Chapter 15

Occupational health, safety and support services

15.1 During the course of the inquiry, some witnesses, in recounting their experiences of the military justice system, referred to the adverse effects that these experiences had had on their health. Others spoke of a work place where safe and responsible work practices were not always promoted and which, in some instances, placed the physical or psychological well-being of ADF personnel at risk. This chapter looks at the links that can be made between the military justice system and the health and well-being of those who became involved with it. It also examines the broader issues of the ADF's duty of care, the health services available to ADF personnel and the support offered to the friends and families of serving ADF members who have been seriously injured or have died suddenly.

Features of military service that impact adversely upon mental health

15.2 A number of witnesses to this inquiry attributed the onset or aggravation of health problems, particularly psychological, to the difficulties they encountered with the military justice system. A psychologist, who has worked within the ADF, gave his overall impression of the military justice system and its potential to adversely affect some ADF members:

> One can see that almost every application of the justice system has a human cost, ranging from stress to humiliation to suicidal thoughts and behaviour.
>
> …
>
> I have seen cadets with suicidal thinking held to continue service against their wishes…individuals in utter despair, at risk of self-harm, with no hope of returning to service…
>
> …
>
> The Army and ADF fail to recognise that everybody is there voluntarily. The justice system treats them as if they were indentured servants. To my mind, one of the worst aspects of the application of military justice and regimentation is an invisible one. Fewer and fewer people are wishing to volunteer for it. We cannot fill our places in officer training. Early last century soldiers were being shot for cowardice, as a management tool. Today, that management tool looks barbaric because it is presumed that those who did not comply could be forced to obey, and it paid no notice to the real reasons, to the suffering behind that behaviour. I wonder how our current techniques of behaviour management will look in 100 years time.[1]

15.3 Other witnesses, such as Mr Nigel Southam and Mr Keith Fitzpatrick, made a direct connection between their treatment under the military justice system and

---

1 In Camera *Committee Hansard*, 10 June 2004, p. 65.

problems they experienced including anxiety, severe depression, psychological breakdown and suicidal thoughts and actions.[2]

15.4 The following section looks at specific aspects of the military environment and justice system that may impact upon mental health issues. They include:

- the general reluctance of ADF personnel to report personal health concerns;
- the failure by senior officers to acknowledge or accept reports of problems or difficulties, preventing the commencement of resolution processes;
- defective inquiry and investigation conduct, such as poor record keeping and communication, lack of support, conflicts of interest and breaches of privacy, that may exacerbate or even trigger mental health problems;
- lengthy and delayed military justice procedures that leave individuals feeling isolated, let down or even defeated, and processes that lead individuals to believe that there is no 'justice';
- failure by the ADF to fulfil its duty of care to provide a safe working environment; and
- inadequate mental health reporting and service-delivery.

15.5 Much of the material presented below draws on evidence discussed in previous chapters.

The reluctance to report health risks or concerns

15.6 Evidence presented to this committee suggests that an environment exists in the ADF which makes it difficult for members to seek help.[3] One of the major challenges facing the ADF is to counter the attitude that seeking help is of itself an admission of weakness.

15.7 Other inquiries have noted that the existing military culture can make individuals reluctant to seek help because they believe that this will damage their reputation.[4] This fear of stigma was manifest in written and oral evidence to the current inquiry that detailed a variety of mostly negative attitudes towards mental

---

2 See chapter 7, paras 7.85–8 and chapter 8, paras 8.109–8.112. Much of this evidence was in camera but see also paras 8.115–8.118.

3 Confidential *Submission C30*, and In Camera *Committee Hansard*, 10 June 2004, p. 66.

4 See Senate Foreign Affairs Defence and Trade References Committee, *Taking Stock*, August 2004. See also *Committee Hansard*, 29 April 2004, p. 6: 'Anyone who has been in the services will tell you that service personnel will cover up medical and personal problems so as not to affect their careers' and also p. 19.

health services and social workers.[5] Colonel Anthony Cotton, Director of Mental Health, Department of Defence, spoke authoritatively on this matter when he stated:

> The help-seeking culture in general—the idea that it is okay to go and get some help—is something that, in my opinion, is foreign to men of our culture. We have seen that in lots of places. I think the military environment exacerbates that because the military environment is all about being robust, being independent and those sorts of things and being able to look out for yourself.
>
> …
>
> The culture makes it difficult for us to do business. We really need a sea change or a significant culture change, because we need people to be prepared to go and seek help. But it is a complex issue, because we need them to be able to admit that they have a problem and seek some help while not diminishing their robustness and resilience. This underpins pretty much everything that we do or is a flavour to what we do. Culture change is a significant thing.[6]

15.8 An ADF psychologist who appeared before the committee stated that the situation is particularly difficult in the ADF because attitudes towards mental health tend to be extreme:

> There is no acknowledgement of the fact that difficulties might be temporary, that it is human to be stressed at certain crisis points in our lives, and that to have a temporary crisis or to seek mental health is a positive thing at certain points in time. There is no acknowledgement of that whatsoever. It is beyond the ability of many of our officers, let alone our soldiers, to make a differentiation between the people who are not coping temporarily and the people who would not cope permanently or would not cope on the battlefield.[7]

15.9 The committee again urges the ADF to acknowledge that the military culture makes it difficult for members to seek help, and to put in place services that take account of and compensate for this weakness. Hotlines and handy 'seek help' cards will not overcome the fear of stigma or ridicule attached to seeking help, nor will they convince ADF members that their concerns will be taken up in a professional manner, treated with respect, and handled in the strictest of confidence.

