CHAPTER ONE

BACKGROUND

> The perceptions and expectations of military personnel and their families have changed. No longer can the military health system just deliver a fit fighting force and care for battlefield casualties. It must also address the potential long–term health effects of military deployment including low level environmental exposures, occupational risks and psychological stress. The Australian Government, including the Department of Defence, has a continuing obligation of care for those who volunteer to serve in the ADF when in service and after discharge.[1]

1.1 The terms of reference of this inquiry were developed to address a number of questions about the extent to which the ADF had the capacity in its provision of health services to minimise potential injury or illness to personnel while on deployment, and post deployment.

1.2 This reflects the concern of veterans and ex service personnel that the health effects of exposure to a range of hazardous substances has not been sufficiently recognised and that compensation is not payable for a range of disabilities which they believe are service related.

1.3 The terms of reference therefore focus on current administrative arrangements between the Departments of Defence and Veterans' Affairs which have divided responsibility. It is suggested that within each agency, and between each agency, there are some serious discontinuities which prevent a more holistic approach to the management of health prior to, during, and after service.

1.4 Several of these issues have been addressed or discussed in recent reports, including the Clarke report on veterans' entitlements,[2] which listed a number of similar matters, and made recommendations for changes; and in specific studies on different conflicts. Nonetheless, a number of questions remain unanswered in that some groups are dissatisfied with the outcomes of these reports, or some inquiries have not yet been completed.[3] These questions include the following, against which the terms of reference are noted:

- If deployment health services in general meet their objective; 1(a)
- If there are adequate processes in place to identify and minimise the effect of environmental/chemical /biological hazards in more recent conflicts, and if the information on these is also maintained on individual files; 1(a), 1 (b), 1(c)

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1 *Submission* 5, Regular Defence Force Welfare Association Inc, p. 1, paragraph 2.

2 Hon John Clarke, QC et al, *Report of the Review of Veterans' Entitlements*, Canberra 2003.

3 See below, Chapters 3 and 4.

- Whether the personal medical and related records of individuals in the ADF, and veterans, contain full and accurate information, including on environmental exposures; 1(c)
- If information provided on health risks and on drugs/vaccinations especially 'pre–deployment', is adequate; 1(c)
- Whether there is rapid access to personal medical records, especially for the purpose of filing a claim; 1(b)
- If there is rationalisation of research work undertaken by the ADF and by the Repatriation Commission and effective amalgamation; and whether this research is addressing the needs of ADF personnel and of veterans of earlier conflicts; 1(f) and
- The roles and effectiveness of all parties/agencies involved in deployment, record keeping, research and claim assessing; 1(e).

1.5 The Australian Defence Force (ADF) comprises three separate forces, Army, Navy and Air Force. The management and administration of each is a separate responsibility, and the day to day provision of health services to serving personnel has varied over time. At times each force had its own set of services, many of which were under-utilised, and it is only recently that there have been effective moves to centralise and integrate, following several reviews in the last few years which have emphasised high costs and waste, albeit mostly in non–deployed services, and recommended centralisation and greater efficiency in operation.[4]

1.6 Much of the emphasis on change in the ADF has followed similar strategies operating in both the United States and the United Kingdom, both of which have deployed substantially larger forces to a wide range of conflicts and other missions.[5] Above all, the objective of these strategies is to ensure that the deployable staff are fit and that injury and illness are minimised and treated effectively. However, there has not been a corresponding emphasis until recently in the ADF on appropriate training practices and occupational health and safety.[6] The effect of this has been to reduce the number of persons who complete the recruitment training, and limit the number of active personnel available for deployment. With a greater awareness of the effect of

4 See Australian National Audit Office (ANAO), Audit Report No.34 1996-97 *Australian Defence Force Health Services,* Canberra 1997 and Audit Report No**.** 51 2000-2001 *Australian Defence Force Health Services Follow-up Audit*, Canberra 2001. For other reviews, see *Defence Efficiency Review* 1996, *Defence Reform Program* 1996/97 (see below, Chapter 2, paragraph 2.17**,** and Inspector General Department of Defence Inquiry HealthKEYS, 2002 (*Submission* 9A, Defence Organisation, Question 7). Defence also advised on the nature of another recent review: 'The purpose of the Defence Health Service (DHS) Review, conducted by Major General J.P. Stevens, AO (Retd), was to evaluate whether the DHS was able to meet Defence's need for health services in the short to medium term and to propose any changes that may be necessary to achieve this,' *Submission* 9B, Defence Organisation, p. 5, Q3—additional details are contained in that document.

5 See Chapter 2, paragraphs 2.1–2.5.

6 See below, paragraph 1.7 and Chapter 2, paragraphs 2.92–2.93.

training and other injuries[7] and also of the poor occupational health and safety record in the ADF,[8] there is now more emphasis on preventive and pro–active approaches.

1.7 Previous lack of harm minimisation policies in operation within Australia resulted in resources being wasted and many problems not being identified until later, which can have the further effect of higher costs for rehabilitation or pensions. At the same time as there have been complaints about the use of chemicals and other substances in conflicts, there has also been a limited understanding of the effect of chemical hazards in the workplace, as illustrated by the report on the F–111de–seal/re–seal process at Amberly.

1.8 The extent of health services required for deployment will vary according to the size of the force and the nature of the deployment. In joint operations with major powers, Australia (with a very small force, relatively speaking) will only be required to send level 3 services which are essentially emergency treatment, as in–patient care will be provided by allies. In other instances, such as Timor, Australia may help operate a UN hospital and take a much greater role, with many more 'medical' staff being deployed. However, deployed health personnel also include psychological services, and there is often a requirement for health updates which may demand the provision of additional preventive treatment in the field.

1.9 Little direct information was provided about the quality of most of these services, but some problems were identified with the availability and accuracy of information on some processes, including exposures to various substances and the recording of such exposures, and with information on vaccinations.

Repatriation Commission/Department of Veterans' Affairs

1.10 Health services and disability payments for former members of the ADF are managed by the Repatriation Commission, which delegates its powers to the Department of Veterans' Affairs (DVA).[9] In recent times there have also been several reviews of, and reports on, aspects of the relevant legislation, the *Veterans' Affairs Entitlements Act* 1986, many of which have addressed concerns about the equity of

7 See Chapter 2, paragraphs 2.92–2.93.

8 'The rates of death and serious personal injury encountered in garrison conditions across all Australian Services remain considerably higher than for matched industry groups. As a result of injuries, significant numbers of personnel are unavailable for deployment and are restricted in performance of their normal duties,' Group Captain Peter S Wilkins, 'Occupational health and Safety Challenges for the ADF', *ADF Health,* 5 (2004) p. 1, and Chapter 2, paragraphs 2.92–2.97.

9 Reference to 'veterans' therefore generally means to persons who are not in the workforce or who have retired. However, many veterans of recent conflicts remain in the ADF or continue in employment as members of the Reserve or other forces. For those working for the Commonwealth, employment–related injury or health problems are dealt with under the Commonwealth Safety, Rehabilitation and Compensation Act (SRCA) which is managed by Comcare. Since 1999, DVA has managed SRCA claims for the ADF. The *Military Rehabilitation and Compensation Act* 2004 will also be used by ADF personnel and reservists.

pensions relative to the cost of living, and recognition of level of disability.[10] Other concerns have been the nature of service, primarily that which is not recognised as war–related, the extent to which certain diseases and injuries are recognised as service–caused,[11] and the role of environmental hazards in particular in contributing to service–related ill health.

1.11 In each of the areas in which concern has been manifested over many years, there has been a perception by distinct veteran communities that:

- governments have failed to meet perceived promises to look after veterans on the basis of increased cost;
- legislation has become more rigorous, [12] excluding many from disability pensions; the Repatriation Medical Authority is 'too scientific' in its Statements of Principle;
- other governments, including the United States, New Zealand, and, at times, the United Kingdom, have been more generous to veterans;
- there has been limited recognition of many factors believed to be responsible for service–related illness/injury, including radiation and chemicals, and exposures to these have not been measured or listed in records; and
- the organisation and maintenance of service records has been chaotic, with what are believed to be relevant causal factors not being listed.

1.12 A number of these issues indicate that some veterans do not recognise that modern warfare has changed, and the nature of many deployments has also changed. While acknowledging that each different type of deployment can result in particular stresses, governments are also seeking to bring the issue of compensation closer to that which is applicable in the broader community. The recent *Military Rehabilitation and Compensation Act* 2004 represents an effort to overcome the problems caused by the existence of a range of legislation where different payments were available based on factors such as date of joining the ADF, and some personnel had double entitlements. While many of these complicating factors will continue because of prior service by current ADF personnel, all injuries and illness from the commencement date will come under the new legislation which will help provide some uniformity.

