but is currently being augmented by ADF specialist reserve staff. The ADF currently has a general surgeon, anaesthetist, orthopaedic surgeon, two perioperative nurses and two intensive care nurses embedded in this facility.

Once stabilised, seriously wounded or injured personnel will be returned to Australia for additional treatment and rehabilitation which is managed by Joint Health Command.

Notification of wounding or injury is raised as quickly as possible to ensure both the family and command chain are informed as soon as possible. Contact between the member and the family takes place as soon as possible.

(b) repatriation arrangements for wounded and injured personnel from operational areas to Australia;

All ADF members who require return from operational areas for medical reasons are evacuated to Australia via the Air Force strategic AME system. The AME system ensures that members are evacuated in a safe and appropriate manner. It also provides a valuable patient tracking function ensuring that returning members are identified to the ADF medical system, Defence Community Organisation and their chain of command for management and support.

While most wounded or injured ADF members can be directly returned to Australia, members who become critically ill or injured while in the Middle East Area of Operations (MEAO) may be evacuated by the US AME system to the US Military Hospital in Germany.

The MEAO AME system operates throughout the area of operations acting on a continuum, transferring the patient as appropriate to access the most appropriate treatment. When there is an Australian casualty in Afghanistan an evacuation request is issued to the relevant Regional Command. This then tasks a rotary-wing AME asset and team to retrieve the casualty for transfer to the most appropriate treatment health facility. The Regional Command notifies the treating health facility to ensure that it receives advance notice of the casualty arrival.

On arrival at the casualty location, the forward AME team will usually only remain on the ground for the least amount of time possible. The casualty is then taken to a Role 2 or R2 Enhanced health facility depending on the clinical situation. On arrival at the health facility, the Australian casualty is assessed and resuscitated as appropriate. If the patient requires treatment unavailable within the health facility, a second patient movement request is sent to the Regional Command; they then would task an appropriate rotary- or fixed-wing AME asset and team to transport the casualty to a Role 3 health facility.

If further specialised treatment is required, the casualty may be transferred to the US Role 4 hospital in Germany. The AME Operations Officer situated in Afghanistan and the Aeromedical Evacuation Control Centre (AECC) would assist in this transfer decision. This AME is usually by the US AME system on a dedicated tactical C–130 AME flight to Bagram, then by strategic C–17 AME flight to Germany. If a delay in Bagram would have jeopardised the clinical situation, a C–17 could be used from any Role 3 health facility for direct transport to Germany.

The Aeromedical Evacuation Officer in-theatre is responsible for coordinating the AME of ADF members to Germany. The Headquarters Joint Operations Command (HQJOC) AECC is then responsible for organising the subsequent AME to return members to Australia when clinically appropriate.

ADF casualties who enter the US AME system are all provided with an ADF medical escort. Within the MEAO there is an Aeromedical Evacuation Liaison Officer whose primary role is to provide this escort duty. Other ADF escorts may also accompany casualties transferred to Germany, such as a unit representative to provide emotional support and assistance to the patient. When a casualty arrives in Germany, the AME liaison role is then transferred to another AME trained liaison officer who has been dispatched from Australia. Typically this liaison officer is an AME and aviation nursing qualified registered nurse, or depending on complexity of the case, an additional AME and aviation medicine qualified medical officer may also be required.

The presence of an ADF medical liaison officer ensures that there is direct communication of clinical details throughout the AME process, as well as visibility of the patient's movements and ensures that the member is never left without support or contact with the ADF. The liaison officer provides clinical updates and advice on patient's 'fitness to fly' for strategic AME. They also provide assistance to any next of kin who may travel to Germany. They are integral to the AME planning process, providing accurate and timely clinical information and usually forms part of the AME retrieval team to Australia.

The Defence Community Organisation administers the Australians Dangerously Ill Scheme that allows for a nominated family member or close friend to access financial assistance to visit and support an ADF member who has been hospitalised through serious wounding, injury or illness. The Defence Community Organisation facilitates the movement of eligible family members under this scheme to visit their wounded family member who has been evacuated to Germany. Family members are usually accommodated at one of two US military supported "Fisher Houses" immediately adjacent to the Landstuhl Regional Medical Center. Fisher House is a non-profit social service providing a "home away from home" for family members of ill/injured patients and is located within walking distance of the treatment centre. The homes are built by the Fisher House Foundation and given as gifts to the United States military Services. The houses are manned six days a week to help family members endure the stresses associated with a loved one's serious medical condition. Social workers are also available throughout the week. In 2012 the ADF has made a donation of $225K to the Fisher House Foundation in recognition of the outstanding support provided to ADF families during these difficult times.

