Australian Government
Productivity Commission

PRODUCTIVITY COMMISSION

VETERANS' COMPENSATION AND REHABILITATION

MR R FITZGERALD Commissioner
MR R SPENCER, Commissioner

TRANSCRIPT OF PROCEEDINGS

AT MERCURE WAGGA WAGGA, 1 MORGAN STREET, WAGGA WAGGA
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COMMISSIONER FITZGERALD: All right, we'll get under way. Thank you very much for attending, and it's good to be back in Wagga. We were here in the latter part of last year, before we put together the draft and that - we visited the Army Air Force bases here in Wagga, and then also in Albury. And that was an exceptionally beneficial trip. So, it's good to be back.

I've just got to make a formal statement to start these proceedings. Welcome to the fourth day of the public hearings for the Productivity Commission inquiry into veteran compensation and rehabilitation, following the release of our draft report in December. I'm Robert Fitzgerald. I'm the presiding commissioner and my fellow commissioner is Richard Spencer. The purpose of these round of hearings is to facilitate public scrutiny of the commission's work, and to get comment and feedback on the draft report and any other issues that might help in informing our final report.

Prior to this we've had public hearings last week in Adelaide, Perth, Darwin. We had good roll ups in those cities. And following this we have hearings in Canberra, Townsville, Sydney, Brisbane, and Hobart. We will then be working towards completing a final report to the government in June, having considered all the evidence presented at the hearings, and in submissions as well as our informal discussions and consultations. Participants, and those who have registered their interest in the inquiry, will automatically be advised of the final report's release by government.

And the government is required to release the report 25 days - within 25 parliamentary sitting days after completion. So, the Productivity Commission produces the draft report, which we did in December, the government produces the report - the final report, but it is compelled to do so. So it has to release it within a timely manner.

We like to conduct all hearings in a relatively informal manner. I'm not quite sure this is informal, but nevertheless. But I remind participants that a full transcript is being taken, and for this reason comments from the floor can't be taken during the sessions, but during the day and at the end of proceedings of the day, I provide an opportunity for any person wishing to make a brief presentation. So, if you haven't - if you haven't been registered to make a formal presentation, if you'd like to make a short statement then just see one of our staff and we'll facilitate that either during or at the end of the session today.

Our participants are not required to take an oath, but they are required to be truthful in their remarks. Participants are welcome to comment on the

issues raised by other participants in other participants and other submissions. A transcript will be made available to participants, and will be available on the commission's website following the hearings. And submissions which are due this month are also placed on the website, unless there's reasons not to do that.

Just in relation to safety issues, there is an exit at the back, the door through which you came. So, should you need to evacuate the room, do that. Don't go through the toilet, otherwise you'll go nowhere. So you can get away. And just on that, there's a toilet there, there's a toilet there, there's a toilet outside, and there's coffee and tea available throughout the session. We'll have a break, a short break, in the middle of the morning, but if you want to get a tea or coffee please feel free to do so. Otherwise I think we're good to go.

The draft report was very large. It's the largest and most in-depth analysis of Veterans Affairs in Australia's history, despite the fact there's been many other reviews. So there are a very large number of areas we've covered, significant numbers of recommendations, both in relation to defence and DVA. And clearly there will be, and there have been, comments in relation to many of the matters we raise. But I just want to make a couple of points before we start.

The report is about trying to create a system for the future. It's not about trying to tinker with the system for tomorrow. So, our focus is where do we want to be in 20 or 30 years? And that's a very important part of this. It isn't just simply playing with benefits, it's much more substantial than that. And the second thing is it does have implications across the whole life of a veteran, from the day they join the Defence Force to old age. And so again, we were trying to work out a system that travels with the life of a veteran, in his or her many iterations, both within Defence and post-defence.

So it's large, it's deep, and it takes a very long term view, both of the veteran, and of the system itself. With that I'd like to welcome our friends from Hume Veterans' Centre, and if you both could give your name and the organisation that you represent, for the record.

MR RYE: Certainly. So, David Rye and - - -

MR TAYLOR: Wayne Taylor.

MR RYE: So I'm the Vice Chair. Wayne is the Chair of the Hume Veterans' Information Center, over in Wodonga. The Hume Veterans' Information Center is part of a veteran information program that was

established 20 years ago for Victoria, in partnership with RSL and the Vietnam Veterans Association. Our centre has been operating for 20 years. We had our 20 year anniversary in October last year, and we provide both wellness or welfare, advocacy, and compensation advocacy support to the region, not just all in Wodonga. We've extended as far north as - as Wagga in the past, over the mountain region, and as far down as Wangaratta.

COMMISSIONER FITZGERALD: Okay. So if you can make an opening statement for about 10, or 10 to 15 minutes, and then we'll have a chance for discussion.

MR RYE: Certainly. I probably won't need 10, 15 minutes for an opening statement. In essence, we certainly agree with the direction that the report has taken. We feel that anything that simplifies the process for a veteran to receive support, whether that's financial support, rehabilitation support, health support is - is definitely a move in the right direction. And I would state that any of our comments, and we have made several comments to the Commission, and our people just do that in general discussion, rather than formally, is from an advocacy point of view. The report does cover other aspects such as - as war graves, that, obviously, we have no influence over. But just from a pure advocacy support.

So on that, processes, obviously, governed by three pieces of legislation that's very convoluted. The current system is very stovepipe in the way that the DVA deals with those three pieces of legislation. It's not one person that's making a decision from start to finish. It goes through several different people. So, improving that process is a big plus. But also the training and experience level of the decision makers, with whatever statutory organization is empowered to make the decision towards veterans.

As advocates, we are held to a national level of competency. We have to be accredited, and maintain currency, to offer our advocacy support. That's not the same case for the people that are making these decisions. In Melbourne, they've got delegates that are rotating through on a six month basis. So, they've got no experience, very little training. So I think this goes - this report and the recommendations within it, go a long way to improving that. So I think, in harmony of not only thinking of the through life, continued support of the veteran, but also the organisation that supports them, and the decision makers within those.

If we can improve their training, experience levels, I think that'll go a long way to smoothing out the process.

COMMISSIONER FITZGERALD: Any other comments?

MR RYE: Only with regards to one thing that stood out to me, and it will be addressed, I think as we go through, is that - and I appreciate that it is a very broad brush, and there's a - DVA is a very big beast. And in many respects it's - it's about bringing DVA, and the Acts, three Acts of legislation, in line. So I think it's important that where possible, where there is specific points, we need to narrow them down. So, when a report is presented to DVA, that where necessary we actually give them those fine points and say, "Yes, we've got a broad brush. This is what you need to address. But there are some areas that need to be touched up as a final point."

And probably, just by way conclusion, speaking generally from a centric point of view, what we find most of our dealings with DVA, the people within DVA are good people. They generally have the interests of veterans at heart, but they're often constrained by their own bureaucracy that they've got to work within, which often causes the difficulties they encounter. So again, anything that can smooth that process, and that bureaucracy out, is going to be a definite - definite bonus.

COMMISSIONER FITZGERALD: Good, thank you very much. You've raised a whole lot of questions, and we'll raise some of those as we go through this particular discussion. Can I just raise the issue about advocacy in the air, just for a moment. As you know there was an inquiry by Robert Cornell in relation to advocacy, and touching on the role of ESOs, which the government has, but has not yet been released to the public. So we will be looking at those particular recommendations and considerations by Robert Cornell, and informing our views as we go forward in the final.

But one of the things we will be also looking at is how ESOs can be better utilised by the government in delivering services to the veterans' community. And I was just wondering whether you have any particular views around how could government better leverage the ESO effort, the commitment by so many volunteers and agencies, to better deliver services to veterans, if at all, apart from advocacy. So we just put advocacy in relation to claims on one side. We'll look at that separately. More generally, do you have any guidance for us about how we should approach the issue of ESOs, and the point that we're making is not about how you shape ESOs, they can shape themselves. But how does government better use ESOs to achieve outcomes for veterans?

MR TAYLOR: From our perspective, the funding we get through BEST is probably one of the most important things we have, in moving forward. Is anyone not aware of what this funding is?

COMMISSIONER FITZGERALD: You might just need to explain that.