Failure to treat complaints seriously

15.10 ADF members must have confidence that their requests for assistance will be accepted as legitimate and taken seriously. As noted in previous chapters, this is not

---

5 See *Submission P23*. See also the discussion on this matter in chapter 7 in particular the committee's main findings on the reasons for this reluctance in para. 7.64 and the committee's conclusion in paras 7.83–7.88.

6 *Committee Hansard*, 21 June 2004, p. 4.

7 In camera *Committee Hansard*, 10 June 2004, pp. 66-67.

always the case. The committee heard accounts of senior officers refusing to accept a 'complaint' or dismissing a complaint as 'vexatious' or 'trivial'; the unwillingness of witnesses to become involved in the investigation of a complaint; and the lack of commitment by those responsible for handling a complaint to pursue the matter.

15.11 Refusing to accept complaints in the first instance effectively limits the operation of resolution processes.[8] The Defence Force Ombudsman told the committee:

> We have received several complaints where it appears Defence has had considerable difficulty in entertaining the notion of investigating a complaint in the first instance despite very clear concerns being expressed both by the individuals involved as well as by other people in relatively senior positions in the ADF. It is axiomatic that if a complaint is not accepted as a complaint, it cannot be resolved.[9]

15.12 Failure to accept a complaint can cause on-going emotional stress and thereby affect an individual's mental health. One witness stated:

> If some aggrieved military people do seem obsessive and preoccupied with their complaints, I suggest the reason is mostly because of a long history of military complaint inertia, lack of feedback, perceived lack of compassion, and attitudes similar to that expressed by the ADA, that complainants are cranks. The resultant stress causes many complainants to drop their complaint in despair, and/or suffer nervous disorders. The matters then remain unresolved while the complainant's career evaporates.[10]

15.13 Chief Petty Officer Hyland asserted that he had medical evidence of a physical assault and corroborative evidence that some type of assault had occurred. In spite of this, his case went through several different sets of authorities, including the State police, only to end up in the 'no action' tray. Not only has the assault caused him 'an immense amount of personal distress' but he also feels disappointed by what he perceives as the military justice system's failure to redress wrongdoing. He believes that he has been 'stonewalled at every turn': that there is a 'malignancy of buck passing or serious lack of effective interagency liaison'.[11] He goes on to state:

> I am exasperated at the lack of closure and have contacted the media to try and put more pressure on the Navy to try and gain answers to my situation. This in hindsight may have not been in the best interests of my career,

8 See also *Committee Hansard*, 9 June 2004, p. 10.

9 *Submission P28*, p. 4.

10 *Submission P52A*, p. 2, and see also p. 3 'I admit to thoughts ranging from murder to suicide regarding my treatment'; *Submission P61*, p. 5: 'Eventually the victims get out by being discharged as unsuitable or dishonourably, due to the [effect] that events have on their personality and performance, or in the extreme by suicide.'

11 *Submission P15*, p. 1.

> however, the emotional turmoil I have undergone may well have clouded my judgement.[12]

Investigation processes as a complicating factor in mental health

15.14 Investigation and inquiry conduct has also had an adverse impact upon many submitters to this inquiry. Both complainants and those complained about have recounted how they were gradually worn down by the stresses and frustrations of inquiry processes.[13] Some submissions noted:

- little information was provided even about the fact that there was an inquiry;[14]
- few opportunities were given to provide evidence;[15]
- absent, incomplete or missing file notes resulted in all the responsibility being placed on the person who believed he/she was the victim, rather than on the alleged aggressor/offender; [16]
- individuals suffered reprisals for complaining or providing evidence leaving members feeling ostracised and without support;[17] and
- lack of confidentiality and privacy breaches during investigations.[18]

15.15 It appears that appeal processes intended to correct defects have, in some cases, also caused or exacerbated mental health problems. Members recall having to battle to obtain relevant documentation to defend their case; non-adherence to procedural fairness; conflicts of interest; intimidation; lack of support; poorly trained investigators; and delays.[19]

15.16 Evidence before this committee concerning the *Westralia* BOI clearly demonstrated how a poorly conducted investigation can contribute to mental health problems, rather than alleviate personal distress after a major incident. Many of those

---

12 *Submission P15,* p. 2.

13 Chapter 8 examined in detailed the flaws in administrative investigations describing in some cases the effects that they have had on individuals. See in particular paras 8.137–8.141.

14 *Submission P63*, p. 3.

15 *Submission P47*.

16 See, for example, *Committee Hansard,* 28 April 2004, pp. 29-30, and *Submission P13A,* p. 2 which states medical information detailing a beating was not placed on a file See *Submission P52,* pp. 2–3 which refers to an event not reported but which left long–term effects on one of the witnesses.

17 See for example statement by Mr Southam: 'These have caused me to be medically discharged as a result of psychological issues, and I have attempted suicide along the way after some three years of trying to find some resolutions in relation to these submissions', *Committee Hansard,* 9 June 2004, p. 64; *Submission P50,* p. 3ff.

18 *Submission P55,* p. 4.