1.13 A major feature of the new legislation is the importance of rehabilitation and of return to the workforce. While many may have been seriously injured in World War 2, Korea and Vietnam, and had a reduced capacity for employment, this outcome

10 See Professor Peter Baume et al, *A Fair Go*: *Report on Compensation for Veterans and War Widows,* Canberra 1994.

11 See Hon John Clarke, QC et al, *Report of the Review of Veterans' Entitlements*, Canberra 2003.

12 For example, through the creation of the Repatriation Medical Authority in 1994, along with the requirement that the Authority rely on medical–scientific information in making Statements of Principle, see below paragraphs 1.16–1.25.

is now less common in more recent deployments and missions.[13] Thus, while there is provision in the legislation for serious disability, there is an expectation that this will be more of an exception, and that treatment will assist with other injuries and illnesses. This is similar to the attitude behind recent equivalent legislation in the United Kingdom.[14]

1.14 This approach is not relevant to veterans groups, many of whose concerns go back to World War 2, and who believe that their entitlements should not be restricted by modern formulae requiring more rigorous medico–scientific evidence. This belief therefore does not accept some of the changes that have occurred in legislation and which have been in place for several years, especially the demonstration of a specific link between service and disease. However, in either case, the relatively limited research on the long–term effects of some exposures complicates this issue, since it raises the question of responsibility for providing information on exposures.

Veterans' issues

Governments and costs

1.15 Successive governments *have* tended to make reforms piecemeal rather than undertaking substantial change because of the sheer size of the veteran population, with cost a likely factor. However, the environment in which veterans' legislation developed between the first and second world wars was conducive to the extension rather than the contraction of benefits. The reverse onus of proof was introduced in 1929,[15] and has remained a key principle in the legislation, although on occasion it has been misunderstood by claimants. In conjunction with the term 'reasonable hypothesis' which linked the disease or injury to service, there was a very broad benefit of the doubt both with respect to facts and medical evidence on the medical causation (aetiology).

1.16 Both a concern about costs and about inappropriate claims influenced changes made in the 1980's and, especially, the 1990's. Originally, the veterans' legislation did

13 This includes serious injury caused in a non–deployment situation.

14 United Kingdom, Ministry of Defence, Veterans Agency/ Department for Work and Pensions, *Pathways to Work*: 'MoD and UK armed forces have a distinguished tradition in respect of successful rehabilitation and return to work. That tradition continues through the supported approach to medical downgrading (focus on rehabilitation at community level and by Headley Court), consideration of employability and the resettlement arrangements for those eligible.

Of these medically discharged each year, only a small number have serious disorders. The armed forces are a highly selected population and many medical dischargees leave only because of the very high standards of mental and physical health required for operational fitness and the relative lack of downgraded opportunities in the post Options for Change.' at http://www.veteransagency.mod.uk/pdfolder/vasecpdfs/pathways_work.pdf, p. 2.

15 The Hon John Clarke, QC et al, *Report of the Review of Veterans' Entitlements*, volume 1, paragraph 3.23: 'An important principle laid down in the legislation related to the onus of proof. Once the appellant had made out a prima facie case, the onus was on the Repatriation Commission to disprove it'.

not have regard to medical–scientific evidence, but a 1993 report by the ANAO[16] and the 1992 Bushell decision[17] had demonstrated the pitfalls of 'reasonable hypothesis' outside of scientific guidelines, leading, via a review,[18] to the development of the Repatriation Medical Authority (RMA) in 1994.[19] The RMA was established specifically to provide a medical–scientific input through the use of Statements of Principles.[20] Although eligibility for claims had become extensive, and the reverse standard of proof remained, a tighter definition of illness and injury restricted access to several veterans. It is this aspect of the legislation which remains the most contentious, because it has removed the opportunity for access to a disability pension where there is no satisfactory aetiology.

1.17 Under S 196B of the Act, the Authority can only operate in accordance with medical-scientific evidence, which is defined at S5AB(2):

> S5AB(2)
>
> Information about a particular kind of injury, disease or death is taken to be sound medical–scientific evidence if:
>
> (a) the information:
> (i) is consistent with material relating to medical science that has been published in a medical or scientific publication and has been, in the opinion of the Repatriation Medical Authority, subjected to a peer review process; or

16 Auditor General, *Audit Report No. 8 1992–93: Efficiency Audit, Department of Veterans' Affairs: Compensation Pensions to Veterans and War Widows*, Canberra 1993.

17 Bushell v. Repatriation Commission [1992] HCA 47; (1992) 175 CLR 408 F.C. 92/035 (1992) 29 ALD 1 (7 October 1992).

18 Professor Peter Baume et al, *A Fair Go: Report on Compensation for Veterans and War Widows*, Canberra 1994.

19 A brief outline of standards of proof in the legislation is given in the submission by the Vietnam Veterans Association of Australia to the Review Committee on the *Veterans' Entitlements Act, 2002* at www.vvaa.org.au, pp. 2–3. A more detailed history of the changes in legislation is given in Chapter 3 of the Hon John Clarke, QC, *Report of the Review of Veterans' Entitlements*, Canberra 2003, volume 1. The United Kingdom provides that claims made for a war disablement pension 'after 7 years', reverses the onus of proof from the 'department' to the claimant but 'reliable evidence' could raise a 'reasonable doubt', which would be sufficient for the claimant to succeed: this appears much the same situation as Australian legislation prior to the 1994 amendments: 'Whilst it is true that the rule switches the onus from the Secretary of State to the claimant at the seven year point, for a claim to succeed it requires only that the claimant produces reliable evidence to raise a reasonable doubt. Therefore, were further research to show any reliable evidence of there being a service–related cause for an otherwise unexplained illness, claims for war pension could succeed.

This applies not only to Gulf conflict related claims, but to any medical condition suffered by any participant in any theatre. The seven year rule applies not from the end of any given conflict but from the point the individual ends their total service. Some Gulf veterans could still be benefiting from its provisions for over 20 years to come,' United Kingdom, Ministry of Defence, Gulf Veterans' Illnesses, *Government Response to the House of Commons Defence Select Committee's Seventh Report—Gulf Veterans' Illnesses, Financial Assistance*, at http://www.mod.uk/issues/gulfwar/policy/gen_reports/hcdc7report.htm#7.

20 See above, paragraph 1.11.

> (ii) in accordance with generally accepted medical practice, would serve as the basis for the diagnosis and management of a medical condition; and
> (b) in the case of information about how that kind of injury, disease or death may be caused—meets the applicable criteria for assessing causation currently applied in the field of epidemiology.[21]

Legislation has become more rigorous

1.18 With the introduction of the RMA, a greater certainty and consistency of decision–making was possible. The emphasis on peer review and 'generally accepted medical practice' made speculative opinions of individual practitioners irrelevant. In reality, this was beneficial to veterans in that it both removed an element of uncertainty and helped maintain the integrity of the compensation process.

1.19 However, some groups claim that the RMA is 'too scientific',[22] which, in the context of their arguments, generally means that the RMA will not accept a new 'illness' or injury, or any causal factor which is not demonstrated by epidemiology or widely accepted professionally:

> Being deployed to a particular conflict is not a causal factor. When an elevated rate of disease is detected among a particular group of deployed veterans, it is necessary to try to identify a causal link, such as exposure to a specific hazard, which will enable compensation to flow to veterans. Under the SOPs, no presumption of causation can exist without some evidence of causation in the published scientific literature.[23]

1.20 The fact is that the RMA cannot work otherwise than according to the legislation. While research may eventually result in symptoms receiving an accepted diagnosis (as is the case, for example, with chronic fatigue), this does not demonstrate a failure on the part of the Authority. Scientific approaches are based on direct evidence of causal links, replication of situations (such as use of dosimetry in respect to exposure to radiation or calculation of dispersal of toxic substances such as Agent Orange), and the exclusion of other causal factors, all of which take time to demonstrate. By its nature, medical-scientific evidence will rarely be produced rapidly, even though popular beliefs may be vindicated by it:

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21 *Veterans' Entitlements Act 1986.*

22 Veterans' organisations have argued in the past that there is little external assessment of the SOPs because the process is medically dominated (Vietnam Veterans Association of Australia, *Submission to the Review Committee on the Veterans' Entitlements Act,* p. 6, at www.vvaa.org.au) Additional arguments are that a single medical view has no status under the SOP (see the opinion of the Repatriation Commission on the work of one doctor on *du,* at *Submission* 8A, pp. 7–8), and that it has often taken considerable time for scientific research to prove or satisfactorily demonstrate links between events such as exposures to substances and ill health (Vietnam Veterans Association of Australia, *Submission to the Review Committee on the Veterans' Entitlements Act*, pp.5-6, 13, at www.vvaa.org.au).