MR TAYLOR: All right. BEST funding is a government funded lot of money that we receive. We vote for, you know - we vote for it each year. BEST stands for Building Excellence in Support and Training. It's been around for quite some time. The Veterans' Centre project in Victoria has been around for 20 years, and I would say it would probably close to the 20 years that it's been around. Up until last year it was only available to selected Veterans' Centres, RSLs, welfare support. It's now open to all ESOs, and it's administered through the grant sub, so human services.

We put in a bid for that. That will cover - that will only cover certain things. It will cover payroll for a permanent staff person, replacement of computers, certain stationery. So there's a restriction on what we can use BEST funding for. The funding is very, very important in order for a Veteran's Centre to move forward. Another initiative which you're aware of, the Victorian RSL is moving down the path of, is a veteran hub. So a veteran hub will be a central focal point that veterans will be able to attend to seek assistance.

So there will be different - my understanding is there'll be different levels of veteran centres, where a veterans hub, a veteran will be able to move forward and have a primary claim at, yes, primary level. They can have an appeal done at the Veterans' Review Board, and they can also see a person at that one centre if they want to go to the Administrative Appeals Tribunal. So to fund that, obviously you can see the impact that this funding would have on your permanent positions available there.

We at the Veteran's Centre in Wodonga have a - one paid permanent, and that equates to, I think, about $60,000-odd a year. So it's pretty important that we receive that funding. We never receive all 100 per cent of the funding, and the rest of our funding is made up through Anzac Day proceeds, which is administered in Victoria through the Victorian Veterans' Council.

COMMISSIONER FITZGERALD: And just in relation to the veterans' hub, what are your views in relation to those, because we are looking at those in the preparation of the final report?

MR RYE: We think they're the way of the future, but that's the way we should shape it so it shouldn't - it shouldn't be restricted to, perhaps - maybe in RSL sub-branch, that has a particular, you know, focus on one particular thing. A Veteran Centre hub should have a number of agencies involved that can serve the sole purpose of maximising the support to the veteran.

One thing that may be looked at in the future - this comes down to DVA. For many years, the future of DVA has been discussed in Wodonga. At the moment, we have a VAN office, which is a Veterans' Access Network Office, and it's been in doubt whether, and for how long, the Veterans Access Network Office, the DVA office, will last. There has been a significant amount of talk about the veteran DVA office moving over to Centrelink. Which from a veteran perspective we don't see that as a really good option.

Veterans at the best of time are reluctant to seek assistance. If they had to walk into a Centrelink office, I think there'd be big problems there. Not knowing, and this is just me talking from experience, potentially a large veteran hub, and the idea in Victoria is that they will be sponsored and supported via an RSL that has pokie machines. That's where the finances will come from that. We're, in Wodonga, we're not close to that, and so we rely on the BEST funding. But with the most appropriate facilities, which I think is really important for government to support, is the right facilities that is conducive for a veteran to attend. Maybe a one-stop-shop where you had a totally lockable section of DVA, that they could walk in and speak to a DVA person, face to face, because we can't help them with every need.

And then they can potentially walk straight next door into a veteran hub, and then seek the rest of the assistance that they need, or guidance. That's just a thought.

MR RYE: But if we just circle back to that government interaction with ESOs, obviously we've seen a lot of influx in ESOs in the last 10, 15 years. They all do fantastic work. There's no nothing - no taking away from that. But I think from a government - everyone's bidding for the same government dollar. And I think if the government has a - a level of measure or criteria to which they award the funding, based on the direct support to veteran community, I think that's the way why they need to look at the funding issue. So obviously if you've got a small ESO that's helping a small amount of veterans as opposed to a, maybe, a larger veteran hub that's helping a lot more veterans, I think the funding should be allocated accordingly.

COMMISSIONER FITZGERALD: Good. And just in relation to the Veteran Services Commission, we have recommended a Veteran Services Commission to administer all of the compensation arrangements, including incapacity and impairment payments, health and community service aspects, that are currently administered by DVA. And as you'd be aware right throughout Australia, governments no longer use departments as a way by which they administer these sorts of schemes. There's a much better way to do that. There is, however, contention and we've heard it in all the things, about where policy and planning and others should sit. We've made recommendations, but most people believe there should be some form of DVA retained, and we'll look at those comments.

But we are very strongly of the view that the actual administration should sit in a separate, statutory authority, which in fact would have a Board of Commissioners responsible to the Minister of Veterans Affairs, be totally focused on veterans, and use this practice, from around all the other schemes. Can you - you've raised the issue about the tight timeframe, and I'll just ask the question about this. The timing is based on the advice from DVA, that the Veteran Centric Reform Program will largely be completed by middle of 2021.

And so our timing is based on the fact of allowing that reform to continue, and then that the next year is - is devoted to developing the new commission. So that's the timing. But it is reliant on the Veteran Centric Reform Program being finalised or at least substantially finalised by that time. Can I ask this question: your experience with the Veteran Centric Reform Program. What's it delivering to you, in terms of a practical sense. Is it working as well as you think it is? Do you think it's got a long way to go? What's your general experience with Veterans Centric Reform?

MR TAYLOR: A lot of what we've seen, you don't see it on the surface. There's a lot of things happening in the background, but in saying that, the things that we - we have been seeing is the veterans portal to myGov. They're the things that we are seeing now. myGov, I don't necessarily believe it is the best way to get - it has to be there, but I think it needs to be there, because not everyone can access, and you need to make claims easy for a veteran. But the - as you're aware, there is problems in the three legislations which makes it difficult when a veteran actually lodges a claim, through MyServices, or myGov, MyServices, potentially they're setting themselves up for a fall. So.

COMMISSIONER FITZGERALD: Who's setting themselves up for a fall?

MR TAYLOR: The veteran who's doing his own claim, or their own claim. There's three different apps. The first thing they need to negotiate is three different apps. So in that, I haven't seen myGov, but I'm assuming myGov is just going to basically say, listen, "Yeah, you're entitled, do it in time to check it, and off you go." Two of the legislations, as you're aware, has the statement and principles.

COMMISSIONER FITZGERALD: Sure.

MR TAYLOR: If a veteran doesn't lodge his claim using the correct terminology, that is applicable to a statement principle or was unaware that if - if I knock my knee and that I had bruising, I attended the doctors for whatever period time, or I was exposed to this - they're not necessarily going to put down that contention. As Dave indicated, and this is firsthand from a senior person within DVA, at the moment. DVA have got a six month turnover, in their staff.

Now, a lot of the - what we're seeing is that the staff down there, because of their inexperience, they're not necessarily looking at the full list of contentions within a statement of principle. They'll only address what the veteran has indicated and therefore he winds up in the appeal process.

COMMISSIONER FITZGERALD: So, just on that, the system is only as good as the information is that's imported. So is the fear that the veteran will fail to fully, you know, to fully display all the conditions, or in fact get confused in relation to what the claim should actually contain?

MR RYE: That's the risk. I mean, the overall program is moving in the right direction. You know, getting certain injuries for a certain period of service as a (indistinct), you know, they'll accept those. Our concern is that by encouraging a veteran to complete their claim on their own, there's a lot of pitfalls that they could fall into. Some veterans will be capable of doing it, and will manage it. But I just think if there's a caveat somewhere in that process of them completing that form online, by themselves, but if there's an information box or a link that could be installed that says, "If you've got any concerns, any questions, here's your nearest advocacy agency that you go and get more advice from."

So not discouraging allowing veterans to do it themselves online, but we've always got to see the back to where they can get support and help if they've got any concerns or questions.

COMMISSIONER FITZGERALD: So given the myGov, MyService websites have only been up for a couple of years, as I understand it, have

you had any clients come back to you that have gone through that process and suffered the fate that you describe?

MR RYE: Yes. Several.

COMMISSIONER FITZGERALD: Several?

MR RYE: Yes. And then there is the review process.

COMMISSIONER FITZGERALD: So, what happens if a person comes back and they're dissatisfied with the determination of the DVA, having used myGov, MyService. What's the next step, it's the review process, is it?

MR RYE: Yes.

MR TAYLOR: Yes.