19 See chapter 9 especially paras 9.58–9.61.

affected by the *Westralia* incident felt let down by the subsequent BOI process. To this day, a number of crew members directly involved in the fire—the victims of a terrible accident—are still trying to come to terms with aspects of the inquiry.[20] Some have unresolved anger about the way they were required to provide witness statements so soon after the fire:

> Potential witness[es] were still suffering from grief and shock. We can all appreciate the need to get the evidence whilst it is still fresh in people's minds but some people just wouldn't have been up to it.
>
> …
>
> The day of the memorial service I was required to give my statement, this happened shortly after the service had finished…I was still suffering from shock and disbelief that this accident had actually happened and I was understandably still confused, in a state of distress trying to come to grips with the death of personnel in my charge. The interview lasted about six hours or so and was very disturbing.[21]

Protracted military justice procedures

15.17 Delay and unnecessarily complicated processes involved in the military justice system were identified in several submissions as causing or aggravating mental health problems.[22] The Ombudsman drew the committee's attention to the impact of lengthy delays on an individual's psychological state as an issue progresses through the many stages of complaint resolution, administrative inquiry and/or disciplinary investigation:

> I would note that we do explicitly consider the issue of the impact psychologically on an individual. There is a case we have decided recently to expedite because we believe there is undue psychological pressure on the individual, and we are pressing harder for a more prompt response. In the legislation, we do have the power to intervene even before the 28 days, should there be circumstances that we believe merit that sort of intervention. That really does impose on us the obligation to look at each case on its own merits, rather than with a blanket policy.[23]

15.18 Stress and anguish can result from several factors, including the time taken to convene an inquiry, conduct hearings, consider material, and reach decisions. It is worthwhile to quote again one witness whose sentiments about her family's experiences over seven years encapsulate the feelings of many submitters:

> Our family's psychological and emotional abuse suffered at the hands of the military justice system has been likened to repeated bashings with a baseball bat perpetuated by multiple unknown assailants on multiple

---

20 See chapter 11, paras 11.49–11.52; 11.73–11.77; 11.97–11.99.

21 *Submission P33,* p. 3.

22 See *Submission P41*. Also chapter 6, paras 6.131–6.138.

23 *Committee Hansard,* 9 June 2004, pp. 3, 13.

> occasions—never sure if it was the last bashing… Our journey is a horrific example of the appalling state of the military justice system, highlighting organisational deficiencies, the system barriers, the lack and/or failure to adhere to the relevant policies, processes or procedures. A complete abuse of process that began in 1998 and continued for seven years—a system in total disarray.[24]

15.19 In addition to delayed proceedings, many submitters expressed concerns about defective processes that left them with the impression that justice had not been done. Several witnesses claimed that disciplinary processes reflected imbalances of power inherent in the Defence Force's rank system and tended to favour those of superior rank. One witnesses stated:

> The rank system makes it difficult as well because anyone with a superior rank will automatically be given more credibility than a lower ranking victim.[25]

15.20 Another witness commented that 'even though no other officers agreed with this [person] they all closed ranks and kept their mouth shut'.[26] The committee has also heard evidence that on occasions individuals have been charged without prior warning,[27] and the availability of adequate and competent legal assistance was erratic or non-existent. One witness stated:

> What I believe should be addressed by your committee is the resources the military throw at investigations, as opposed to the lack of advice the member receives.[28]

15.21 The problems with the disciplinary process discussed in this report have important consequences for the mental health and well-being of service members and their families. The stresses placed on individuals under investigation in many cases appear to have had longer term effects, including loss of confidence, loss of employment, suicidal thoughts, attempted and actual suicide. The SAS soldier's case discussed in chapter 3 stands out as a stark example of the extreme, relentless, and unnecessary pressure that can be placed on a member through the conduct of an investigation and pursuit of a prosecution.[29]

15.22 Administrative inquiries have also left families and individuals with the feeling that justice had not been served. The most glaring example of this was the *Westralia* BOI. Family members felt that obstacles such as obtaining access to

---

24 Confidential *Submission C10,* p. 10. Quoted with the permission of Mr and Mrs Hoffman.

25 *Submission P61*, p. 5.

26 *Submission P50,* p. 5. See also *Submission P65,* p. 3.

27 *Submission P50,* p.11; *Submission P53,* pp. 3–4.

28 *Submission P49,* p. 3. See also *Submission P65,* p. 5: 'The next day I faced trial before my Commanding Officer who receives his legal advice from the coxswain, who is also the prosecutor.'

29 See chapter 3, paras 3.29–3.31.

information and the difficulties in attending the BOI suggested that a 'cover up' effort was underway.[30] Many held the perception that the inquiry was conducted in the interests of absolving the Navy of any responsibility or blame for the death of the four sailors:

> I have no doubt the Westralia BOI was nothing more than a navy public relations exercise.
>
> ….
>
> There was a Board of Inquiry rushed into action, before the four deceased sailors were buried. No time or consideration for the families of those deceased, and little information of the inquest was given to the families other than media articles.[31]

15.23 Families also questioned the 'justice' done to the four service members that lost their lives on the *Westralia*:

> The four deceased personnel were never represented at the BOI. The Board members and Council Assisting the Board were accountable directly to the Navy, and that is the way they appear to have run the BOI.
>
> MIDN Megan Pelly, POMT Shaun Smith, LSTM Bradley Meek and ABMT Phillip Carroll had nobody to investigate their actions. None of the Board members or Council Assisting the BOI took any steps to get character analysis or probable action assessments done.
>
> Had anyone been interested in finding out what these brave young sailors may have been doing during the fire, the Board may have come to a different conclusion for their actions as the WA Coroner did (see Coroner's Report, pp. 24-25).
>
> Had the Navy or the BOI panel provided representation for the deceased sailors, it may have avoided the public embarrassment associated with a lengthy drawn out inquiry.[32]

15.24 Dissatisfied families and otherwise affected people pursued the 'justice' they found lacking in the 1998 *Westralia* BOI for a further five years.[33] Having obtained no satisfaction from the military justice system, they eventually gained some sense of justice after successfully lobbying for a coronial inquiry.