23 *Submission* 8, Repatriation Commission, p. 16, paragraph 84.

> The timescale of the epidemiology studies is determined by the work which must be carried out to ensure that a rigorous scientific assessment takes place. Accordingly, although many veterans are anxious to know the outcome as soon as possible, the studies cannot be accelerated.[24]

1.21 Prior to the amendments made in 1994, S 120 of the Act provided that the Commission '*shall* determine' a war–caused injury, disease or death 'unless it is satisfied beyond reasonable doubt, that there is no sufficient ground for making that determination'.[25] S120(3) required that there be a 'reasonable hypothesis' linking injury, illness or death 'with the circumstances of the particular service', but there was no guide to what constituted a reasonable hypothesis. With the introduction of the Statements of Principle, a reasonable hypothesis could only be an SOP or a determination of the Commission under S180A(2).[26] 'Reasonable satisfaction' was also to be assessed with reference to SOPs or an S180A (3) determination, reducing opportunity for individual opinions or speculation. Further, the Repatriation Commission was not able to determine claims unless or until the RMA either issued a SOP or stated that it did not intend to make one on the relevant illness or injury.[27]

1.22 The Specialist Medical Review Council[28] can review Statements or decisions not to determine Statements, and in this sense is an appeal mechanism. The Statements are also disallowable instruments,[29] which, in instances where a particular situation is not covered, does provide an opportunity for further public discussion. Nonetheless, S180A was also introduced under the same legislation as the RMA, the Specialist Medical Review Council, S120A and S120B and S 5AB,[30] and therefore seems intended to be a fail–safe. In spite of the emphasis on science and medicine in the other sections, S180A does not require the Repatriation Commission to be 'scientific' in exercising this discretion. If any 'political' decision is to be made, this will be carried out through the Repatriation Commission.

1.23 The Repatriation Commission could not be said to have made any determination that *ignored* medical–scientific evidence. The one instance of an S180A determination since the legislation was amended in 1994 was made under unusual circumstances when the RMA members had not yet been determined. However, although based on medical reports, it appears primarily a political decision.

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24 United Kingdom, Ministry of Defence, *Gulf War Illnesses—A New Beginning,* at www.mod.uk/issues/gulfwar/policy/newbegin, paragraph 32.

25 *Veterans' Entitlements Act* 1986, S 120(1).

26 *Veterans' Entitlements Act* 1986, S 120A (3).

27 *Veterans' Entitlements Act* 1986, S 120A(2).

28 See *Veterans' Entitlements Act* 1986, Part X1B, S 196W.

29 *Veterans' Entitlements Act* 1986 S 196W(3).

30 *Veterans' Affairs (1994-95 Budget Measures) Legislation Amendment Act* 1994, No. 98 of 1994.

1.24 The RMA had not had an opportunity to consider then recent US material on Agent Orange use in Vietnam and make any Statements of Principle on links between Agent Orange and various illnesses before the relevant Minister had received a report from two experts who had also been reviewing US information (Professors McLennan and Smith). The Minister announced in October 1994 that five illnesses[31] were referred to:

> Professors MacLennan and Smith came back and gave a report, which I made public at the end of last week, which specifically stated that in their view there was a sufficient link between herbicides used in Vietnam and some cancers. They said that there were approximately five cancers involved: multiple myeloma, leukemia and three forms of respiratory cancer—namely, lung, larynx and trachea cancer.
>
> In the context of the Veterans Entitlement Act and in the context of the generous nature of the repatriation system in this country—probably one of the best, if not the best in the world—it was decided that we would accept the recommendations of Professors MacLennan and Smith to the effect that we would give the Vietnam veterans the benefit of the doubt. [32]

1.25 The information provided by Professors McLennan and Smith was also similar to that provided by the United States Department of Veterans Affairs. Distinguishing *inter alia* its role in making recommendations regarding policy, from the National Academy's role in reviewing scientific evidence,[33] USDVA had recommended adding multiple myeloma and respiratory cancers. The United States DVA Task Force, however, had not accepted a link between herbicides and leukemia, which Professors McLennan and Smith did. [34] The use of S180A however, has been limited:

> …the Repatriation Commission has been cautious in applying this provision and, while not requiring the level of scientific evidence required by the RMA, has taken the view that the legislation requires some evidence and a plausible scientific basis.[35]

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31 The Repatriation Commission submission refers only to four diseases, *Submission* 8, pp.8–9: 'The Repatriation Commission has issued four S180A Statements, for the following conditions: Chronic myeloid leukaemia, Acute myeloid leukaemia, Acute lymphoid leukaemia, Chronic lymphoid leukaemia.' This suggests that the other disorders were accepted by the RMA, with only certain leukaemia's requiring the 'benefit of the doubt', see *Submission* 8, Repatriation Commission, p. 17, paragraph 85.

32 *Hansard*, House of Representatives, 13 October 1994, p. 2008, The Hon C A Sciacca. See also *Submission* 8, Repatriation Commission, p. 17, paragraph 85.

33 Professors R McLennan and P Smith, *Veterans and Agent Orange Health effects of Herbicides used in Vietnam* (27 September 1994), pp. 6–7.

34 Professors R McLennan and P Smith, *Veterans and Agent Orange Health effects of Herbicides used in Vietnam*, p. 9: 'If the association between leukaemia and smoking is accepted, the number of cases of leukaemia in non-smoking veterans would be small, and these should be given the benefit of the doubt'.

35 *Submission* 8, Repatriation Commission, p. 17, paragraph 85.

1.26 The RMA has also been seen as lacking an awareness of 'military' factors which are considered relevant in determining eligibility under Statements of Principles. Defence suggested that input from 'a senior Defence Health representative' into RMA determinations would be useful.[36] This position was supported, indirectly, by both the Regular Defence Force Welfare Association, which stated that the Authority lacks a complete perspective in some areas, affecting the outcome of claims,[37] and the Australian Peacekeepers & Peacemakers Association which suggests that the RMA needs to both become aware of some issues especially mental health ones, and ensure that the Statements of Principle reflect the results of research.[38]

1.27 However, as the Repatriation Commission points out, there will always be some conflict between what claimants perceive as appropriate and what departments or agencies are able to provide under the law:[39]

> Health research does not always produce evidence of a causal link between service and injury or death, which is fundamental to the acceptance of claims for compensation under departmental programs.[40]

1.28 Given that organisations may request a review and provide submissions to such reviews, there is already in place a process through which new information can be presented for consideration by the RMA.

1.29 The only area in which the Committee believes there could be some improvement with respect to the RMA is to make the website more user friendly, with clearer information on accepted disorders, rather than categorising them under medical terminology such as 'malignant neoplasm'.

More generous legislation in other countries

1.30 Some veterans believe that other countries have accepted the same information on matters such as exposure to chemicals or ionising radiation, and established a causal link in much the same way as the RMA does in respect of other matters. However, while there is a scientific basis to the causal factors in veterans' legislation in other countries, this does not always mean that there is detailed evidence of it, or that all symptoms are determined to be specific disorders.[41] Some countries have

36 *Submission* 9, Defence Organisation, p.7, paragraph 33.

37 *Submission* 5, Regular Defence Force Welfare Association, pp. 5–6, paragraphs 28–30: 'the current SOPs make it difficult for a Navy veteran to be successful for a claim relating to PTSD as the SOPs are written from an Army or land–based perspective' (paragraph 28).

38 *Submission* 6, Australian Peacekeepers & Peacemakers Association, p. 4.

39 *Submission* 8, Repatriation Commission, pp. 15-16, paragraphs 79–80.

40 *Submission* 8, Repatriation Commission, p. 16, paragraph 82.

41 See below, paragraph 1.40.

decided for many reasons to use presumptive cause, often to cut down individual litigation,[42] but will retain a requirement of further evidence in other instances.[43]

1.31 Essentially, all presumptive cause arguments are based on a demonstrable link between factors, but other principles may extend or narrow the field of eligible persons. One example is the role of the US National Academies' Institute of Medicine demonstrating the likely pattern of distribution of Agent Orange in Vietnam, based on data about other chemicals, and the role of the US Veterans Affairs department in deciding that all US personnel in Vietnam had been exposed to Agent Orange.[44] Regardless of the methodology of the inquiry, the scientific approach established a probable cause, but the field of those eligible to make a claim was determined by another, non-scientific, agency. In reality the VA decision may embrace more people than were actually exposed, but this is deemed less relevant than an outcome which may have been more concerned to demonstrate an interest in veterans' needs.