COMMISSIONER FITZGERALD: And is that - when you say review there, are you talking about the VRB? Or are you talking about any internal review?

MR TAYLOR: (Indistinct). So, with VRB, if you're got the MRCA or DVA, or the reconsideration if you're under DRCA.

COMMISSIONER FITZGERALD: Right. We've made a recommendation in relation to, firstly, applying the same review processes across the three Acts. So there'll be no discrimination or change between the three. The second is that there'd be a formal reconsideration process after the initial delegations decision, if you disagree with it, which would have an outreach process, you know, obtaining information, and talking to the claimant. Then the VRB, in a dispute resolution role, and then the AAT in a determinative role.

Can you just talk to me about - do you have any particular thoughts about that review process?

MR RYE: I think they've missed a step. There should be - and again, through the length of time that we've been operating, and building some of a rapport with some of the senior people, of DVA in Melbourne, there just needs to be - and it could be resolved through more experience and training of delegates. But when a delegate does make a fairly basic mistake, that disadvantages the veteran, if there was a team leader, or a person within DVA that you could just simply ring and say, "Listen we feel this is a fairly simple error. Could you please have a look at it? If

you think we're right overturn the decision. If you think we're wrong, then we'll commence the process."

COMMISSIONER FITZGERALD: Right.

MR RYE: So if it would formalise what we're doing informally, but I think nationally, I think that would be a big benefit. But the VRB, you're aware, that they've instigated that ADR process.

COMMISSIONER FITZGERALD: Yes.

MR RYE: We're finding that very successful. That's a really positive step. But then, I wouldn't remove the next part of that, the VRB, which is the formal - - -

COMMISSIONER FITZGERALD: The decision making.

MR TAYLOR: - - - decision making. When I read through, I did have a concern that you were looking that, potential, I think was 2022. bringing it back so DVA administered the review process. I have concerns in you - you're putting a fox amongst the chickens. Last year, and I was actually talking to Dave, I think it's more - this was - can't be more about the fact that there's a lack of expertise in DVA. And it is also in part, too, because of the way the legislation runs with the DRCA. Last year I finalized 17 appeals, 14 of those were had a basis of VEA, MRCA. All 14 were successful. The three which were DRCA based, two of those were a reconsideration. Both failed and one was an AAT, that I took to the AAT, and that was - that failed as well.

So the internal review process that's happening under DRCA, I don't think is open enough to be done internally.

MR RYE: So it should be open the same way VEA and MRCA is, for cyber appeal process.

COMMISSIONER FITZGERALD: Sure.

MR RYE: Independent appeal process.

COMMISSIONER FITZGERALD: The logic behind our recommendations which people may have read or not, is to try, firstly, to improve the quality of decision making by the original delegate. Secondly in the reconsideration is to make sure that all the available information is presented and that there be a conversation and a dialogue with the veteran, early. Then you move to the VRB which is where, as you rightfully say,

we've recognised this is the dispute resolution procedures really come into play.

The only question for us has been whether or not it should be able to make decisions, which is unusual in the way in which appeals review processes operate. But the aim, ultimately is to try to drive improvements in the front end, the early stages of that process.

MR TAYLOR: One is one thing which I have noted from DVA, because on many occasions I've asked delegates - and not just one delegate, but many delegates - we've got a really good relationship at the centre, and quite often, as Dave was saying, we'll ring up, in fact, on Wednesday we're in Melbourne, and we're going to take a rejected claim down one of the delegates who's going to be there, and we've got no doubt we'll go in and backdoor the review process and have a look and see what he can do. That's the type of report we have.

But when we ask the question as to why - why is it a claim being knocked back, but it's getting up at the board so easily, in many cases in the alternate dispute resolution process, they said that - they continually saying the same thing that - that the Veterans Review Board have greater powers from what we do, although they're both working - now I don't know, I don't think it is greater powers, because they're working to the same statutory legislation. But it seems that the VRB have more flexibility.

MR RYE: I think they've got more experience. The members that actually sit on the VRB are a lot more experienced in the three pieces of legislation than what some of the delegates are.

COMMISSIONER FITZGERALD: Sure. One of the dangers we see however, and I think this is not denied by DVA, is that the VRB has become a bit of an automatic backstop. If you muck up the early decision making, it doesn't matter because it's going to be deal with at the VRB. And we are trying to change that whole culture, I'm sure you would to, to a much greater improvement ,in the early part of the process so you don't actually have to get to the VRB. But, who knows. That's the aim.

MR RYE: I mean certainly from our - our perspective, it's the other way. But we believe where we're submitting fairly robust claims.

COMMISSIONER FITZGERALD: Yes.

MR RYE: And again it's those simple errors where just, maybe, a piece of information has been missed by a delegate. You try and talk to the

delegate directors to see if they are prepared to change their mind, and their response is, "If you think we've made a mistake you put in an appeal."

COMMISSIONER FITZGERALD: Yes.

COMMISSIONER SPENCER: Right. If I could take us to another issue now and that's around the issue of transition, and the importance of that. Although, we've heard in recent time some people prefer the term "reintegration". But look, I think everybody's absolutely unanimous that that period of leaving service, particularly if you're medically discharged, is a crucial time. And there are a number of initiatives underway where defence and the ADF is working with DVA to, sort of, share information and that's all to the good.

We obviously think something more substantial and structural is needed to address that issue, and as you know, our recommendation is the Joint Transition Command. And as part of this, there's all these issues linked together. So this is why it's so complicated, as you know. But partly it is another observation we've made around the tension that exists between the role of Defence, and in relation to its personnel. We've signalled in our report that we think Defence should have more responsibility, more obvious and incentives around that responsibility, for its personnel beyond service as well. So there are a number of issues that go to that.

But coming back to this notion of the Joint Transition Command, as you know, we're saying that we think if that is the responsibility of Defence, it would exist for a time afterwards. We've suggested six months, but we're interested in other people's views on that. And you would bring together the people and the expertise that is needed to address a lot of critical issues at that point. So given your experience, because you're right at the, you know, at the - at the coalface a lot of these issues, in terms of the veterans you are dealing with, particularly that vulnerable time. Interested in your thoughts and your suggestions, about first, the notion of that transition command, secondly your reaction to how we see that operating.

MR RYE: Look, again it would be interesting to see what Defence say about that, but as another local example, that we've managed to instigate in our area, if anyone is being medically separated from army in the (indistinct) in the military area, part of their march out process, when they go through their transition, is an appointment to come and see us. So they don't actually get cleared from the unit without an appointment to come and see us and get the process flowing.

And in some instances, we've had some success where a determination has come down with a - with a separation date. We felt that there wasn't sufficient time to actually put in place what needed to be put in place from a DVA perspective to support that particular veteran, and we've gone back through to defence and had the - the separation date held in abeyance until we get everything sorted that we need to get sorted. So, the transition processes is vital. No offense to anyone that's not army, I'm ex-army, I transitioned four years ago and had a very successful transition process.

I think army probably does a little bit better than, perhaps, the other two services. So by making that that joint, is - is not a bad decision.

MR TAYLOR: There is one thing that will jog your memory, because this is actually directly - they had direct involvement in this, but it was highlighted to me again on Friday when I went and got a haircut, and I was talking to one of the senior rehab consultants out at lunch with the barracks. He is on base there permanently. And the lines of communication between Defence and the DVA, there's a disconnect. And I'll leave that one with you because you had direct - - -

MR RYE: Yes. Well that was that was more of a policy issue between the two Acts, the Defence Act and the particular piece of legislation where an individual fell between the two. With me the department would act on either, but that was different actually to the transition back.

MR TAYLOR: And the reason I brought this up is, on Friday this - and I asked him to provide more detail and he said he'd get back to me this week, that he's seen on numerous occasions veterans that are being held up. They've gone to DVA for assistance, and DVA have said, "No, we cannot provide" - even that, in one case, he said, this particular veteran had been out for four years. He said DVA would not accept liability for that medical treatment because technically he was still a defence member.

UNIDENTIFIED SPEAKER: (Indistinct) in reserve.

MR TAYLOR: (Indistinct) a breakdown in that communication so that proper transition hasn't been able to occur.