The Defence Community Organisation works closely with the military chain of command to manage the support requirements of the member and the family to ensure the wounded or injured member has the best chance of recovery and the family is adequately supported to reduce their stress.

Identification and confirmation of the most appropriate destination medical facility, for the patient on return to Australia is done in consultation with the patient, next of kin, Joint Health Command and the member's respective Service. The most suitable means for the AME is identified by the AECC; military air, civilian charter or civilian airline, using standard or critical care (Military Critical Care Aeromedical Team) AME teams as appropriate. This ensures the patient receives appropriate care and is returned safely to Australia.

Most AME returns from the MEAO and Germany can be conducted on civilian airlines using RAAF AME teams; when this is not appropriate then ADF aircraft can be utilised. In the last two years, the RAAF has conducted two multi-casualty AME retrievals of injured ADF members from Germany. In both cases, these AME missions involved multiple patients with complex care requirements, including intensive care type support. These missions were conducted on C-17 aircraft using both Permanent Air Force and Reservist AME trained personnel, and the dedicated C-17 AME equipment suites. There have also been several C-17 AME conducted directly from the MEAO when the patients were not suited to other available means of transport.

(c) care of wounded and injured personnel on return to Australia, including ongoing health, welfare, and rehabilitation support arrangements;

Once it is known that an ADF member has been wounded or injured, Joint Health Command liaise with HQJOC, the Air Operations Centre (an Air Force element embedded within

HQJOC) and health staff within the area of operations to ensure that the wounded or injured member is repatriated to the most appropriate health facility. This could be a Defence health facility or a public or private hospital depending on the nature of the condition and requirements for health care. Wounded or injured personnel are repatriated to a facility within their home area where possible; however this depends on the nature of the wounds or injuries and the services available at that location. Access to family and their Unit/Service support is also considered in the return to Australia planning.

The Defence Community Organisation provides emotional and practical support to the family in the form of social work and counselling or referral to appropriate community support and services.

On return to Australia, medical/clinical management of the care of the wounded or injured individual is transferred to Garrison Health Operations and a comprehensive range of clinically appropriate health care is delivered through one of the five Regional Health Services. As previously stated, the overall responsibility for ensuring the support and welfare of the member remains with the member's Commander.

Within five to ten days of returning to Australia, the member is placed in the ADF rehabilitation program to manage all their health and rehabilitation requirements.

The ADF rehabilitation program aims to:

a. reduce the impact of injury or illness through early clinical intervention;
b. reduce any psychological effects of the injury;
c. return the member to suitable work at the earliest possible time; and
d. provide a professionally managed rehabilitation plan tailored to individual needs.

There are three complementary programs for the recovery and rehabilitation of ADF personnel and each has a different purpose and scope depending on the clinical, vocational and psycho-social needs of each individual. These programs include the ADF Rehabilitation Program, the Paralympics Sports Program and the Simpson Assistance Program.

ADF Rehabilitation Program. The ADF Rehabilitation Program is delivered by the Garrison Health Organisation and provides an occupational rehabilitation service. This includes the coordination of care through Comcare approved rehabilitation consultants, who are the conduit of information between other support Services, Command, medical and the member. In addition, the ADF Rehabilitation Program provides rehabilitation assessments, rehabilitation programs and specialist assessments such as home, workplace, activities of daily living, functional capacity and vocational assessments. This program also provides for non-clinical aids and appliances.

Paralympics Sports Program. The Paralympics Sports Program, through an established relationship with the Australian Paralympic Committee, supports all serving ADF members with acquired disability to adopt an active lifestyle, regain their physical fitness and participate in adaptive sport right through to elite Paralympic sport.