1.32 The United States has more recently accepted a relationship between ill–health and war service much more readily, thus providing more generous access to disability payments. The reason for greater acceptance by the United States of causal links is difficult to discern, especially as the US did not respond particularly quickly to problems arising from the Vietnam War,[45] or even the first Gulf War. Relevant factors contributing to change may include:

- the additional conflicts in the 1990's and the amount of time spent in deployment;

  The United States has been continually involved in conflicts and other missions in a number of countries through the 1990s, with substantial forces generally being deployed. There is therefore a greater data base of personnel available,[46] although in some instances research may be complicated by the

42 See, for example, the statement made in respect of Gulf War claims in the United Kingdom, for cases proceeding in civil courts: 'It is likely that each claim will have to be considered on its merits because each individual's symptoms, degree of disability and personal circumstances, which would determine the level of award, will be different. However, it is possible that a pattern may emerge in handling the first cases which would facilitate the handling of the remainder', United Kingdom, Ministry of Defence, Gulf Veterans' Illnesses, *Government Response to the House of Commons Defence Select Committee's Seventh Report—Gulf Veterans' Illnesses*, at http://www.mod.uk/issues/gulfwar/policy/gen_reports/hcdc7report.htm#15.

43 See below, Chapter 4, paragraphs 4.28, 4.29, 4.42.

44 See above, paragraph 1.25, and see below, Chapter 4, paragraph 4.50.

45 See Chapter 4, paragraphs 4.45–4.46, 4.50.

46 For example, there are some 697,000 Gulf War US veterans, and the UK Ministry of Defence maintains close contact with the US in terms of research. 'The US authorities have a significant programme of work underway in respect of Gulf veterans' illnesses ($155M has been spent and 192 projects commissioned). Hence it is important for the UK Ministry of Defence to keep in close touch with developments there. The Ministry of Defence continues to have a full time Gulf Health Liaison Officer based in Washington DC, who is also the UK representative on the (US) Military Veterans Health Coordinating Board's (MVHCB) Research Working Group. …

fact that some personnel have been involved in multiple exposures over a period of years, and relevant data has not always been collected.

- There is a substantial number of high quality scientific/medical research and review centres in the United States to whom several matters have concern have been referred; their reports are often the basis of legislative and regulatory decisions on eligibility for disability benefits.

1.33 Exposure to numerous hazards and to different operations has illustrated the possibility of injury arising from chemicals and other substances. These have been studied intensively, in spite of the problems in obtaining data and providing information on participants that are referred to below.[47] The fact that relatively new military personnel (including women and ethnic minorities) have been involved in conflicts and have also complained of similar effects from exposures, has helped support beliefs that such claims are not being made only by those who have been in previous conflicts and hence may be affected by multiple factors.

- The greater variation in personnel, with, for example, US forces in the 'Gulf War' including large numbers of women and ethnic minorities.

1.34 On political grounds alone, it would be unwise to not acknowledge the reality of the experiences of either women or ethnic minorities. There is also a much more obvious statement of past incompetence in respect to past policies in the US political arena, without apparent concern as to liability, and possibly a more effective machinery through which existing legislation can be updated.

United Kingdom

1.35 In the United Kingdom, there has been detailed discussion for some time on both the nuclear tests and the effects of the Gulf War. The major issue with respect to the nuclear tests is that the service is not considered war–related, and therefore there is no access to a 'war' disability benefit, even if it were accepted that exposure was sufficient to cause ill–health.[48] All cases therefore must proceed through the civil courts.

1.36 The Gulf War syndrome has resulted in a different outcome. Originally, there was some interest in whether it could be established that the illnesses forming the 'Gulf War syndrome' were 'the result of error',[49] establishing liability. This matter does not seem to have been resolved, and the issue of 'error' has become less

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Both directly and through the liaison officer, the Ministry of Defence maintain close links with the US authorities, including the Executive Office of the President, the Department of Defence (including the Office of the Special Assistant for Gulf War Illness (OSAGWI), the Department of Health and Human Services, and the Department of Veterans' Affairs.' http://www.mod.uk/issues/gulfwar/policy/hcdcmemo3.htm (April 2001).

47 See Chapter 2, paragraphs 2.3–2.6.

48 See below, Chapter 4, paragraphs 4.8–4.13

49 United Kingdom, Ministry of Defence, '*Gulf Veterans' Illnesses—A New Beginning'* (July 1997), at www.mod.uk/issues/gulfwar/policy/newbegin, and below, paragraph 1.37.

important, possibly because there were multiple exposures, some from Coalition forces. However, there remains the option of making a civil claim, a path which has been taken by some veterans:

> The Government is not persuaded that, on the basis of the information currently available to it, there is a case for paying additional no fault compensation to Gulf veterans, separate from and above that which is already available to both Gulf and other veterans by way of war pensions and ABRS. However, the matter will be kept under review in the light of developments and ministers have made clear that if legal liability is established by future research or investigation, MOD will of course pay compensation. [50]

1.37 Like Australia, and, to some extent, the United States, the United Kingdom has not accepted the 'Gulf War syndrome':

> 1. Since returning from the Gulf War in 1991, some British veterans have become ill. Many believe that this ill–health is unusual and directly related to their participation in Operation GRANBY. This is a view also held in some other Coalition countries, particularly the USA, where Gulf veterans have fallen ill since the conflict. However, there is still no medical or scientific consensus on this subject and, after six years, many veterans now feel frustrated at the lack of progress and abandoned to their plight.
>
> …

50 United Kingdom, Ministry of Defence, Gulf Veterans' Illnesses, *Current Activity Relating to Gulf Veterans' Illnesses—Memorandum 2,* at http://www.mod.uk/issues/gulfwar/policy/hcdcmemo.htm. See also House Lords, Official Report, 17 October 2001,Column 680—700: 'We have made a concession to Gulf veterans by undertaking not to rely on the defence of limitation under the Limitation Act 1980 without giving solicitors prior notice. I tell the House that as of 30th September this year we had 1,890 active notices of intention to claim from veterans and members of their families in respect of illness allegedly arising from the Gulf conflict.

However, the Ministry has yet to receive any writs or claims of sufficient detail', reprinted in United Kingdom, Ministry of Defence, Gulf Update December 2001, p. 7, athttp://www.mod.uk/linked_files/gulf_updatedec01.pdf.

See also: 'Since the repeal of Section 10 of the Crown Proceedings Act 1947 on 15 May 1987, British Service personnel have had the same right to claim compensation from the MOD as any other employee against his or her employer. No writs or claims of sufficient detail have been received from Gulf veterans to allow MOD to handle these cases. If such claims are received, the MOD will try to resolve them as quickly as possible and will pay compensation where a legal liability exists. It is likely that each claim will have to be considered on its merits because each individual's symptoms, degree of disability and personal circumstances, which would determine the level of award, will be different. However, it is possible that a pattern may emerge in handling the first cases which would facilitate the handling of the remainder. Where a legal liability is established the vast majority of compensation payments made by the MOD are made without proceeding to court.(United Kingdom, Ministry of Defence, Gulf Veterans' Illnesses, *Government Response to the House of Commons Defence Select Committee's Seventh Report—Gulf Veterans' Illnesses*, at http://www.mod.uk/issues/gulfwar/policy/gen_reports/hcdc7report.htm#15.

> 3. At present there are three significant unknown elements which affect sick veterans. First, some of them have symptoms which have not been fully diagnosed: it simply is not clear what is wrong with them. Second, it is not known in all cases what the cause or causes of the veterans' illnesses might be. Third, it is accordingly not possible to say whether those illnesses are the result of an error on anybodys' part.[51]

1.38 Following on this, the United Kingdom agreed that there would be a three principle approach:

- Access to medical advice (which had become available from 1993[52], through the Gulf Veterans Medical Assessment Programme–GVMAP) and which later included psychiatric assessment and treatment;[53]
- Appropriate research into the illnesses and 'factors which might have a bearing on them; and
- The public availability of all information.[54]

1.39 Research, when completed, produced much the same results as have been available to US and Australian researchers:

> The consensus of the international scientific and medical community is therefore that there is insufficient evidence to enable this ill–health to be characterised as a unique illness or syndrome.

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51 United Kingdom, Ministry of Defence, '*Gulf Veterans' Illnesses—A New Beginning'* (July 1997), at www.mod.uk/issues/gulfwar/policy/newbegin.