COMMISSIONER SPENCER: Yes. No, and we're hearing that the notion of in service, out-of-service is changing, because of the reserve situation, and some people moving back and forth between those different roles.

MR RYE: This particular instance was, some someone that was entitled to a DVA entitlement, DVA refuse to give it to him because he was still,

technically, in the standby reserve. Even though he was administratively separated, so it is automatic transfer the standby reserve for five years. His medical issues didn't come to light until about twelve months after he'd separated, came and saw us. This individual was so physically and mentally broken he was never, ever going to be recalled to active duty. But Defence wouldn't take him off the standby reserve list because they are automatically in by the Defence Act.

DVA wouldn't make an exception, because they were constrained by their legislation, and again, the matter was only resolved through a personal relationship that the Senate had with a high ranking officer in army, but went and saw the Chief of Army, and got the Chief of Army's delegation to resolve it.

COMMISSIONER SPENCER: So, clarifying that issue of transition when is it, is it to back to civilian life or in the reserves and who has responsibility? So, one of the things we're trying to do with the Joint Transition Command is to say Defence has that responsibility, rather than relying on goodwill and cooperation, they have clear responsibility during that period. We're suggesting for a six month period after discharge. Do you think that's the right period of time? After that it becomes DVA, or in our case VSC.

MR RYE: No, it needs to be longer.

COMMISSIONER SPENCER: Needs to be long? Why do you think that?

MR RYE: I think a minimum 18 months perhaps two years. Because as we've seen a number of times, a lot of people separate, think they're fine, no problems whatsoever. And it's sort of 12 months 18 months two years later, and it might be something like perhaps going back to an Anzac Day service, or something, that will trigger - trigger something, and that's when the whole issue comes to light. And I know transition isn't directly related about - necessarily about health and wellbeing, but even some of the services that transition does offer, I think if it was opened a little bit longer than then six months.

Because a lot of people get out too, and they go, "Oh look I'm going to go and do this." And they go, "Oh, hang on a sec. I actually hate this, I don't want to do that," and there is a bit of a loss. If they can reach back then, at that point in time, and still access those transitional services that are available to them, especially for retraining, I think that would be would be better.

COMMISSIONER SPENCER: Right. Thank you. Can I just quickly check on your thoughts regarding the pathway that we've outlined to move to a two stage scheme. As you know we believe that the VEA is highly valued by those people who are receiving their benefits under the VEA, and that should be allowed to continue, with some slight modifications. That eventually MRCA would become the single scheme. But that is, you know, for some period in the future. The timetable issue we've taken note of, and we'll look at that again because, you know, the - as Robert said, what's important is to make sure that the VCR process has had a chance to be completed, or substantially completed, and the benefits become apparent then.

So we'll look at that again. But that is a from a very complex situation which we appreciate both from the point - well, from point of view of everybody involved in this process, it creates enormous difficulties, tensions, and stress. Our pathway to that two scheme approach over that period of time, or perhaps that might be changed. Does that makes sense to you? Do you have any issues about that?

MR RYE: Yes it does. But I just qualify that and say it should be seen as an interim step to ultimately what might be, 20 years down the path, where it is a single piece of legislation.

COMMISSIONER SPENCER: Right, right.

MR RYE: So I think you should perhaps, slightly modify the language around that scheme to perhaps reinforce that it is an interim step to an end, and an end goal.

COMMISSIONER SPENCER: Right. Well, that's certainly our intention, so we'll look at that, yes.

MR TAYLOR: Having two schemes it's great, if you can narrow that down. In saying that, one of the things that you've focused on too, was the rehabilitation aspect which should be a primary function of what we want to achieve. The VEA is not designed whatsoever to have that function. DRCA does. So, and MRCA does. So if you were to roll that in to the VEA, it may not necessarily be the best way forward. What may be of more advantage is getting rid of - the VEA has a material contribution, but DRCA has a significant contribution as you know. Bring it back to material contribution. Get those little idiosyncrasies out, that way you've still got a focus on your rehabilitation.

COMMISSIONER FITZGERALD: So, I'm not quite - well, a couple of things just if I can say that. The first stage of this is to try to harmonise

the Acts where possible, in relation to language, tests, the statements of principles would apply across all three Acts, the same review processes would apply. So as an interim measure we're trying to say, "How can you harmonise some aspects of all of those Acts." Then, as Richard was indicating they're ultimately moving by 2025 to two schemes, VEA and MRCA/DRCA combined, and then long term, something else.

One of things we have suggested is the VEA would be not available for new claimants after 2025, if they'd never put in a claim prior to that date. The second thing we've said is that people under the age of, I think it's 50, at the date of 2025, would have an option to move into MRCA and DRCA if they so chose. So, there's an option to come across. So we are seeing that VEA would travel, and for those that are currently receiving VEA there'd be no changes, generally. But at some point new claimants would be not be able to access the VEA.

MR TAYLOR: I spoke about broad brush, and this would be a finer detail. I think in moving forward down that path you have to get rid of the alone test under the VEA. The alone test, and I'll give you an example of how the impact of the alone test. As it currently stands, you've got a veteran that's got all injuries bar one under the VEA. He has an injury under the DRCA, one injury. Now of its own, it doesn't impact on his ability to work. But as a greater picture, it does. This veteran will never be able to being received a TPI pension, even though the conditions under the VEA - for instance, he may have post-traumatic stress, and not capable of working anymore. So a finer detail like that.

COMMISSIONER FITZGERALD: Yes. Richard.

COMMISSIONER SPENCER: No, I'm fine.

COMMISSIONER FITZGERALD: Now, you've raised a number of questions in relation to your submission, and we'll get one of our staff to come back to you and clarify some of those, separate to today. Are there any of those points that you, in the last five minutes we have, would like to particularly raise either as a question or as a comment that we haven't raised so far.

MR RYE: Yes thanks. That is to do with the card system. You've suggested that - you've questioned whether the model or card system should exist, or it's a single card system. Or looking at an alternative to the automatic granting of a Gold Card for someone with a qualifying service at the age of 70. Probably just seeking from you some greater clarification around what you're thinking is.

COMMISSIONER FITZGERALD: Well, a couple of things we have said in the report: those that are currently receiving Gold Cards and are currently entitled would continue to receive Gold Cards, so nobody loses that benefit today or until such time as it's a change. The issue for us is, is there a better way of funding health services, for the whole of the veterans' community, other than through a Gold Card going forward. The Gold Card comes from a particular era. It serves a particular group of veterans, and it's part of the architecture. But if you actually look at it, it's not well targeted. It keeps getting expanded, and the rationale for its expansion is not clear to anybody. And so the question for us is - is not whether the DVA should continue to fund all services, but what is the most effective way to do that.

So we're looking at the notion of smartcard, where you can actually have just one card, but it identifies different conditions, a bit like what White Card does. We are looking at whether private health insurance has any role to play or not, and we have no view about that. And we're looking at different ways to fund health services than currently is the case. So it's a genuine exploration of we are sure of is the default answer can't keep being Gold Card. You can't - everyone can't keep saying, "Oh, it's the Gold Card," because the Gold Card doesn't actually serve war veterans all that well.

It's no good having the Gold Card if you can't access services, and there are issues around it. So our aim is not to get rid of the Gold Card. But it is to say, "Is there a better way of funding health services for veterans and their families going forward." And that's the exploration we're having. But I want to be very clear, no one who currently gets the Gold Card is going to lose it, and that's not our aim. Our aim is, as I said right at the beginning, looking much further into the future.

MR TAYLOR: One thing, when you when you're looking at that. If you've got a veteran, and a smart card is a great idea, and it could be why - I don't think the Gold Card, all that does is differentiate for providers.

COMMISSIONER FITZGERALD: Sure.

MR TAYLOR: Yes, that's all it does. When you've got a veteran that has got a second a significant amount of incapacity, they've got a high - for example, 80 impairment points. You don't want to have a card that says that's all you're entitled to as far as your health care, because a veteran doesn't want to be tied up with going back, and you don't want to tie DVA down going back, knowing that someone who has got these ailments, will generally generate another ailment.