Simpson Assist Program. Joint Health Command identified a rehabilitation capability gap relating to the overall clinical services for severely injured members and support to their families which resulted in the development of Simpson Assistance Program and Government

funding. The Simpson Assistance Program will deliver new recovery and rehabilitation services by developing a tailored, integrated and multidisciplinary approach to accelerated rehabilitation for seriously wounded, injured and ill members. Simpson Assistance Program initiatives will contribute to rehabilitation excellence through a focus on:

a. a new Intensive Recovery Program to be trialled in Townsville and Holsworthy in 2013;
b. new holistic psychosocial member and family support services;
c. improved clinical treatment options;
d. provision of meaningful engagement options to Defence members on rehabilitation;
e. improved coordination of services (case coordination as well as a member's healthcare needs perspective);
f. rehabilitation research investment funding; and
g. an ADF Rehabilitation Strategy and improved governance and reporting.

Intensive Recovery Program. The Intensive Recovery Program is the major clinical investment in delivery within the Simpson Assistance Program. The Intensive Recovery Program aims to fill the void between the specialist rehabilitation services available through public/private partners and the general restorative therapies available through Garrison Health. The Intensive Recovery Program will implement a specialist and highly experienced rehabilitation team, and the required equipment and supporting facilities, to provide individually-tailored recovery programs to members with complex circumstances. The team will also provide a specialist advisory and assessment service within the region and nationally. Following an extensive scoping phase, the Intensive Recovery Program will be piloted over 18 months, commencing in February 2013 in Lavarack Barracks (Townsville) and at Holsworthy Barracks (Sydney).

Support for Wounded, Injured or Ill Program

An analysis and identification of gaps in the support to ADF wounded, injured or ill personnel resulted in Defence and Veterans' Affairs jointly implementing the Support for Wounded, Injured or Ill Program (SWIIP) which is designed to take what is generally acknowledged as a good system and make it better. SWIIP aims to ensure the focus is on the member and their family, and that complexity involved in obtaining support is reduced and that any gaps in support are closed.

Army – Support to Wounded, Injured and Ill Program. The Army – Support to Wounded, Injured and Ill Program (A-SWIIP) facilitates the effective management of seriously wounded, injured and ill Army personnel, through a framework within which members are provided the support needed to recover.

Responding to the needs of a seriously wounded, injured or ill member and their family necessitates the coordinated and focussed efforts of the chain of command and supporting agencies to ensure that every member returned to the workplace after an injury or illness contributes to ongoing capability.

The framework of A-SWIIP ensures that Commanders are able to mobilise and coordinate all the resources required to support their wounded, injured or ill soldiers. Commanders appoint a

Unit Welfare Officer as the soldier's primary contact to access local services and oversee the Welfare Board process.

Welfare Boards with multidisciplinary representation are conducted regularly to track progress, coordinate support and identify any issues to be resolved.

Army Member Support Coordinators are regional subject matter experts on casualty management. They provide the member and unit an established point of contact to assist with provision of aids for independent living, access to compensation submissions and assistance in meeting travel and accommodation requirements.

The A-SWIIP framework functions to manage seriously wounded, injured or ill soldiers requiring convalescence, hospitalisation and/or significant assistance with activities of daily living.

The three broad levels of management are:

a. normal medical management – applies where no medical employment classification (MEC)[3] action is required and supported by usual command arrangements;

b. standard rehabilitation – applies to members who are classified as MEC 3 for periods up to 12 months and managed via Unit Welfare Boards; and

c. extended rehabilitation – applies to members with severe wounds, injury or illness and is managed via Individual Welfare Boards.

Extended rehabilitation is a two year program designed to provide time in which to evaluate the member's ability to be retained in their previous trade, retrained or transitioned. Options exist for a further three year extended transition period focused on vocational/civil employment skills and education. This phase prepares the member for separation from Army.

Navy SWIIP initiatives. Navy has stood up similar processes to Army including Member Support Coordination officers. During the initial phase of the wounded or injured member's treatment a medical employment classification determination will be made and this is the authority to administratively post the member to the nearest Navy Personnel Support Unit. At this stage, the Member Support Coordination officers will be the liaison between the medical facility and Command. The Commanding Officer of the Navy Establishment in which the Personnel Support Unit is located has the ultimate responsibility for the health and welfare of the member under their command.