Duty of Care

15.25 During the course of the inquiry the committee also became aware that in some cases there was evidence that the ADF had failed to meet its duty of care towards ADF members. The following section looks at ADF's duty to ensure that all

---

30 *Submission P33*.

31 *Submission P30*.

32 *Submission P30*.

33 *Submissions P51, P32,* and *P30.*

personnel are working in an environment that is as safe as it possibly can be with regard to both physical well-being and mental health. The committee considers that the ADF should ensure that precautions are taken to avoid placing service personnel at unnecessary risk of physical or mental harm.

Physical safety

15.26 One factor that became increasingly obvious as this inquiry progressed was the apparent lack of awareness by those in middle management of inappropriate or risky behaviour. Their unawareness or inaction meant that unsafe work practices continued unchecked until an incident requiring investigation shed light on such practices. Unfortunately, in some cases, the incident sparking the investigation involved the death of an ADF member.

15.27 In the case of Private Jeremy Williams, senior officers had failed to implement recommendations from an investigating officer's report completed two years earlier that had exposed improper conduct, including harassment and bullying.[34] According to the investigating officer's report into Jeremy's Williams' suicide, the situation had remained largely unchanged since the first report identified the existence of harmful practices in the unit—senior members in the chain of command had no knowledge that denigration and harassment existed.[35]

15.28 The inquiry into the loss of Seaman Gurr revealed that drinking practices on board his ship, and probably other ships, put personnel at risk. Vice Admiral Chris Ritchie told the committee that people in positions of middle-ranking authority in the ship 'ought to have brought knowledge of that sort of event to the commanding officer's attention but did not…that is where the system of leadership in that ship fell down'.[36] He went on to state:

> I do not accept that there was a culture of illegal drinking on board HMAS *Darwin*. I would accept that there was a culture of illegal drinking amongst a small group, a particular trade category, on HMAS *Darwin*…I certainly do not contend that it was one-off, but I do contend that it was a small subgroup. Indeed, the board of inquiry found that it was not a one-off event and that there had probably been instances before which could have been brought to a head much earlier and were not.
>
> Certain people in that ship did not take those responsibilities seriously enough……

34 See chapter 6, para. 6.30.

35 Annex A, Appointing Officer's Decisions and Action Plan Investigation into the Death of 8299931 PTE J.P.Williams, February 2003, pp. 35–6. This document was provided to the committee and is classified as Staff-in-Confidence. The committee has taken great care to ensure that the privacy of any persons referred to in the report has been respected.

36 *Committee Hansard*, 1 March 2004, p. 22.

> I am not convinced it is a problem that is limited to HMAS *Darwin*. If it was in HMAS *Darwin*, there probably were subcultures in other places.[37]

15.29 The investigation following the death of Corporal Jason Sturgess in a vehicle accident also exposed unsafe and dangerous work practices. Although factors such as poor vehicle maintenance were not found responsible for the accident, the fact that these practices and such a lax attitude to safety matters prevailed is of concern. According to Jason's uncle, Mr Jonathan Ford, who had some experience in safety investigations and audits,[38] the report on Jason's death referred to unserviceable brakes, inadequate record procedures and other deficiencies. The were also questions about the safety of vehicle seat belts.[39] Jason's Aunt, Ms Coral Giffen, expressed the view that:

> Being in the ADF should not mean that there is an unacceptable death rate from accidents or failure of equipment. If anything, under peacetime circumstances, under normal circumstances, because of the very job that we ask them to do when we ship them overseas, when we deploy them, we should be even more respectful of the need to keep them safe when they are not at home. How awful to think that our young people may find that the worst enemy that they face in their career in the defence forces is actually their own government, their own command and the people who vote those people in.[40]

15.30 The examples given here are not isolated cases. They demonstrate that all three services have at times failed to provide a safe work environment for personnel, and highlight the need for the ADF to have mechanisms in place that will enable the early detection of unsafe work practices. The cases discussed so far relate to physical safety concerns. Numerous witnesses have also related accounts of where they believe the ADF was remiss in not taking account of emotional and mental health needs.

Mental Health

15.31 Evidence of people's experiences in the military and encounters with the military justice system suggest that the ADF may also not adequately meet its duty of care in relation to mental health.

15.32 The case of Lance Corporal Nicholas Shiels serves as a stark reminder that the ADF, on occasion, has not adequately considered the mental health of those under its charge. Nicholas was involved in a live firing exercise in which he accidentally shot

---

37 *Committee Hansard*, 1 March 2004, pp. 22–3.