So if you're going to have a card, a smart card, maybe a card would be all conditions. Now I know it sounds similar to a Gold Card, but you'd have no conditions or specific conditions on a smart card. The money you're going to spend on having that person go back to get a new condition, although he's very incapacitated, mentally it's not good for him and financially it's not good for DVA.

MR RYE: And I guess my - I guess part of your exploration around private health insurance, if that's a potential answer.

COMMISSIONER FITZGERALD: Well it's just an option.

MR RYE: It may or may not be. The only thing I caution there is that if you've got a veteran that needs immediate treatment, they're going to a public emergency room and a private health insurance doesn't do anything for them, so.

MR TAYLOR: We see, in Wodonga, it's happened quite a few times. A veteran who is covered. for all conditions, Gold Card, goes in, sees a specialist, specialist sends him in for a knee replacement and the specialist says, "Five hundred dollars." So if you leave it open to the broader health professionals to determine, I think they'll be coming back charging veterans. And we do see, in the broader Wodonga area.

COMMISSIONER FITZGERALD: Okay. Just a couple of other things, if I can, just in your list. We've sought, in relation to the standards of proof, we are saying that our preference would be to have only one standard. Currently there are two standards. People don't agree - a previous inquiry said one standard came up with a midpoint. So we're looking at that, but your view here is that if there is only one, it should default to the reasonable hypothesis.

MR RYE: Certainly, because that's going to benefit the veteran.

COMMISSIONER FITZGERALD: Well, can I ask this question - - -

MR RYE: But also it's not - just not that - it also like the decision making process for the statutory authority whether that's DVA or whoever it might be.

COMMISSIONER FITZGERALD: Sure

MR RYE: It'll make it easy for them as well.

COMMISSIONER FITZGERALD: Well, it makes it easier, that's true. We have to look at the costs, the costs and the other consequences of doing that. Can I ask this question, but in practice - I understand the legal differences between reasonable hypothesis and a beneficially applied balance of probabilities. I understand the difference. In practice, is there a significant difference to the way it's actually applied.

MR RYE: Yes yes yes.

COMMISSIONER FITZGERALD: So, what's your experience been about that.

MR TAYLOR: The way it currently stands, is that the reasonable hypothesis - in the process, the reasonable hypothesis only makes up one portion. Now we know when people serve overseas, potentially they are exposed to things that you wouldn't be in, back here in Australia. And they've obviously used the reasonable hypothesis to try and compensate for that. In the process, and there's a case law, Deledio v Repatriation Commission.

Now in Deledio v Repatriation Commission, they actually break down the steps. Once you get to the bottom step, all the reasonable hypothesis does, is says that, "Hey, listen, there is a reasonable hypotheses that - that statement, you've met that statement.

COMMISSIONER FITZGERALD: Sure.

MR TAYLOR: When you get down to this fourth step in Deledio, then actually - you've actually got to look at the evidence, and evidence then comes into play. So regardless whether you've got a reasonable hypothesis or a balance of probability.

COMMISSIONER FITZGERALD: But you think the way it's being applied by DVA and the VRB, there are significant differences in the outcomes for veterans.

MR RYE: Absolutely. Well I'll categorize it as this. Again, in our experience, of our centre, we find less of those administrative errors occurring when we're submitting a claim under a reasonable hypothesis as opposed to balance of probabilities. Does that make sense?

COMMISSIONER FITZGERALD: Yes.

MR RYE: I'm currently doing an appeal at the moment, and this particular veteran served in Somalia. When his claim went to the DVA,

they actually looked under MRCA, and used a balanced probability. But his service in Somalia occurred under the VEA, so we said, "Hey, listen, you need to look at it under the VEA," because the reasonable hypothesis had an extras standard, or extra convention in there.

COMMISSIONER FITZGERALD: So we're out of time. Richard, do you have any final questions?

COMMISSIONER SPENCER: No, it's fine.

COMMISSIONER FITZGERALD: Are you sure?

COMMISSIONER SPENCER: Yes.

COMMISSIONER FITZGERALD: Any final comment before we conclude?

MR TAYLOR: Just have a look at non-liability healthcare for veterans. Because at the moment - - -

COMMISSIONER FITZGERALD: in what sense?

MR TAYLOR: There's veterans that are not covered by non-liability healthcare, that should be. In particular - - -

COMMISSIONER FITZGERALD: We'll just expand - if you could expand that bit?

MR TAYLOR: So, you're aware of non-liability healthcare. Yes. Right. So non-liability healthcare, as it currently stands, you've got a veteran that served - say he served in 1971, '69, '70, '71, right? He's covered. He's never served overseas. He's covered by the DRCA. Right? His non-liability healthcare extends only to mental health. A veteran under the Veterans' Entitlement Act, his non-liability healthcare is mental health and cancer. A veteran under the MRCA, his non-liability healthcare in peacetime is mental health, if he served overseas it's mental health and cancer.

The only thing I can put it down to is that they're looking at occupational health and safety, set during those times hence VEA are covered by both. And the fact that if you serve overseas on MRCA, you're not being exposed to those threats. But someone under the DRCA in 1969, they're probably exposed to more than any - anyone, but they're not covered for cancers.

COMMISSIONER FITZGERALD: Okay. Well, we're looking at what the entitlements would be under a combined MRCA/DRCA. So we'll take that on board. Yes. Okay. Good. Thank you very much for that. That's terrific. Thank you. Is Mr Pope here?

MR POPE: Yes.

COMMISSIONER FITZGERALD: Would you like to go up now? And then we'll have a break after that. Okay, that's right. I just should mention that Sophie, is it? From Open Arms is here, and if anybody would like to talk to her or have any issues that arise as a consequence of any of the informational sessions today, please use her. Open Arms has been at all of our public hearings, which is terrific. It's also good because they are a very important part of the - the scheme that we're looking at, generally.

Rod, if you could just give me your full name and your date - sorry, your full name and the organization you represent, if you represent any.

MR POPE: Yes. So, Rodney Pope, Rodney Peter Pope. That's my full name, and I'm here to really, I guess, as an individual with a specific research background in this area.

COMMISSIONER FITZGERALD: And you're currently with which institution?

MR POPE: With Charles Sturt University.

COMMISSIONER FITZGERALD: Terrific. So, Rod, the system is, if you can give us a 10 minute precis of what you'd like us to think about, and then we'll ask some questions.

MR POPE: Sure. So, for the benefit of observers, just very briefly, my background is, I'm a Professor of Physiotherapy with Charles Sturt University currently. My main area that I work in is occupational health physiotherapy, with tactical forces. I started my career some 30 years ago, very early working at the Kapooka, at the Army Recruit Training Centre. I was a physiotherapist there. I was head physiotherapist for eight years there.

In that time we developed some good systems for preventing injuries, and so as a result of that, I was invited by the defence health service branch to develop the Defence Injury Prevention Program to roll out across the ADF to prevent injuries across the ADF. And I continued to do that work for about six years, to 2006. Following that, and subsequent to that, in the

remaining years I've continued to do contract work for defence, and other technical forces around Injury Prevention and improving performance of personnel. And so that's, I guess, the background that I have in coming to the discussion and the input that I've had so far to the report.

So I guess, firstly, I'd like to just congratulate the Commission, I think, on what is a comprehensive, and long, rounded, and balanced report in terms of the recommendations. I'd like to restrict my discussion today to Chapter 5 of the report, which focuses on injury prevention, that being my main area of expertise, and most of the discussions that we've had to date around that.

So the key points I wanted to raise, there is a number of them. The first is that in terms of the - chapter two of the report, it actually notes there from the Defence Force Welfare Association, that ADF members do not have a union that contributes to negotiations about their pay and conditions. But I think it would be worth potentially, and I would raise it for consideration of the commission, the potential to note that again in Chapter 5, and revisit that with regards to advocacy around injury prevention and health and safety of personnel.

So I think, what I see across other tactical forces that do have unions is that unions advocate very strongly as independent advocates for personnel in those other tactical organisations, and that benefits those personnel in terms of work health and safety in those environments. So that's just a comment and something perhaps for the Commission to consider.