The Member Support Coordination officers will continue in the liaison role between the appointed Joint Health Command Rehabilitation Consultant and the Personnel Support Unit once the member has been discharged from hospital and commences rehabilitation. The Member Support Coordination officers will coordinate with the member, the member's next of kin and the Rehabilitation Consultant to ensure all non-health agency or other authorities' actions are coordinated to align with the healthcare of the member. The Member Support Coordination officers will ensure that the member or their representative is visited by DVA Affairs On Base Advisory Service personnel for the processing of DVA compensation claims. The Member Support Coordination officers will ensure that the member's care and rehabilitation is raised for discussion at the member's parent unit Command Focus Group. On behalf of Command, the Member Support Coordination officers will ensure that periodic case

[3] Medical Employment Classification (MEC) - MEC 1: Fully Employable and Deployable, MEC 2: Employable and Deployable with Restrictions, MEC 3: Rehabilitation, MEC 4: Employment Transition, MEC 5: Separation.

conferences are convened to track the progress of their care and have the member, their representative and other key stakeholders agree to treatment/rehabilitation course of action.

If the member's medical condition indicates that a return to work in their current or alternative employment is likely, a return to work strategy will be planned at one or a series of Case Conferences by the Rehabilitation Consultant, the Member Support Coordination officers and the Personnel Support Unit Case Officer. In addition to the active clinical rehabilitation of the Navy member, the Rehabilitation Consultant, the Member Support Coordination officers and the Personnel Support Unit Case Officer ensure that the member has 'meaningful engagement' during periods when they are not undergoing actual rehabilitation treatment.

If the member will not be able to return to work in the Navy a transition timeframe is developed to ensure a strict succession of actions are implemented to ensure the smooth transition of the member. These are coordinated by the Member Support Coordination officers with oversight from the Personnel Support Unit Case Officer. These actions include, but are not limited to resettlement counselling and liaison.

Air Force SWIIP initiatives. Air Force will establish the Member Support Coordination Office incorporating the existing Compensation Claims Liaison Officer-AF. It will encompass both compensation claims support and the Member Support Coordinator function. The Member Support Coordination will assist commanders with the effective management of members with complex health circumstances and link into the Soldier Recovery Centres where required. This will ensure that all relevant support services are in place for the member. The dual role of the Member Support Coordination Office will also ensure that these members will receive appropriate and prompt compensation assistance.

Air Force is also in the process of establishing Individual Welfare Boards for individual case management of Air Force people. These Boards will be conducted at unit level and will allow a member's commander to consider all aspects of a member's health and wellbeing so that appropriate action is taken to ensure the best outcome for the individual.

Soldier Recovery Centres. Army has established the Soldier Recovery Centres under Army's contribution to the Support to Wounded, Injured & Ill Program. Their mission is to provide command, leadership and management of complex rehabilitation cases.

Whilst the majority of personnel health and welfare issues can be resolved through normal command and management processes, Army recognises that additional resources and management are required to coordinate the support and services required to personnel and their families with complex care requirements.

The Soldier Recovery Centres aim to provide a positive recovery environment where personnel are engaged in meaningful activities and are enabled to focus on their recovery mission.

Soldier Recovery Centres are staffed with specialist Medical Corps personnel equipped with the skills, knowledge and dedicated focus to facilitate the recovery process following the wounding, injury or illness. They do this through effective coordination with the range of service providers and agencies (including Joint Health Command, Defence Community Organisation, Transition Support Services and the DVA), development of tailored recovery training and education programs, and support for personnel and their families.

Although the primary goal is usually a return to work in the same role prior to entry into the recovery program, this may not always be possible. Other outcomes could include a return to work in a different role in the Army or ADF or a successful transition from Army.

Soldier Recovery Centres are operating in Townsville, Darwin and Sydney. An additional Soldier Recovery Centre in Brisbane will be fully operational by the end of 2012.

(d) return to work arrangements and management for personnel who can return to ADF service; and

Defence is committed to ensuring that for those who become wounded and injured, their recovery, rehabilitation and return to work is a priority.

Through clinical and occupational rehabilitation services Defence is successfully reducing the impact of injury or illness, including mental health conditions, and returning significant numbers of ADF personnel to the workforce.

The increased focus on a return to work and recovery based approach to rehabilitation in the ADF and the impact of operational deployments are the basis for the significant increase in rehabilitation referrals and active individual rehabilitation programs over the past two years.

(e) management of personnel who cannot return to ADF service including:

i. the medically unfit for further service process;

The ADF Rehabilitation Program aims to support their return to work in current or different duties or trade or, if this is not possible, they will be rehabilitated, medically separated and supported to transition to the civilian environment.