38 Mr Ford indicated during evidence on 22 April that he had worked in the mining, oil and gas industries and had been an Air Force member. He had undertaken safety investigations and audits, and had experience in reporting to statutory authorities. *Committee Hansard*, 22 April 2004, p. 18.

39 *Committee Hansard*, 22 April 2004, p. 26.

40 *Committee Hansard*, 22 April 2004, p. 19.

and killed a fellow soldier.[41] Mr Paul Sheils, Nicholas' father maintained that, from this moment on, Army abrogated its duty of care towards a severely traumatised young man who was in total disbelief and trying desperately to rationalise the tragic circumstances that had occurred. He told the committee:

> We want to emphasise the major factors in Nicholas's demise as being the failure to diagnose PTSD, the abysmal lack of follow-up medical treatment, poor or flawed man management by superiors and, in particular, the appalling negligence of Army psychologists, all of which ultimately contributed to his death.[42]
>
> …
>
> The Army failed to look after Nicholas in his work environment during peacetime training. Comcare found that the Army contravened 24 areas of its duty of care under the occupational health and safety act. No senior officer was court-martialled for this. Why not? In the initial aftermath of the accident it was crucial that Nicholas be given support and counselling commensurate with his trauma. Because he did not receive this, he commenced a downward spiral that resulted in his death. There is an implicit comparison between the treatment normally available to civilians and that which was given to our son. It is not up to us to prove that the Army failed in its duty of care for our son: it is indisputable. The evidence is clearly outlined in the Comcare report, the coronial inquest findings and ultimately in his death.[43]

15.33 One of the most disturbing aspects of this case was Nicholas' participation in another live firing exercise soon after the accident. Mr Shiels told the committee that, despite his heavily traumatised state, Nicholas was not placed on sick leave, nor did he receive proper medical treatment immediately following the tragedy. Mr Sheils claims that his son was instead 'instructed to undertake the same "live firing" exercise two days after the death of his colleague.'[44] Mr Shiels told the committee:

> In our presence he was told, not asked, to undertake the same live firing exercise just two days after the accident—the instigator being the on-scene Army psychologist.
>
> You must remember that here we have a young private—bottom of the rung—involved in an accident, the consequences of which were that his mate was killed. Army hierarchy were in damage control. He relived the accident over and over, with questions and statements from both Army and state police. As a private you are powerless and subject to the Defence Force Discipline Act. He was not in a position to refuse an order. We were absolutely staggered. However, we knew that we had absolutely no say. We expressed our reservations because of his already fragile state. We saw

41 *Submission P23,* p. 1.

42 *Committee Hansard*, 29 April 2004, p. 3.

43 *Committee Hansard*, 29 April 2004, pp. 3–6.

44 *Submission P23,* p. 1.

> Nicholas pressured to undertake the same live firing exercise again. The handling of the situation emphasised the outmoded idea: if you fall off your horse, get back on it and get over it.[45]

15.34 He stated further that, before the second live fire exercise, Nicholas was put in front of the 200 troops who were asked 'who will volunteer to be Private Shiels's partner?' Not only did the actions or lack of action by the Army add to this young man's suffering, but the military justice system further contributed to his distress. Nicholas was discharged from the Army in February 1995, having served just under three years. He attempted suicide on 29 December 1996 and died on 31 December 1996.

15.35 The sequence of events after the *Westralia* accident followed a similar pattern. Again, those in charge failed to appreciate the severe trauma suffered by those involved in the accident. Where mental health care was provided in the immediate aftermath of the *Westralia* tragedy, witnesses have told the committee that it was inappropriate. Personnel who had been on the Westralia at the time of the fire were given 'group therapy' sessions by the critical incident stress management team. Personnel found these sessions incredibly stressful, traumatic and unproductive. Mr Gary Jenkins stated:

> At the briefing the psychologists tried to get everybody to talk about what they did on the ship that day but I couldn't talk about it and started to get very emotional and annoyed. Some of the crew were starting to ask questions about the way we did things, and why we had sent the hose team back in, what was Midshipman Pelly doing in the room and so on. I felt that I couldn't answer them at this stage and walked out. This major disaster briefing was a joke. It didn't help in any way, in fact it made things worse for me.[46]

15.36 Aside from the inappropriate mental health care delivered immediately after the incident, witnesses have also told the committee that their ongoing mental health care needs were inadequately provided for. One witness stated that Navy had been advised that she required further psychiatric treatment. This information, however, was not given to her. She informed the committee that:

> I have proof of gross negligence on [the part of] the Navy, who received a report from a Psychiatrist stating I had PTSD from the fire and needed counselling every two weeks, and also anti-depressants but the Navy kept that letter to themselves and this advice went unknown to me until I found the letter on my medical file when I was discharged.[47]

---

45 *Committee Hansard*, 29 April 2004, p. 4.

46 *Submission P45*, p. 2.

47 *Submission P37*, p. 4.