One of the informants in chapter five, Peter Hawes, noted:

> *"I was happy and healthy when I joined the services, and ready to do my duty, to go wherever I was asked, to go and to do repairs and other military activities in the field, and while at home base that would make even the most liberal union or OH&S representative cringe and run away in horror."*

So I think that, again, just from an informant that you've had to the Commission, just indicates, I guess, that there was a belief there that if there was a union there, that they perhaps would not have just let things happen along the way. So that's my first comment.

The second was, the commission has been looking at an information request 5.1, has been looking at the fact that Sentinel significantly understates the true incidence of most types of work health and safety incidents, and I've had a bit of input to this already. However I note that on page 203 of the report, with regards to the smart device injury

surveillance system, currently implemented at Lavarack Barracks, the draft report states that:

> *Initial results from the Lavarack program indicate a level of musculoskeletal and soft tissue injury reporting that is significantly greater than the corresponding records on Sentinel.*

So, again, strengthening that finding that there have been some definite deficits, historically, in what's been recorded on the Defence work health and safety injury surveillance system. And my comment there is that it may be worth considering, I guess, in terms of recommendations, that in addition to supporting those initiatives that Lavarack Barracks at Holsworthy around the use of smart base, that it may also be worth Defence actually conducting some analysis of the differences between what's being recorded on that system, that smart device system, and what is being recorded in Sentinel.

Because that may well be informative for the development of a new hybrid system which you've recommended in recommendation 5.1, integrating data from the health system of defence with the occupational health and safety, work health and safety surveillance system of defence. So that's just to make that point.

If I can go on to talk a little bit more, just about the systems in place that you've discussed at Lavarack Barracks and Holsworthy, they're more than injury surveillance systems. And the report notes that - they note that - well, the report notes that:

> *This injury reporting system is combined with scientific assessments to determine an individual's injury risk profile. A real time data collection and monitoring system and a periodised strength and conditioning program to improve baseline performance and deliver enhanced combat readiness that informed by the system is tailored to each individual.*

So, what's actually happening here with the smarter base, and I'm familiar with smarter both from other tactical forces using it, is that the susceptibility of individuals to injuries, and their fitness levels, is being recorded and monitored, so that some individualised training and conditioning, strength and conditioning training, can be implemented for individuals to make them more resistant to injury, effectively musculoskeletal injuries, make them able to perform better on the job without injuries, or more safely on the job with without injuries.

Now this is to be commended, and I think it's an important part of any sort of injury prevention system. But the point I want to raise, I guess here is that it's important to recognise also, that there is a risk with this, that if we focused purely on the intrinsic risk factors for injury, as is the fitness of individuals particularly in this case, that actually only accounts for between five and 10 per cent, at a maximum, of the variance in injury risks between individuals. And the remaining, sort of, 90-odd per cent of injury risk variance between individuals, depends on the extrinsic risk factors that they face every day on the job.

So, we're thinking about hazards, we're thinking about errors, including training - training errors, and we're thinking about other contributing factors in those environments. And it might be, for example, in the social environment they're operating in. So the operational tempo at the time, if they're tired, and people tend to be more fatigued, and so that then impacts on injury risks and so on, just as one brief example.

So I guess my comment here, my primary comment here, is that in making this recommendation for Defence to support these systems that are in place at Lavarack Barracks and Holsworthy as pilots for what can be done for injury prevention across defence. I think that's good as far as it goes. But I think that it should be the added caveat that it's important that combined in those systems is a key focus on extrinsic risk factors, as well as an intrinsic risk factors. So, there's some clear work being done to identify hazards, to identify other areas that are not to do with the individual who has been injured, and to identify other contributing factors in the systems that create and lead to injuries that are actually occurring.

So, for example, we look at my own PhD work, which I did some 20 years ago now. What we found in that particular study was that the aerobic fitness levels of Army recruits account for only about 1.2 per cent of the variance in their injury risk across those individuals that are in training. So aerobic fitness is important, and it makes a big difference at the extreme, so when people come in very unfit, or they are very fit, it makes a big difference when you compare those two groups in their injury risk.

But when we look at the - the middle of the road people who are reasonably fit, but not terribly fit, it doesn't make too much difference to their risk of injury. However in comparison to that, with some of the other studies we did, where we looked at changing some of the ground surfaces for training, we were able to virtually eliminate ACL ruptures that were occurring at one point, and by changing training errors, occurring with female recruits particularly, we were able to almost eliminate our pelvic stress fractures that were occurring at that time in the

female recruits. So that's examples of extrinsic risk factors, and the differences I guess in terms of what each approach can do.

Linked with that is the need, I think, to make sure that injury prevention programs employ a systematic, local participatory approach to identifying and addressing these key hazards, errors and other contributing factors to injury and that's including the intrinsic risk factors. So, I think there's a risk in delegation of the injury prevention to specific individuals, whether they be safety officers or whether they be preventive health officers who are there for that particular role alone.

So, those people who will bring key expertise but they don't necessarily understand all of the training or the operations that are going on, and the full context of what's going on. So it's really important that they are supplemented by others that are working with them on injury prevention who actually have a good understanding of the full context of what's actually going on.

Now, what this also means is that we can't do injury prevention from the top levels of Defence down, so we can't just do injury surveillance and then identify the key hazards that are occurring, the key training areas, and the key contributing factors at a high level in Defence and then promulgate that down through Defence and expect injuries to be prevented. We've really got to get people who are on the ground, at particular units, in particular trades or professions who are actually understanding the activities and the venues that are being used and cannot help to identify on that basis what's actually happening on the ground and be involved in the injury prevention process.

So that participatory approach was used in the Defence injury prevention program that's mentioned in the report. And that can be potentially a key point of difference with an injury prevention program going forward. And so, I would just, I guess, encourage the Commission just to consider that further in terms of those - that recommendation around the - the processes that are in place at Lavarack Barracks and Holsworthy, which are great, but perhaps may need to be reviewed and extended to make sure they include those sorts of approaches.

I think, adding to that, is just a quick note just to say risks are not always identified in a timely fashion by injury surveillance. There's other things we need to do apart from injury surveillance to identify risks and this is where that local participatory approach can come in. It's really by having a proper risk management process in place. So, for example, if we look at the deseal/ reseal catastrophe that occurred, that would – that clearly wasn't identified in a timely manner through injury surveillance, but it

could have been, probably, identified if people had have been looking at the risks in that context and understanding what was being used in terms of substances in the context in which people were operating in that environment, and people who were local, who understood what that role was, were involved in some of the risk management pre-emptively.

So injury surveillance particularly does not work where you've got small teams because the numbers of injuries and things that occurred from a particular cause are small in number. So, in terms of statistical power they don't reach the level, the numbers that we need to start to see a problem. So they don't work well in that environment and they don't work well where the operations or the training are not recurrent; they're not the same sort of thing happening again and again. Because injury surveillance depends on the system being stable and things continuing to happen in the same way going forward, which happens in most workplaces, it happens in sports; the same thing's done each time. And so, if you do injury surveillance now, you see there's a problem, you can then intervene to stop it from happening again.

But where we have in a Defence context, activities which are novel and where things are emerging because of changes in welfare, the way things are done, then what tends to happen is that those threats or those hazards risks and so on can only be identified through a proper risk management process with some brainstorming from the experts who are the people on the ground during the job or about to do the job. We can start to go through it, understand the context they're about to go into and begin to look at what might happen.

So I think that's an important aspect to this and, again, the Defence injury prevention program embraced that approach alongside injury surveillance to identify some of the problems that may emerge pre-emptively so that then things didn't happen and action could be taken to reduce those risks.

On page 208 of the draft report, there's some discussion of introducing a premium on Defence. Basically, a notional premium around the cost of injuries and illnesses arising, or compensable injuries and illnesses arising from Defence operations and duties. I guess, my comment here is not about that specifically, but it's about just incentives for Defence and for commanders to make a difference around injury prevention.

And one of the first things that I had to recognize when I came in, so I came into setting up and implementing the Defence injury prevention program, thinking in my head that the dollar cost of injuries would be meaningful to commanders, and they would be interested in that, and that that would be a driver for them to actually reduce or to address injuries

occurring and to prevent injuries. And what I found, in fact, was that that was much less of a driver, that was important to the Department of Defence and to the bean counters, if I can call them that, the higher levels in Defence, who basically were doling out the funds and working out what the budgets were going to be.