In an effort to achieve a seamless transition for a member, the various elements of Defence (including Joint Health Command, the three Services, and the Defence Community Organisation) and the DVA work closely and collaboratively. Of particular importance is the early involvement of the Department of Veterans' Affairs to ensure that the appropriate arrangements for support post-discharge are understood.

Medically separating ADF members are referred to a regional ADF Transition Centre as soon as it is deemed likely that a member may be classified as medical employment category (MEC) 4. There are 18 regional ADF Transition Centres that advise and assist members and their families on accessing whole of government transition support services, completing Defence separation requirements and accessing separation benefits and entitlements. As part of the separation preparation, the ADF Transition Centre links members to a variety of services including DVA compensation, ComSuper, Centrelink, Veterans and Veterans Families Counselling Service and other support services as required.

ii. transition from ADF managed health care and support to Department of Veterans' Affairs managed health care and support; and

Transition from ADF managed health care and support to DVA managed health care and support is the responsibility of the relevant single Service. Transition support services provided by the Directorate of National Programs in the Defence Community Organisation ensure that members and their families remain well informed, and are encouraged to access educational, financial, rehabilitation, compensation and other government services to facilitate a sound transition.

Informing military members of these vital transition support services is one of the roles of the regional ADF Transition Centres where members are required to finalise their administrative arrangements well before their date of separation from the ADF.

If the member is on a Rehabilitation Program, then prior to separation the Joint Health Command assigned Rehabilitation Consultant ensures the member understands and has access to all appropriate services. The Rehabilitation Consultant ensures the member completes all required separation tasks. The ADF Rehabilitation Program provides access to vocational and functional assessments to assist the member in determining appropriate vocational choices post separation. The Rehabilitation Consultant works closely with ADF Transition Centres and the Department of Veterans' Affairs to provide information to assist in their determination regarding funding and training requirements.

Defence is also committed to providing flexible support for those military members who need to separate at short notice for medical or compassionate reasons. Separating members are provided with effective and appropriate rehabilitation support. The Rehabilitation Consultant liaises with all key stakeholders, including the treating doctor, ADF Transition Centres, DVA and the Defence Community Organisation to ensure all ongoing services required are in place, including medical assistance and vocational rehabilitation, before their transition to civilian life.

Defence also ensures ADF members receive a smooth transition to the DVA and other support agencies. This includes a handover from the ADF Rehabilitation Consultant of key information and the Rehabilitation Authority to the Department of Veterans' Affairs.

In addition to the regional ADF Transition Centres, information on transition support services is available through a variety of resources. For example, the *ADF Transition Handbook* is a quick guide to transition information and support and is available on the internet.

The DVA On-Base Advisory Service was introduced as a Support to Wounded, Injured & Ill Program initiative in October 2011 at selected bases around Australia. Skilled DVA staff provide information, advice and support to all ADF members on matters relating to the provision of the DVA services and benefits. This service is provided using an agreed visit schedule ranging from five days/week to one or two days per week or month. This ensures a more streamlined and integrated approach between Defence and the DVA to support wounded, injured or ill ADF members.

Functions of the DVA On-Base Advisors include:

a. providing support for any current or prospective compensation claims;
b. providing early identification of health, rehabilitation and income support requirements post separation;
c. liaising with Member Support Coordinators and other Defence personnel dealing with injured members and provide appropriate advice;
d. presenting and participating in transition management seminars and information sessions and events;
e. where requested, briefing ADF personnel and families as part of their pre and post deployment briefings; and

f. developing and maintaining relationships with the ADF community, Garrison Health Operational Staff, ADF rehabilitation consultants and where necessary Defence transition staff.

The co-location of the DVA officers in Joint Health Command health facilities wherever possible has encouraged a collegiate approach between both Departments ensuring ADF personnel are provided timely and accurate advice. A commitment to the longer term availability of this service has been undertaken and this includes ongoing access to existing infrastructure capability within Defence health facilities.

The implementation of the DVA On-Base Advisory Service is a significant service delivery enhancement for members of the ADF. Member enquiries to the On-Base Advisory Service have steadily increased since the service's inception, and feedback received in relation to the service is positive.

iii. ongoing health care and support post transition from the ADF.

DVA provides ongoing health care and support post transition from the ADF. Defence is unable to make comment on this particular element.