15.37 Another victim of the *Westralia* fire, Able Seaman Matthew Liddell, received some psychiatric care but it appears to have been insufficient to deal with his PTSD.[48] His mother, Ms Dulcie Liddell, told the committee that Matthew had attempted to revive a badly burnt crew member. As a direct result of his experiences following the fire he suffered PTSD, and eventually took his own life. Mrs Liddell told the committee:

> Matthew was hospitalised in St John of God for a few days, then transferred back to HMAS 'Stirling' medical facility. After discharge about a week or so later he was then sent back to HMAS 'Westralia' which was in my opinion very wrong, this did a lot of damage to his mind—it is a lot like sending someone back into the lion's den after they're been already attacked and mauled. Matthew did not want to go back to the 'Westralia'. There were too many traumatic memories, he couldn't cope with emotionally which resulted in bad nightmares, a great loss of sleep, which consequently resulted in a high degree of irritability and anxiety. Even though he'd had counselling on a few occasions, this did nothing to alleviate his problems, maybe his treatment was not taken seriously enough.
>
> Just before Xmas of 1998, Matthew was hospitalised with severe depression, this should have been a warning and to have something constructive done—The Navy then decided for 'the purposes of maintaining his mental health he could not stay on the 'Westralia', it only took them months to come to this obvious conclusion.[49]

15.38 Ms Liddell explained further:

> The assessment team of psychiatrists, social workers and psychologists who follow the Guidelines of the National Centre for War Related P.T.S.D. found Matthew qualified for admission to the P.T.S.D. treatment program. This programme commenced 24-9-99. This is 16–17 months after the 'Westralia' disaster. Why so long?[50]

15.39 The committee notes that Navy has acknowledged that it lacked a good understanding of PTSD, but has expressed its willingness, and taken action, to obtain a better insight into the condition.[51]

15.40 Jason Gutteridge's case is an example where Army failed to manage a soldier's obvious mental health difficulties. Mrs Debra Knight, Jason's mother, told the committee that Jason had been in a military prison and had attempted suicide twice

---

48 *Submission P13,* pp. 2–3. Information on Able Seaman Matthew Liddell varies, with the Navy stating that extensive care was provided, including after discharge (*Submission* 16B, p. 2) and his mother believing that he was not admitted to specialised treatment for PTSD until 16 months after the fire (*Submission* P13, p.5) as well as not being able to move away from Perth to avoid the memory of the fire.

49 *Submission P13,* pp.1–2.

50 *Submission P13,* p. 4.

51 *Committee Hansard*, 5 August 2004, p. 38.

over a short period immediately preceding his death. Despite these attempts at suicide, Mrs Knight was never informed about Jason's difficulties. The evidence before the committee suggests that Jason's friends assumed most of the responsibility for Jason's care.[52] Mrs Knight only discovered, some months after his death, that he had been experiencing emotional difficulty and had made two previous attempts at suicide.[53]

15.41 Mr Keith Showler, a Flight Sergeant with the RAAF, told the committee that after continued harassment and abuse from an Army Major, he suffered a 'nervous breakdown'. Mr Showler received immediate medical attention but could not continue receiving mental health care because adequate records detailing the initial treatment were not made.[54] He had to access ongoing psychiatric care at his own cost. In this instance, not only did the ADF fail in its duty of care to provide an environment where the risk of mental health difficulties was reduced, but it further failed to provide adequately for Mr Showler's mental health needs after the initial incident.

15.42 These varied experiences—from Navy, Army and Air Force—all demonstrate that shortcomings in mental health care are not confined to a particular service. They are common to all three. There seems to be a broad-based failure within the ADF to adequately meet the duty of care owed to Service personnel.

Managing mental health reporting and service provision

15.43 In addition to receiving evidence from submitters concerning their experiences, the committee heard from the ADF regarding its management of mental health issues, including reporting mechanisms and support service provision.

Reporting mental ill-health

15.44 Mental health issues seem to be under reported in the ADF. The problem may actually be much larger than the evidence to this inquiry, or the records kept by the ADF, suggest. The committee has already discussed a general reluctance within the ADF to report wrongdoing or lodge complaints. In para. 15.5 the committee asserted that this reluctance may extend to and impact upon an individual's ability to identify and seek help for mental health needs. The committee considers, however, there are also shortcomings in the way that the ADF records mental health data and assesses the performance of its mental health programmes.

15.45 The ADF acknowledges that it is operating in something of a vacuum regarding mental health services because it has no prevalence data. Colonel Cotton told the committee:

> It is going to be difficult for us to get any real measure of the effectiveness that we have had in reducing the incidence of mental ill-health in the ADF

52 *Submission P18* and *Committee Hansard* pp. 32–33.

53 *Submission P18.*

54 *Submission P3*, p. 2.

> because we have no prevalence data. We do not know what the current rates are
>
> …
>
> We will get a prevalence study up and running probably next year, which will give us some benchmark data that we can then use for a subsequent evaluation, probably a couple of years on from that. The simple fact is that we do not have good data on prevalence rates at the moment to do comparisons.[55]

15.46 A committee member asked whether there was any data at all that could be used to benchmark the state of mental health in the armed forces. Colonel Cotton replied that these things could be done, but the effort involved in retrieving data from paper records would be enormous. He stated:

> Defence Health is starting a process of routine health studies for every deployment and that has a mental health component. But the simple fact is that we do not have the electronic information systems to do that easily.[56]

15.47 The committee does not accept that an armed force with a budget running into billions, access to some of the most technologically advanced weapon systems in the region, and the sophisticated software to manage these, does not have an electronic information system sufficiently advanced to maintain adequate mental health records and service provision.

15.48 In the absence of service-specific data, the ADF expects to monitor the outcomes of its mental health strategies using information from the federal government's National Mental Health Strategy.[57] The ADF would therefore appear to be relying on broad-based, nation-wide 'whole of government' mental health indicators to assess the success or otherwise of its own specific programmes.