But to commanders, the things that were much more important were around basically personnel availability for deployment on any given day. And once we started to estimate that and we started to give some feedback to commanders on how injuries were actually impacting on the numbers of personnel they had available for duties on any given day and the likelihood that they would have critical individuals available to fulfil key roles within teams, that's when commanders started to come on board to prevent injuries.

So one of the things I would suggest, again for consideration by the Commission, is whether there should be consideration of an incentive around estimates of impacts of injury on personnel availability for deployment on any given day. And I think that's likely to have a bigger impact for commanders and be useful information for them because, from my perspective, injury prevention is a force multiplier. And I think that's important to commanders.

The second issue is just - - -

COMMISSIONER FITZGERALD: Just the time – so we'll just - - -

MR POPE: Sure.

COMMISSIONER FITZGERALD: If you could just wrap up in a minute?

MR POPE: I am wrapping up. Yes, this is my last point, is with regards to incentives. Again, I think another really valuable and positive incentive that I found in the injury prevention space, is to make sure we have some recognition of the action that commanders are taking around injury prevention. I've seen great pride from commanders in the work that they have undertaken to prevent injuries, and the results that they've achieved. And then, through them talking with their colleagues and disseminating that sort of information to their command colleagues, there's been good results in terms of seeing that extended to other units as well. So that there's that kind of ripple effect that occurs once we start recognizing, I guess, what commanders are doing in this space.

COMMISSIONER FITZGERALD: Good. Thanks very much, Rod, and thanks for your assistance prior to the draft. Can I just go to the very last set of points you were raising, and that is in relation to incentives? So the three incentives that we've been looking at is force capability, the Workplace Safety Legislation, which largely had a big impact since 2011, and the notion of an actual premium not just the national premium.

At the unit level, we're very aware of what you've just indicated, that it's not about money and that's likely not to drive anything at that level. But do you believe that a premium applied against ADF, and for those that don't know it, there is already a premium that is actually raised. It's a notional premium it's not actually applied, so there is a premium; do you think that a premium has a value even if it is really only affecting the behaviour of the top order of Defence?

MR POPE: I think this is a mixed bag. So, from my perspective, I think there are risks with a premium. So I can see the benefit of it and obviously that's been seen, I guess, in other occupational settings, where we've seen the benefit of premiums being put into place. Where they've got a business model in place, particularly, I guess is where that tends to occur, and that's where it'll occur, as you say, at the top levels of Defence.

The risk is, though, that the organization as a whole will then start to feed down to commanders at a more local level. This pressure to reduce injury rates that are measured by some system that may or may not be accurate in terms of the rates. And the big problem we've had is around reporting. And what this can do, I believe, is it can actually then reduce the rates of reporting of injuries that are actually occurring, so we end up not seeing a clear picture of the injuries and we end up not gathering the information we need to inform injury prevention.

So that's the risk in it, and I'm not quite sure of the solution to that. I can see the purpose in it, to actually drive the organization to give better accountability but I'm not quite sure what the solution is to addressing that other risk of them underreporting due to that pressure from above to reduce injury rates.

COMMISSIONER FITZGERALD: Yes. In relation to your point about only sort of 10 percent, if not less, of injuries really occur because of the individual fitness of a serving member as distinct from these other 90 percent which are externalities or as you say extrinsic factors - can I just understand what you think needs to be put in place? So if I can just put this - the Workplace Safety Legislation undoubtedly had a big impact within the three forces. Everybody tells us that, inside the forces, outside the forces, and that's very clear.

And its big impact was in 2011. So since that time, we feel and from the information provided, there's been significant improvement in relation to workplace safety, generally; is that your experience or view, looking at it from both inside and outside?

MR POPE: Yeah, look, I think again, it's quite mixed. So, with some of the data I've been looking at recently, so I think some of the data in the draft report was really informative to look at some of those fatality rates, and the serious personal injury rates, which in most cases you can almost guarantee that they will be reported. And so, to see them coming down over time was fantastic and that was really good news and I hadn't seen that data before. So that was fantastic. But at the same time I'm looking at other data. So, for example, from one of the recruit training bases, from one of the services, which is mentioned in the report, and what I'm seeing is that we're seeing injury rates in recruit training that are very similar to what we've seen historically through time.

So, I think we've got probably a bit of a mixed bag here, where we are making progress and I'm really pleased to see that we are making progress around this. But I think there's still a lot of work to be done, and I think there's still a lot of scope for continued work to be done in this area.

COMMISSIONER FITZGERALD: Your message - your central message in the first part of your presentation is, don't put it all on the individual, their own fitness and what they're doing. Rather, it's about risk. So when we met with the Navy they'd introduced a thing and I hope I've got the right term, Ship Safe Approach, which is looking at the totality of risk and injury on their naval vessels and they're extending that concept to, and I've just forgotten what the name of it is, but a whole workplace safety framework. And they believe it's got great success.

I'm not sure you'd be familiar with those but that is really tried - seems to me to be trying to take account of what you're talking about: putting the risk and the environmental factors, you know, as equal, if not more important than the individual fitness. Have you seen other examples of that?

MR POPE: So, historically, yes. Look, there's been some great examples. So I think one of the key things to note is that with the Defence Injury Prevention Program, when that was occurring, there was a whole career path for physical training instructors and senior physical training instructors to become injury prevention advisers within the services. So that worked by basically relying on the fact that they understood physical activity, what people did, looking at training areas, those sorts of things.

Then they were then able to look at injury surveillance, look at other systems of risk management.

But they were basically able to facilitate as insiders and people that personnel respected within the services; they were able to facilitate a really solid local participatory injury prevention process along with the work, health and – at that time, occupational health and safety communities that were in play. So I think – yes, so we've seen good results from it. We know from the evaluations of that type of an approach that it does reduce injury rates. Those sorts of things go into place. I'm not familiar with the couple of models that you've just presented to me, but yes, those are historical ones.

COMMISSIONER FITZGERALD: So could I just ask this question related to all of that. One of the issues that people have said to us in some of the forces, not at senior level but at other levels, is that all of these focus on safety has, in fact, or has the potential to dumb down training and affect work force capability. It's impossible for us to actually know whether that's so or not. Nevertheless, I was wondering whether you have any view that – where – is there a tipping point where in fact you could start to, in fact, negatively impact on the training and the capability of the workforce in a detrimental way?

We certainly don't think that point has been reached, but nevertheless there are some concerns by various officers in all of the forces that have that view or at least have a fear of that occurring.

MR POPE: Yes. Look, I absolutely agree that that is a possibility, and I think that's another, I guess, aspect to the going forward, the sort of injury prevention system that we put into place has to take a holistic risk management approach where it doesn't just consider risks of injury and illness that might occur but it also occurs - it also takes into consideration those risks around achievement of outcomes of training and mission success. So it's really important that all of those risks are considered within that that injury prevention framework that's adopted going forward. So the Defence Injury Prevention Program certainly did that. Those that were involved in that process were trying to do that specifically to take a holistic approach.

And that's why it was so important that we had this participatory approach where there was an understanding within that team that was doing injury prevention, locally, of what the requirements were for achieving training outcomes, what they were for achieving operational outcomes, so that that was factored into the decision making. Because when we look at the ways that we deal with risks, hazards, you know, errors and other contributing

factors, there's a range of different approaches that we can potentially take to address those. It's not always just one option.

And so we can then consider those other risks, in terms of the one - which options we select and the directions that we go to reduce those risks.

COMMISSIONER SPENCER: Just to pick up on that point about the tension, about injury rates. The – in looking at overseas examples of other military systems, one particularly struck me, the comment by the chief medical officer, because he said, "Look, we have a duty of care. We also have a duty to prepare." And then he said - and they track and their systems are very good at tracking injury rates and what was happening. But he said, "If the injury rate's too high I'm really concerned about that." He said, "If the injury rates are too low, I'm concerned about that."

And it seemed to me to be a very direct statement about the tension that leadership in ADF has to deal with and I think we all recognize that. The other thing I wanted to go to, in that context, is the culture of the organization. And to be clear, everybody engaged in this will have, as the driver, the - having good care, appropriate care in service for the people they're responsible for. So it's not about intentions. It's about, sometimes you don't know what you don't know. And I think this is where the kind of insight you're giving us is very helpful as to how do you manifest a system that gets to what the overall objective should be?