52 United Kingdom, Ministry of Defence, Gulf Veterans' Illnesses, *Current Activity Relating To Gulf Veterans' Illnesses: Memorandum 3*, at http://www.mod.uk/issues/gulfwar/policy/hcdcmemo3.htm.

53 'In 1999, an arrangement was set up whereby individuals, who in the opinion of the MAP physicians would benefit from a psychiatric assessment, can be referred at the Ministry of Defence's expense to consultant psychiatrists with a specialist interest and expertise in post traumatic stress disorder (PTSD). A network of such consultants across the country has been set up. Treatment of ex-Service personnel is undertaken by the NHS in the usual way. If the patient is assessed as not suffering from stress reactions to trauma, but some other psychological problem, he/she can be referred on to an appropriate NHS specialist within his/her own area for further assessment and treatment. When these arrangements were reviewed in mid-2000 it became clear that some veterans were waiting too long for appointments and for the reports from these referrals. A fast–tracking arrangement was introduced and is currently meeting targets of appointments within six weeks of referral and a report within four weeks. GVMAP also decided to conduct a follow-up of the effectiveness of the treatments recommended in these cases.

This will be done in conjunction with the referral network and aims to analyse the outcomes of treatment plans in 60–80 cases', United Kingdom, Ministry of Defence, Gulf Veterans' Illnesses, *Current Activity Relating To Gulf Veterans' Illnesses: Memorandum 3*, at http://www.mod.uk/issues/gulfwar/policy/hcdcmemo3.htm.

54 United Kingdom, Ministry of Defence, Gulf Veterans' Illnesses, *Gulf Veterans' Illnesses—A New Beginning* (July 1997), at www.mod.uk/issues/gulfwar/policy/newbegin.

> The Medical Research Council addressed this in a review of research published on 22 May 2003 and came to the same conclusion. The Ministry of Defence's approach must be guided by these findings from the scientific and medical community, and we do not therefore recognise "Gulf War Syndrome" as a medical condition.[55]

1.40 However, the United Kingdom defence compensation system was sufficiently flexible to be able to provide for symptoms as opposed to an accepted 'medical condition', on the basis that being disabled was the relevant factor:[56]

> …it is important to note that this does not stop 1990/1991 Gulf veterans who have left the armed forces and are ill, either ex–Regulars or ex-Reserves, from claiming a War Pension. **War Pensions are awarded not for a list of disorders but for any disablement which can be accepted as caused or made worse by Service, whatever that disablement is called**. The question of whether or not there is such a thing as "Gulf War Syndrome" is not therefore relevant from the point of view of War pensions.
>
> In addition the Armed Forces Pension Scheme and the Reserve Forces (Attributable Benefits Etc) regulations provide enhanced injury and death benefits to regular and reservist Service personnel whose injuries, illnesses or death, was were, on the balance of probabilities, attributable to, or aggravated by, their Gulf service.[57]

1.41 War pensions are not available to persons who remain in the forces, and it is assumed that those who made civil claims in respect of Gulf War syndrome are either still serving, or those who were unsuccessful in their application for war disablement pension. These pensions are tax free, and the claimant does not have the onus of proof;[58] indeed, as noted above, even when the onus of proof changes, the claimant remains in a favourable situation.

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55 United Kingdom, Ministry of Defence, *'Gulf War Syndrome'*, at www.mod.uk/issues/gulfwar/gws

56 United Kingdom, *Naval, Military and Air Forces (Disablement and Death) Service Pensions Order* 1983, as amended.

57 United Kingdom, Ministry of Defence, '*Gulf War Syndrome'*, at www.mod.uk/issues/gulfwar/gws, emphasis added.

58 United Kingdom, Ministry of Defence, Gulf Veterans' Illnesses, *Government Response to the House of Commons Defence Select Committee's Seventh Report—Gulf Veterans' Illnesses*, at http://www.mod.uk/issues/gulfwar/policy/gen_reports/hcdc7report.htm#15:'For deaths arising, or disablement claims lodged within seven years of termination of service, the onus lies with Secretary of State to show beyond reasonable doubt that the disablement or death is not due to service. There is no onus on the claimant to show any link between disablement and service.

1.42 In spite of this apparent concession as to disablement, it is important to evaluate the United Kingdom situation. There is no payment of pension unless one has at least 20 per cent disability;[59] and the rate of pension is not high, although pensioners may also be eligible for a range of allowances and other benefits. United Kingdom Ministry of Defence data for September 2003 states that the majority of war disablement pensioners receive 50 per cent or less pension, with the largest group receiving the 20 per cent level (the level at which any disablement pension is paid).[60] At this date, there were 208,000 active war disablement payments.[61]

1.43 Pension access, therefore, is likely only to provide an income supplement, and should not be seen as full income support. What is likely to be of greater value to veterans and those still serving is the very public recognition of the entire Gulf War experience by the United Kingdom government, including the continual assessment by the House of Commons Defence Select Committee, the research being undertaken, and the effort to ensure that Gulf veterans at least do not become part of the socially excluded.[62]

Australia and the Gulf War syndrome

1.44 Australia is not in a position to provide access to a disability pension, because there is currently no disorder accepted by the medical profession as the 'Gulf War

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Even where a claim for disablement is made more than seven years after termination of service, or where death occurs more than seven years after service, the onus of proof is still more generous than the burden of proof in civil tort which rests on a balance of probabilities. Article 5 of the Naval, Military and Air Forces (Disablement and Death Service Pensions Order 1983, as amended provides that it is necessary for the claimant only to raise reasonable doubt, based on reliable evidence, that the death or disablement is due to service. The benefit of any reasonable doubt is always given to the claimant'.

59 Under 20 per cent disability usually will receive a one–off payment/gratuity.

60 *UK Defence Today*, September 2003 http://news.mod.uk/news/press/news_press_notice.asp?newsItem_id=2744: 'Approximately 4 out of 5 Disablement Pensioners have pensions awarded at the 50 per cent rate or less. The largest group are those at the 20 per cent rate. Approximately 4 per cent receive the 100 per cent disablement rate. The overall average weekly amount of war disablement pension and associated supplementary allowances is £61.33'.

61 *UK Defence Today*, September 2003 http://news.mod.uk/news/press/news_press_notice.asp?newsItem_id=2744. Payments to other service personnel are also made under different schemes in the United Kingdom, so 208,000 does not represent the total number of persons receiving some form of pension in respect of war service. There are 5 million veterans and 8 million dependants in the United Kingdom, *Improving the Delivery of Cross Departmental Support and Services for Veterans—A Joint Report of the Department of War Studies and the Institute of Psychiatry*, Kings College London, July 2003, p. 5, paragraph 2.3, at http://news.mod.uk/news_press_notice.asp?newsItem_id=2616.

62 See in particular *Improving the Delivery of Cross Departmental Support and Services for Veterans—A Joint Report of the Department of War Studies and the Institute of Psychiatry*, Kings College London, July 2003, at http://news.mod.uk/news_press_notice.asp?newsItem_id=2616.

syndrome', and those deployed in the Gulf War are not unique in experiencing these symptoms:

> …we found that Gulf War veterans experienced a higher rate for many symptoms reported than a comparison matched group of personnel who did not serve in the Gulf. As the clusters of symptoms and the type of symptoms were the same in both groups there was no evidence of a unique symptom that could be called Gulf War Syndrome.[63]

1.45 The RMA therefore cannot proceed, and, given that there have already been some epidemiological studies in the United Kingdom which did not show any unique syndrome, nor lead to a new diagnosis, it is unlikely that the RMA will be able to proceed any further for some time, if at all. However, the Repatriation Commission notes that in some circumstances veterans in the situation of having symptoms may receive access to medical services, much the same step as was taken originally in the United Kingdom:

> For veterans who have symptoms that do not fall into established diagnoses, or do not fit with systematic evidence for a new category of diagnoses, it is difficult for our system, founded on evidence-based diagnosis, to provide compensation. The Repatriation Commission does, however, have the authority to selectively provide medical treatment in these circumstances.[64]
>
> Under a policy change announced by the then Minister, the Honourable Bruce Scott MP, any veteran returning from a deployment with symptoms that are difficult to diagnose is provided with treatment until the condition is diagnosed.[65]

1.46 The acknowledgment of the experience of Gulf War veterans is important, and the provision of medical services is a means of achieving this, although it could also be argued that this approach may encourage veterans to consider everything is a disorder or compensable in terms of a pension rather than in terms of required health services. The provision of these services is valuable, although a delay in access may have caused the belief that little attention was being paid to what had become a commonly experienced syndrome.

There has been limited recognition of many factors believed to be responsible for service–related illness/injury, including radiation and chemicals, and exposures to these have not been measured or listed in records.