15.49 The committee questioned Colonel Cotton regarding suicide rates in the armed forces. He confirmed that suicide rates have at times exceeded the rates in the general population. A committee member asked Colonel Cotton whether it was appropriate to compare the ADF against the general population, given that the issue did not involve the general community *per se*, but rather, involved a single employer. Colonel Cotton replied that the ADF does not generally tend to examine its statistics against other employers, but acknowledged 'it would be interesting and useful to do that'.[58]

15.50 The committee considers that the ADF needs to improve its reporting and management systems. It should not measure its performance against the general population, but rather, should act swiftly to develop adequate reporting and mental

---

55 *Committee Hansard*, 21 June 2004, p. 21.

56 *Committee Hansard*, 21 June 2004, p. 21.

57 *Committee Hansard*, 21 June 2004, p. 21.

58 *Committee Hansard*, 6 August 2004, p. 39.

health management systems that are adapted and appropriate to its specific circumstance.

Providing mental health services

15.51 Colonel Cotton informed the committee that the ADF is in the process of upgrading and enhancing its mental health service provision, and was generally adopting a more proactive approach:

> The ADF mental health strategy represents a major change in direction for the delivery of mental health care to the ADF. It is based on the Australian national mental health policy and uses a public health model of mental health service delivery. This means that it is focused on health promotion and preventing mental ill health rather than simply responding to ADF members who become unwell. This does not mean that we do not provide treatment to individuals who become unwell, but we are putting a lot more effort into stopping individuals getting to that point.[59]

15.52 In referring to gradual changes that have been implemented or developed for the provision of mental health care, General Cosgrove noted:

> In the past few years the ADF has significantly improved the mental health care provided to its members. We have a mental health strategy that integrates the efforts of personnel in health, psychology, social work and chaplaincy in the ADF to better meet the needs of our people and commanders. Considerable efforts have been made to address alcohol and other drug issues, to enhance our ability to respond to suicide related behaviour and in how we deal with the potentially traumatising effects of military service. We have put substantial resources into training ADF health and allied health staff to provide care to ADF members. In most areas, the level of care substantially exceeds what is provided in the general community.[60]

15.53 The ADF has a process of information development and service provision, and also produces and disseminates material to raise awareness of the services it provides. The ADF has produced material on PTSD, mental health generally, and on the links between mental health and substance abuse. While these are very important, help to increase the awareness of mental health, and recognise that mental health difficulties are common reactions to a range of issues, there also needs to be an awareness that the responsibility of the individual and his or her colleagues is limited. It is vital that the ADF adopts a pro-active stance towards mental health service delivery and develops the infrastructure required to adequately provide for the needs of service personnel.

15.54 The ADF informed the committee about a hotline ADF personnel can access to discuss problems and obtain referrals to services:

---

59 *Committee Hansard*, 21 June 2004, p. 3.

60 *Committee Hansard*, 6 August 2004, p. 39.

> The purpose of the all-hours support line is not to provide a telephone counselling service or anything like that; it is to provide access for someone in crisis to ADF provided facilities. What they will do is that if someone calls and they are in crisis now they will be put onto the 24-hour support that is available in their region but the people at the end of the line, who are all trained health or allied health professionals, will make an assessment and if that person can be best dealt with the next day they will refer them the next day.[61]

15.55 According to Colonel Cotton, Service personnel are not, however, readily accessing this phone service.[62] Several factors could explain this, including the fact that, regardless of being able to speak to someone outside the ADF during times of crisis, individuals are subsequently referred to ADF-provided services. The committee has previously postulated that individuals may be unwilling to access ADF-provided services due to cultural factors and fear that this may adversely impact on career prospects. Personnel's willingness to access services like mental health hotlines will not improve until a cultural shift occurs in the ADF, and personnel begin to accept that penalties or stigma will not and should not occur when mental health services are accessed.[63]

Services to families and support to next of kin

15.56 The committee has received evidence concerning the way families have been treated while matters have progressed through the military justice system, and has also considered the provision of support services to grieving families and families otherwise encountering difficulty.

15.57 The ADF has introduced a number of processes to assist personnel and families to cope with ordeals such as accidental death and suicide. A number of these have been operating for some time, and others have been set up in response to particular reports. They include:

- the introduction of the 'sudden death protocol';
- providing assistance for families to provide input into inquiries; and
- providing support teams, including chaplains and social workers to help families when a death has occurred, and liaison officers who can take

---

61 *Committee Hansard*, 21 June 2004, p. 4.

62 *Committee Hansard*, 21 June 2004, pp. 9, 13. He stated it was 'undersubscribed' and he thought it 'would get used more'.

63 *Committee Hansard*, 21 June 2004, p. 3: 'When we set the line up, one of the key things was to provide some anonymity because we have this strong sense that people do not use resources because of the spectre of it affecting their career'.