1.47 With each deployment, veterans and currently serving personnel in Australia as well as in the United Kingdom and United States, have raised numerous issues about the extent of damage to their physical and mental health in combat or from a range of environmental factors, and their governments' seeming indifference to this.

63 *Submission* 8, Repatriation Commission, p. 16, paragraph 81.

64 *Submission* 8, Repatriation Commission, p. 16, paragraph 81.

65 *Submission* 9B, Repatriation Commission, p. 14.

These concerns go back to at least World War 2,[66] and the Korean War,[67] and the range of exposures has been considerable. Some have resulted from what were thought of at the time as environmental safety protection, such as the use of DDT to prevent malaria, and apparently also the use of DDT and kerosene, including on clothing, to check the effects of rats and other vermin.[68] Others have occurred because of the particular circumstances of a combat zone, including the burning of smoil, or the extensive use of herbicides and defoliants, as in Vietnam (Agent Orange included) to destroy vegetation and crops. Exposures also include those relevant to specific tasks, and may have been continuous until safer items became available.[69] Additional contributing factors also can result from the combat situation, such as lack of food, contaminated water, poor quality health services, unhygienic conditions, extremes of temperature which cannot be mitigated,[70] and combat stress.

1.48 To a degree, the lack of scientific knowledge of the effect of these hazards has previously limited research, and the fact that some disorders may only manifest later in life has meant there has been little data on possible outcomes. Political factors have also hampered acknowledgment of the effects of many substances, such as the use of napalm on civilians. The Gulf War is the first modern war where, in spite of initial resistance, there has been quicker recognition of the existence of some problems. At this point, the recognition, through research, has identified primarily what might be called mental health issues rather than environmental exposures and contributing factors. In part this is because technology has facilitated the collection of data suggesting that chemical and biological weapons have had a limited role. The long term effect of depleted uranium is still a contentious issue for some veterans, although much of the available research suggests that there is limited room for concern.

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66 Although chemical warfare, including mustard gas and phosgene, obviously also had a substantial effect in the First World War and for long period afterwards.

67 *Better Living Through Chemicals*, at http://eport2.cgc.maricopa.edu/published/d/du/dduncan91/collection/1/3/upload.htm, notes that napalm (petroleum and detergent) was used in World War 2, and Korea as well as Vietnam: 'it also "deoxygenates" the air, which can cause asphyxiation, and often generates enormous quantities of carbon monoxide gas'.

68 See http://www.parl.gc.ca/37/3/parlbus/chambus/house/debates/049_2004-05-06/han049_1455-e.htm, question on use of chemicals in Korea, in Canadian Parliament, and *The US Biological Warfare in Korea*, South Korean documentary, at http://www.kimsoft.com/2000/mbc.htm.

69 See the list of exposures including carbon tetrachloride, tin, lead, solder, electromagnetic fields, chlorinated solvents, for naval personnel in various occupations, US Navy Veteran Cohort, 1950–1997, in F.D. Groves et al, 'Cancer in Korean War Navy Technicians: Mortality Survey after 40 Years', *American Journal of Epidemiology,* 155 (2002) p. 812, Table 2. This supports the statement by the Repatriation Commission that 'exposure to a potential hazard may be related more to individual tasks within an occupational speciality rather than to an overall deployment, *Submission* 8, p. 15, paragraph 73.

70 See *Submission* 8, Repatriation Commission, p.17, paragraph 87, which notes that some of these matters are still relevant subjects for research.

1.49 Governments have also become increasingly responsive to issues that have been raised by veterans, a response which reflects the increased availability of medical/scientific knowledge and development of new methodologies, as opposed to anecdotal evidence or a single medical view. In some instances, attempts have been made to calculate the effect of such exposures. In others, research has indicated a higher level of some diseases than in the comparable age group of non–deployed men, although the extent to which exposures have contributed to this is not always clear.[71] However, the concern remains that because there was little interest in collecting data, or limited capacity to do so, some approximation of this data will not be sufficient to demonstrate either a specific illness or injury, or any individual's risk factors.

1.50 With respect to more recent deployments, some evidence suggests that more sophisticated methods of measurement of exposures has enabled the collection of data on chemical, environmental and other hazards.[72] Other information indicates that while the technology exists, human error and inadequate administrative processes have limited the collection of data.[73] The House of Commons Defence Select Committee noted in particular, in respect to the first Gulf War, that negative information was often quite as useful as positive evidence:

> The review highlights the problems created by inconsistencies in recording events at the time and by deficiencies in preserving records subsequently, when trying to examine such events nine years later.
>
> ... it must be recognised that there is an element of doubt about the assessment that UK troops on Al Jubayl on 19 January were not exposed to Iraqi CW agents ... we are dealing with history and the passing of nine years introduces an element of uncertainty. We no longer have available all of the information that we would like to see.
>
> The review recommends that 'in future, such alerts should be investigated more thoroughly at the time, even when it is suspected that there is no actual chemical threat' and that records of such alerts should not be destroyed, even when it becomes clear that alarms were false.[74]

1.51 If comments made by United States' agencies about the disparity between intent and practice are true, it is also possible that some data Australia may be relying on in respect of exposures is not available.[75] This will have a long term impact because there may continue to be gaps in available information and in individual records, even when a more sophisticated health record system is in place. At the same

71 See Chapter 4, paragraphs 4.40-4.42 on Korean war mortality rates.

72 See Chapter 2, paragraphs 2.25–2.27, and Chapter 3, paragraphs 3.9–3.12.

73 See Chapter 2, paragraphs 2.3–2.5.

74 United Kingdom Parliament, Select Committee on Defence Seventh Report, *Progress in Ascertaining the Causes of Gulf War Veterans' Illnesses*, paragraph 58, at http://www.parliament.the-stationery-ffice.co.uk/pa/cm199900/cmselect/cmdfence/125/12506.htm#a13

75 See Chapter 2, paragraphs 2.3–2.5.

time, it has to be recognised that while the extensive research being undertaken in both the United Kingdom and the United States may provide information that will be useful in at least making approximations of exposures, this will not necessarily lead to any specific diagnosis. While veterans in both these countries may receive the benefit of the doubt, be deemed to have been present during a specific event, or are able to demonstrate war–related disability, even the most explicit data on exposures may only result in medical treatment for Australian veterans.

The organisation and maintenance of service records has been chaotic, with what are believed to be relevant causal factors not being listed.

1.52 Much of the information provided to the Committee did not demonstrate that there were problems overall in obtaining access to service records. The main complaints from the point of view of veterans were that some data that should have been there were not. Obviously, data on environmental and other exposures in the past has been limited, and in some instances individual events have also not been recorded. These 'events' fall into two categories:

- Records of medical treatment or injuries; and
- Events or occurrences that may have a later impact.

1.53 The Committee would welcome signs that progress has been made in protocols for ensuring the electronic transfer of all data from allied theatre and other hospitals, or at least guaranteeing a paper copy.

1.54 With respect to the second issue, it is true that the nature of conflict may preclude a detailed report of every event that occurred, even though formal records[76] are used to reconstruct possible past scenarios:

> Where a Vietnam veteran says that he saw someone raped, that is more delicate and tricky, but there are ways and means for us to get information. We should emphasise that there is no burden of proof on the veteran: we have to take his word at face value, unless we have something evidentiary to make us think it is not correct.[77]

1.55 Up to a point, the current process of providing key information on a conflict may at least identify some possible problems in the future, but these are not a guarantee that all precipitating events will be registered. Even where an individual is considered to have a recognised disorder, it is possible that this will be challenged as not war–related. It is always necessary, because of the legislation, to be able to provide certain key events and to have these accepted as relevant:

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76 For example, ships' logs (Farmer and Repatriation Commission [2004] AATA 781 (23 July 2004), and the equivalent for other forces; patrol records, interviews with other platoon members, historians etc (*Committee Hansard*, p. 81, Repatriation Commission). See also Chapter 3, paragraphs 3.36–3.41, and Chapter 4, paragraphs 4.73–4.74.

77 *Committee Hansard,* p. 81.

> …he does suffer from Alcohol Dependence … However, that Alcohol Dependence is not a war–caused injury or disease and the Respondent is not liable to pay a pension to the Applicant pursuant to s 13(1) of the *Veterans' Entitlement Act 1986*.[78]
>
> …. The Tribunal concludes there is no evidence before it to disprove the hypothesis beyond reasonable doubt.[79]

1.56 The ADF does have in place processes by which such events can be recorded,[80] but it should also be accepted that many traumatic events are not immediately remembered in detail, even though aspects of them may be. Added to the rather late post–deployment health assessment[81]—which may not be available at all to reservists—this can result in crucial individual data being lost.[82] The only solution would be for each individual to maintain a record, and this is not practical for a number of reasons, not least being an unwillingness to relive some experiences.