> care of and co-ordinate services, thus minimising a family's need to be involved in details.[64]

15.58 The Service Chiefs have also often had contact with families during times of tragedy. Much of the ADF's contact with families, however, is organised through the Defence Community Organisation (DCO):

> Members of ADF families can approach DCO officers directly in order to obtain assistance or any ADF member can obtain access to the DCO as he or she requires. However, in times of crisis or tragedy involving a serving member, it is usually the ADF chain of command which activates the DCO to assist a family.[65]

15.59 Rear Admiral Brian Adams, head of Defence Personnel Executive, told the committee that DCO staff partner with medical, psychology and chaplaincy providers within the ADF to provide critical incident mental health support services and counselling to people affected by a loss—including deceased member's colleagues and families. The DCO may also engage independent external professional providers if caseworkers feel that it is in a family's interests to do so and the family is agreeable to it.[66] Rear Admiral Adams stated:

> The DCO ensures a system of support is built around the family from within the wider community to support the longer term recovery and support needs of the family.[67]

15.60 Mr Bernard Collaery, a lawyer who has assisted many families through the military justice system, nonetheless advised that the process left some gaps in information and support which could contribute to long term issues. He told the committee:

> The other people who do not get the critical incident debriefing and proper treatment are the relatives, who, sometimes by perception—wrong, right or otherwise—become absolute thorns in the side of the government and military people, sometimes when issues could be put down straightaway.[68]

15.61 Responses to ADF support services have varied. This variability may have been the result of process changes over time, and of differences in the attitudes of the forces. Mr Collaery praised the 'current Chief of Air Force' whom he described as

---

64 *Committee Hansard*, 2 August 2004, p. 2: 'The [military support] officer is responsible, along with people such as the chaplain, for organising a funeral in the case of a death, assisting with managing the estate and providing a conduit between the member's unit and the family to ensure information is communicated clearly, accurately and in a timely manner. The DCO also allocates a social worker to the family who, in the early stages, assists the family.'

65 *Committee Hansard*, 2 August 2004, p. 1.

66 *Committee Hansard*, 2 August 2004, p. 9.

67 *Committee Hansard*, 2 August 2004, p. 2.

68 *Committee Hansard*, 9 June 2004, p. 56.

'just an exemplary man in the way he deals with issues. I have great admiration for him':

> Whilst I am very critical of the Air Force over the F111, his ability to send notes to the families on the anniversaries of the deaths of his operational crew just marks the man. That process has to be led and that man is leading that in that arm.[69]

15.62 Ms Gurr, mother of the sailor lost at sea in 2002, found the support she received was excellent. On the other hand, Mrs Liddell was critical of the DCO:

> The DCO from Mitchelton dropped off pamphlets at my daughter Michelle's house in Keppera. There was no conversation, no talking about it; nothing was explained.[70]

15.63 Mrs Satatas, mother of a young man alleged to have committed suicide in 2003, also considered that the help she received was inadequate.[71] The mother of a pilot killed in 1993 expressed similar concerns, stating that there had been no assistance in getting to the funeral, and no counselling provided.[72] While there have been improvements since 1993, other factors still appear to limit the provision, and quality, of services to some people.

15.64 The Committee notes and welcomes the initiatives taken by the ADF to improve its health services for serving ADF members and the support services its provides for families of serving members who have been injured or died suddenly. Evidence shows that this is an area that needs the ADF's close attention.

Conclusion

15.65 The report could go on to describe in detail aspects of the delivery of mental health services in the ADF but this would go further beyond the terms of reference. The committee concludes this chapter by emphasising that the military justice system should be a mechanism that not only deals with wrongdoing but is instrumental in preventing wrongdoing from occurring. It should be a means of stopping the emergence or continuation of conduct that puts the well-being of individual members at risk. Its procedures should not add to the ordeal experienced by people who are caught up in the process. The military justice system should not be part of the problem, it should be part of the solution— it should resolve problems, not create them.

---

69 *Committee Hansard*, 9 June 2004, p. 57.

70 *Committee Hansard*, 22 April 2004, p. 49.

71 *Submission P2*; *Committee Hansard*, 2 August 2004, p. 12. See also *Submission P13*, p. 5 which was highly critical of the DCO although more positive about help provided by chaplains.

72 *Submission P32*, p. 5.

15.66 The committee draws attention to the evidence that highlights the shortcomings in the military justice system and how such failings have contributed to or caused mental heath problems. This awareness alone should convince the ADF of the need to put in place the recommendations made by this Committee to reform the military justice system.

15.67 The recommendations contained in this report are intended to remove some of the systemic problems that cause Service members unnecessary stress and anxiety. The committee hopes that implementation of the suggested reforms will encourage ADF members to report wrongdoing or make a complaint, and will promote the attainment of impartial, rigorous and fair outcomes. The committee hopes that a reformed military justice system will enable those who feel unable to pursue a matter through the chain of command to seek redress through independent and impartial bodies.

15.68 An independent body created to correct administrative defects and an independent military court will perform important oversight functions, ensuring that investigators are better trained, that inquiries and investigations observe the principles of procedural fairness, and that delays are kept to a minimum. These bodies will be in a better position to take account of the needs and well-being of those caught up in the military justice system.

15.69 Furthermore, by expanding the involvement of civilian police and courts in areas where they have the expertise and structures to better handle such matters, and creating a court that reflects principles enshrined in the Commonwealth Constitution, ADF members can expect to enjoy the same rights and have the same safeguards as all Australians. Overall, the recommendations are designed to put in place for ADF members a justice system that will provide impartial, rigorous and fair outcomes and one that is transparent and accountable.

SENATOR STEVE HUTCHINS
CHAIRMAN