1.57 The Committee was concerned at the slow roll out of the HealthKEYS system, not so much in terms of the past but because there is no facility to transfer information from current paper or disparate electronic files to the new system. Thus individuals who are currently serving and may still be in the forces for several years, will not have a complete electronic file.

1.58 Some of the information provided to the Committee, such as the loss of the Air Force records, indicates that there is a backlog of data to be processed.[83] The relatively late commencement by the ADF of a centralised tri–force IT system linking personnel and medical records means that some existing problems such as lost data, and data that was not provided, are likely to continue. Where there is a failure to follow established practices, such as full recording of vaccination information, this is also difficult to reconstitute. There is not always sufficient information available to personnel on these problems which would at least allow them to make a personal record of events including injuries, vaccinations and exposures which may be necessary in the future.

1.59 The United Kingdom was surprisingly open about some similar problems during the first Gulf War:

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78 Farmer and Repatriation Commission [2004] AATA 781 (23 July 2004), paragraph 92.

79 Benjamin and Repatriation Commission [2004] AATA 738 (13 July 2004), paragraph 62.

80 See *Committee Hansard*, p. 81 (ADF) and see also Chapter 2, paragraphs 2.30–2.40, 2.51–2.53, 2.60, 2.64–2.66, 2.67–2.69.

81 Chapter 2, paragraphs 2.53–2.54.

82 Although, as is also discussed in Chapter 4, either research or the standard of 'reasonable satisfaction' may result in otherwise unlisted information being accepted, as seen in the case of Organ and Repatriation Commission [2004] AATA 671 (29 June 2004), paragraph 76: 'Given the passage of time and the often encountered difficulty in finding relevant records, the Tribunal accepts the applicant's accounts of what took place…'

83 *Submission* 9, Defence Organisation, p. 4, paragraph 19.

> In summary, UK forces deployed to the Gulf with no established routines for recording primary care clinical information during a long deployment in the field, nor any robust method for recording immunisations and ensuring that the information was subsequently captured and transferred to the F.Med 4 [permanent medical records, equivalent to those GPs hold for civilians].[84]

1.60 Although there is no plan to enter any current information from ADF deployments into the new system, the fact that concerns about exposures, vaccinations, and medications have been raised suggest that the ADF must provide some equivalent electronic record for personnel to cover the period of service prior to the commencement of HealthKEYS.

1.61 This was also a lesson learnt by the United Kingdom from the first Gulf War:

> It appears that record keeping was inadequate from the start. It is certain that there was a significant failure to transfer what immunisation data was available on to permanent medical records after the Gulf conflict and that much of that data is probably now irrecoverable.[85]

1.62 United Kingdom research and reports have provided information on a number of issues from the first Gulf War which do not seem to have been raised by Australian personnel in respect of the second Gulf War. Nonetheless, these reports are all useful sources for both the ADF and DVA especially in the identification of potential problems, such as false alarms for chemical or biological warfare, and the effect this may have on personnel. After all, if there is to be recognition of the effects of conflict, this also has to include the effects of not knowing if there has been an exposure, or not being sure if protective equipment is in good condition, just as much as the effects of the different stresses of working in a peacekeeping mission with limited authority and control, or being affected by heavy smoil.

Deployment capacity

1.63 With the pressures arising from increased deployments at much the same time as the above mentioned reviews of health services,[86] there has been some concern that ADF health services were not capable of meeting needs, including during pre

84 United Kingdom Parliament, House of Commons Select Committee on Defence Seventh Report, *Progress in Ascertaining the Causes of Gulf War Veterans' Illnesses*, paragraph 49, at http://www.parliament.the-stationery-ffice.co.uk/pa/cm199900/cmselect/cmdfence/125/12506.htm#a13.

85 United Kingdom Parliament, House of Commons Select Committee on Defence Seventh Report, *Progress in Ascertaining the Causes of Gulf War Veterans' Illnesses*, paragraph 49, at http://www.parliament.the-stationery-ffice.co.uk/pa/cm199900/cmselect/cmdfence/125/12506.htm#a13.

86 See above, paragraph 1.5.

deployment and deployment periods,[87] as well as both immediate and longer–term post deployment periods. Concerns identified have not only related to the number and quality of services, but to the capacity of the ADF and the Repatriation Commission/DVA both to identify the need for new or changing services to meet current issues as well as needs in the future, and to act as much as is possible in accordance with community standards and expectations. These standards have helped to create new demands or expectations, additional to those required by earlier reviews.

1.64 These have been the stimulus in some ways for the development and testing of new health services, since they have demonstrated to a more aware management that the constant effects of war can vary in nature given the different circumstances of the tasks involved and the extent to which individuals have the capacity to deal with these.

1.65 Further, broader community awareness of the effects of drugs and alcohol, of more direct responsibility for, and participation in, individual health status has led to the development of a wide range of health services in the ADF, even though not all of these may be readily accepted. There is an increasing emphasis on mental health issues within the ADF and on the need to acknowledge that these are an integral part of the deployment process.

1.66 In discussing the quality of deployment health services, witnesses noted changes that had occurred in the community over time and the extension of these into the military culture which was seen generally as less open. It was thought that certain of the difficulties that had arisen had their basis in an incomplete acceptance by the military of community standards prevailing in matters such as access to information, informed consent, and the capacity to make choices without penalties. Specific examples included the controversy over non-acceptance of anthrax vaccinations,[88] a belief that services were not provided to meet the varying needs of veterans from more recent conflicts and other operations, and a lack of readily comprehensible information, including on items such as depleted uranium:

> There is a much larger debate in the civilian community regarding environmental risks and unexplained illnesses such as chronic fatigue syndrome and the potential risks from low–level chemical and radiation exposure in everyday life. It is understandable that veterans are concerned that they may be susceptible to a new or unexplained disease caused by their exposure in a hazardous environment.[89]
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> …

87 The ADF commissioned a review of health services which was originally expected to report by the end of March 2004, *Submission* 9, Defence Organisation, p. 1, paragraph 5. In evidence, the ADF stated that this report had not then been completed, *Committee Hansard,* p. 91.

88 This issue is discussed at Appendix 3.

89 *Submission* 5, Regular Defence Force Welfare Association Inc., p. 4, paragraph 21.

> The days where you just receive injections and do not ask about side effects, or have medical procedures undertaken without a full explanation, have passed.[90]

Duty of care

1.67 Many of these community standards were expressed in terms of a 'duty of care', one that society owed its citizens and one that the ADF owed its personnel. Although there was no expectation that many other components of military culture should be dismissed because of the impact of such standards, it was considered feasible to demonstrate levels of respect for individuals in the ADF through modifying some of the processes that may have been seen as traditional. It was also thought that while the concept of individuals being responsible for their own health was sound, and a part of increasing community awareness of taking control and meeting an individual 'duty of care', the ADF and DVA also had the responsibility to provide services which met the needs of personnel and veterans as these were affected by broader social changes.

1.68 Duty of care is a concept which is continually evolving:

> In law all employers owe a duty of care to their employees, the general public and the wider environment. For the Ministry of Defence (MOD), there is also an obligation to manage the often greater safety risks associated with military operations. For the purposes of this document, the term '*safety'* covers the protection of people, property and the environment. The term *'environment'* is sometimes highlighted separately to encourage recognition of the growing importance being placed on environmental management. [91]

1.69 The relationship between governments and communities or individuals in terms of 'duty of care' is a complex one, but it is accepted that the 'government as employer' at least, owes a duty of care to its employees. This is both a statutory responsibility[92] and a principle of common law. A duty of care encompasses the health and safety of employees through provision of, and adherence to, standards which should apply uniformly.

1.70 This statutory responsibility may replace, to some degree, an older concept of a leader's responsibility for those under his command insofar as this was based on general principles rather than statute. However, there is room for both. Duty of care also requires that individuals minimise the risks to themselves and to others, and do not deliberately engage in conduct which is likely to result in injury. Doing so will generally result in a refusal to pay compensation if injury occurs. In this context, the

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90 *Committee Hansard*, p. 30, Australian Peacekeepers & Peacemakers Association.

91 See United Kingdom, Ministry of Defence, *JSP430 MOD Ship Safety Management*, at www.mod.uk. linked—files/dpe/JSP430.doc, p. 5.

92 Through legislation such as the *Safety Rehabilitation and Compensation Act* 1988 and the *Military Rehabilitation and Compensation Act* 2004.

refusal to have an anthrax or other vaccination seen as necessary for the particular combat zone would be overcome by the policy of 'no vaccination, no deployment', so that any potential difficulties arising for the individual and others would be reduced.[93]

1.71 The responsibility of commanders is extensive and can include ensuring the provision of necessary information, equipment, and guidance, including safe working environments, provision of required protective clothing, and necessary medical services. It can also include actions which may reduce future problems, such as the practice of some forces of discussing possibly traumatic events on a daily basis, rather than ignoring or minimising them.[94]

1.72 Notwithstanding the fact that there can be discrepancies between public perception of standards and the actual content of community standards, it is essential for an institution such as the ADF to continually develop its understanding of duty of care, especially where this may substantially lag behind what is commonly thought of as normal. Transparency and access to information and processes was seen as available to an individual in the community, and therefore will come to be expected by others.

1.73 The issues of 'duty of care' and 'community standards' are of particular interest to the Committee, which has examined prevailing cultures and expressed values which place an emphasis on the well–being of ADF personnel, to see if they are translated into action:

> …there are some serious human dimensions behind the need for this inquiry. We need to have a better conceptual understanding of the issues and of the history so we can go forward. Those affected need to know and understand the difficulties, but at the same time there is—particularly on their part—a need for some answers to questions that have been repeatedly asked for 30 or 40 years. If there are weaknesses in the system, we need to identify them and try and fix them. We also need to accept that our people are the most important part of the ADF. They are not a commodity to be used and thrown away. Active service in the field is not an excuse on the part of the administration to avoid responsibility for care. [95]

1.74 Some submissions stated that a lack of information both about vaccines and other matters did not assist ADF personnel in the making of informed choices, especially with regard to possible long term implications of certain vaccinations. To

93 See Appendix 3, which notes the problems caused in this situation through not advising of the requirement prior to departure.

94 *Improving the Delivery of Cross Departmental Support and Services for Veterans*—A *Joint Report of the Department of War Studies and the Institute of Psychiatry,* Kings College London, July 2003, at http://news.mod.uk/news_press_notice.asp?newsItem_id=2616, p. 25, paragraph 3.9.3 .4: 'the Swedes are keen to make talking about trauma an everyday occurrence within their regiments. There is structured time for debriefing every evening, which is protected time (often accompanied by beer)… British regiments [on the other hand] can be seen as 'the repressed leading the depressed' (on peacekeeping in Bosnia).

95 *Committee Hansard*, p. 2.

assess the current ADF understanding of 'duty of care', it is useful to look at a case study, the problem with anti–anthrax vaccinations. These were undertaken with a strong awareness of community standards and of the concerns that personnel from the first Gulf War had experienced:

> That was in fact one of the reasons that we put so much effort into our education campaign for anthrax vaccination, and why I was adamant that there would be a signed consent form—signed by the member following a verbal brief from the MO—so there could be absolutely no doubt whatsoever in anyone's mind as to the nature of the vaccines that they received prior to this deployment. My staff and I were firmly committed to the fact that we were not going to create a situation where there could be confusion on the part of individuals.[96]

1.75 Although effort had been put into providing information about the vaccine, other administrative issues contributed to an adverse result, suggesting that better coordination of information is required. This case study is at Appendix 3.

1.76 The duty of care also extends to best practice provision of services to both current personnel and veterans. Along with changes in the deployment and post-deployment process have come improvements in co-ordination between departments and, as noted above, some improvement in the capacity to provide accurate information on individuals, particularly older veterans. Currently, work is under way in the ADF to improve information collection and management both for deployment health and other reasons, and for the more effective management of the health of personnel post deployment. These will be impressive when in place and operating fully, although it is unfortunate that they have no capacity to include current data on currently serving personnel who may still be in the ADF in 2009, the date by which some systems will be operative.[97]

1.77 Appendix 3 is also useful as a case study on information issues, not so much on anthrax vaccination data but on the problems which can arise when both information and the ways in which it is communicated are not at best practice levels.

1.78 Much of the ADF and DVA research and program development that has occurred in the past two decades, and especially during the 1990's to the present has been intended to identify needs more accurately and develop services for both current personnel and veterans which meet the objectives of a healthy deployment force and address the concerns of those from previous deployments. While it is unlikely that deployments will have no short and long term casualties, there has been a trend towards more effective and coherent planning which can limit the range of effects of current war and more quickly develop services that meet the particular needs arising from both conflicts and work such as peacekeeping.

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96 *Committee Hansard,* p. 62.

97 See Additional Estimates, FADT, 18 February 2004, *Answers to questions on notice*, Defence, part 2, p. 6, and also below, Chapter 3, paragraph 3.6.

1.79 In brief, there is, in theory, a much more proactive approach from both the ADF and DVA which is able to take advantage of medical and scientific research in order to reduce hazards or the effects of these, and provide services and education/information programs which may help individuals identify and seek help for problems before these become entrenched. Similar processes are occurring in both the United States and the United Kingdom, although there are difficulties in restructuring substantial forces and implementing such changes, which are openly admitted.

1.80 This inquiry is primarily intended to determine how far these advances have become a part of both the ADF and DVA strategies, and whether previous and current dissatisfaction with either arises from the extent of change, the fact of change, or the belief that change has not improved the capability of the ADF or the capacity of the veteran to be an effective part of society, or to have his/her contribution valued.

Outline of the report

1.81 The terms of reference require that the Committee consider several issues, including the adequacy of administrative arrangements for deployment and of the management of records, the links between ADF and DVA, and the appropriateness of the research programs of both.

1.82 For some, DVA, the RMA or the Commission—or all three—are considered responsible for what are perceived as unfair or inflexible practices which exclude some veterans from disability benefits. However, none of these three parties can act outside the legislation, and as has been discussed, each individual country has both legislation and policies which may provide different outcomes.

1.83 Chapter 2 considers terms of reference 1 (a)(c) and (d) and identifies some areas of possible concern about the availability of accurate deployment information, the extent to which an individual in the ADF can effectively monitor his/her own health, and the effectiveness of some processes which may be well-intentioned but not always appropriately directed. In so doing, it demonstrates how successfully the ADF has adapted to substantial change, some from the broader community and some from similar change in overseas forces.

1.84 Although the adequacy of vaccination processes was term of reference 1(c), there is a more detailed consideration of the anthrax vaccination problems at Appendix 3. There were some faults with this process—a few with respect to information and the expectations of personnel, and some which demonstrate some information co-ordination issues for management. To consider these in detail in the report itself would interrupt the assessment of deployment health processes, and place an undue emphasis on one small aspect of these. Nonetheless, because of the effects on individuals and the potential for future confusion it was necessary to determine if the confusion occurred because of a lack of information, the timing of information, or the overall coherence of information available.

1.85 Chapter 3, (1(b)), which considers the administrative and coordination processes of both the ADF and DVA, examines the way in which technological

change can assist veterans in particular through facilitating the development and maintenance of accurate record systems and the production of information. It also looks at the links established between ADF and DVA to help ensure a connected pattern of services for those leaving the ADF and requiring assistance.

1.86 Chapter 4, (1(f)), considers the research programs of both ADF and DVA to see if these are directed towards identified needs and lead to the development of programs which meet such needs. In so doing, it refers to some contentious situations including the effect of Agent Orange, the British nuclear tests, and Gulf War syndrome.

1.87 Term of reference (2) has been considered throughout the report, with findings and recommendations provided in order to meet the requirement that recommendations be made 'which will give greater assurance to the individual that their health risks are minimised, and fully recorded for the purposes of future compensation where justified'.

Submissions and hearing

1.88 Ten submissions were received to the inquiry, and these are listed at Appendix 1.The Committee held one public hearing on 26 February 2004, in Canberra and a list of witnesses at that hearing is at Appendix 2. At the conclusion of the hearing, additional questions on notice were advised, and these were forwarded to both the Repatriation Commission and the ADF. Answers to these, which comprise *Submissions* 8A and 9B respectively, have been incorporated into the report, and effectively replace a second public hearing. Answers to questions asked but not fully answered in the hearing have also been provided by these and other witnesses and fully considered by the Committee (*Submissions* 5A and 9A).

References

1.89 References to the committee transcript are to the corrected edition of the public hearing of 26 February 2004. This can be read on the Foreign Affairs and Trade site: www.aph.gov.au/committees/Senate, under the name of the inquiry. Submissions are also available at the same site, although some attachments to submissions are not on the website. Copies of these can be obtained from the Committee Secretariat. All other references are quoted in full and some documents referred to in Appendix 3 have been attached to that appendix to facilitate evaluation.