You raised a couple of very interesting issues, because if you go to civilian systems, quite often the premium idea is said sometimes to be more meaningful because there's (indistinct) associated with that. But, when you look at the other drivers of performance, Workplace Health and Safety, leadership around that, really driving that through the organization is critically important, and arguably gets better results, frankly, than a sort of a blunt instrument around a dollar figure.

But I'm just wondering, and my question goes to, with your experience of insight into how this plays out in a military context, when you look at civilian schemes I'm just wondering what - and the best performance schemes there - what do you see in terms of culture that could be addressed, needs to be addressed in your view? And I think just to add a comment to that, some people have been very concerned when we talk about workers compensation schemes, because they say, "Well, isn't this just you know taking what should be a military specific scheme and turning it into a civilian scheme?" And I guess the suggestion that somehow it's going to be less than what we now have or should have. I think, just to be clear on that, we're interested in best practice, which, right at the outset, minimizes prevention, appropriately, deals with long term

consequences, and gives insight and knowledge about that to enable a continuous kind of reassessment and risk management process of the sort that you've described.

So when you think about best practice, when you think about what you've seen in other areas in other parts of the community life and then you think about the cultural issues there and then you think of the military, is there something that needs to be addressed there over time that we need to think about?

MR POPE: I think - I think over time, things are changing. But, I think one of the big differences has been over time, that there's been a perception, I think, within tactical forces, generally, not just military, that incidents that occur that cause injuries and illness are inevitable because of the nature of the duties. And I think that's changing. And I think commanders at all levels throughout the ADF, definitely, I think are understanding that that's not the case.

I think that they are understanding that injury prevention is a force multiplier, that proper risk management is a force multiplier, that they can save themselves a lot of headaches, get people on the ground and actually look after their troops which they want to do by actually doing an injury prevention well. And I think that's why they get behind these sorts of things, once they understand what it's going to mean to them in terms of returns for both them and for their troops or for the personnel, I should say.

So I think that is developing over time. I think the culture of underreporting that has occurred over time is probably linked to that, is that there's a sense, well, why are we reporting if incidents are inevitable?" But, secondly why are we reporting if we never see the benefits of that reporting back at our local unit level? Because all the stats are just gathered and there's a huge lag time at the top levels of Defence where that stuff is gathered together. And it's, you know, I guess, compiled and analysed at that level, but we don't necessarily see the results of that, that are meaningful for our particular unit or our particular base.

So I think that's why it's absolutely critical that we have these reporting suites that actually do provide commanders with real-time information on what's happening on the ground in their particular unit or base that can inform their own efforts. Now, one of the key components of that, I think, is the narratives that occur, and they're collected within the Sentinel form at the moment, the injury and incident data collection form. There's narratives in there that talk about the specific venue and specifically what

happened at the time. Now, often, that information is not used at a high level in Defence to prevent injuries because it's meaningless at that level. It doesn't tell us about, you know, the commonly - the common name of a venue at a particular site where things are occurring. But it's very meaningful for the local people and they can see straight away by reading that narrative, I can see this is exactly what's happened at this location. I know that location. I know what's there. I understand the context. And I think that's why this local participatory approach is really critical in addition to what's going on at the higher levels in Defence.

COMMISSIONER SPENCER: Okay. Good. No, thanks, Rod. Yes.

COMMISSIONER FITZGERALD: Now, that's fine. Is there any final comment that you'd like to make? You've given us an extensive commentary.

MR POPE: Look, not at this stage. I think I have given you most of this in writing. I think, just going back to my first point about unions, I'm not suggesting that we should introduce unions to Defence.

COMMISSIONER FITZGERALD: That's probably a very wise thing.

MR POPE: But what I am - what I am suggesting is that if we don't have a union there probably needs to be some other sort of advocacy that is taking place in the injury prevention space so that that's actually occurring with some independent advocacy for personnel within that space.

COMMISSIONER FITZGERALD: And I noticed that recommendation of yours so we will look at that and explore that a little bit further. It is one of the very few workplaces where the actual members, or workers, don't have that sort of advocacy. But it may be facilitated in other ways but we'll certainly look at that in more detail. So, thank you very much for that, Rod.

Can I just – before – can I just check who's in the – is Bob back here? Yes. And is Richard Salcole? Yes. Bob, would you be okay, if we went out on after morning tea? Would that suit you? And then do Richard? And then what we'll do is ask - if during the break, we'll take a 10 minute break - is Judy here?

COMMISSIONER SPENCER: Judy's here, yes.

COMMISSIONER FITZGERALD: Judy's doing this. So, I was right.

COMMISSIONER SPENCER: Yes, substituted for this - - -

COMMISSIONER FITZGERALD: Okay. So sorry, I just made a mistake. So, Judy, we'll do you straight after morning tea, then Bob and then Richard. Is that okay? If you want to make a personal statement at the end of those presentations, can you just see either Aaron or Colin and we're happy to do that? It may be just a short presentation and I must say, Darwin, Adelaide and Perth, people have availed themselves of doing that. So, just see them during morning tea. We'll take a 10 minute break and then we'll have Judy, Bob, Richard, and then any other personal statements.

SHORT ADJOURNMENT **[11.23 am]**

RESUMED **[11.34 am]**

COMMISSIONER FITZGERALD: Are we set? Judy, if you can give your full name and any organization that you represent.

MS EMBERSON: Hi. Thank you. I did not know I was speaking. I'm Judy [Ann Emberson]. I'm an OT. I was – been OT for 40 years this year. And thank you for letting me talk. I hope - I've read some of the submission. And I hope I can be - offer some insight. I'm recording, now. Music.

COMMISSIONER FITZGERALD: No, that's fine. So, if you can just make a presentation for 10 minutes.

MS EMBERSON: Sure. Thank you.

COMMISSIONER FITZGERALD: And then we'll just have a chat.

MS EMBERSON: I've just started to deal with young veterans. I've mostly been an OT in the community in the Riverina 15 years. Veterans, 20-odd. And so, of course, I deal with, from 104 year old and yesterday a 34 year old. And I do - so I'll be a little bit fragmented because I didn't know I was presenting. The issue about colour of card, for the clinician means we have to write a submission to justify everything, from a back support to a cushion for a White Card holder. I would suggest that some therapists then don't bother to prescribe things, because they can't - they're not interested in writing a report.

Physios don't like writing reports. That's a general observation, but it would be nice if they refer to the OTs. We can do the justification of small items.

I sense with the young ones, or people on a White Card, they sense that nothing can be excess and when we are successful with a letter, they're very appreciative and have a great sense of worth. Certainly, Gold Card's easy for therapists and clinicians. So, that's a little summary, and I could talk about other issues. The small rural towns are very under covered for veterans' community nursing. What we can get in Wagga, that is community nursing night and day for free, is not available, Junee, 50 ks away. They've got to go on an aged care package.

I noticed that veterans' home care aren't aware of the veterans' community nursing, although I think they're in the same building. I, personally, help a lot with carer's allowance. Ask the doctors for this referral. Exercise physiologists in the home have made a dramatic difference on even 90 year old war widows and veterans.

I then, because I'm on the ground all the time, I see a lot of people as they get frailer and deteriorate. So we access, sometimes I've had to call ambulances and I do a lot of work with the carer. The young ones we've just started, this is something innovative when you're talking about your good ideas for your young people, is using the respite – this is my idea – respite service in the home with the young male veteran. A male, let's say home care worker, to sadly the males that are at home, not working, the expectation is that they are domestics. They have the domestic of the house. It's not always their interest. So perhaps there's a proactive role there. We've just started that with one or two young male veterans. Then the younger wife is happier that a male care provider's in the house.

I feel strongly that senior veterans are at home very isolated because of course I can't over-service. I would love that a friendly visitor service was happened out of the league or, you know, something in the Riverina. It's just terrible that they're home alone with no one to talk to. And I know they're doing a program in the RSL nursing home.

Community nursing services, which is the night and day, is doctor driven. So, I go to the doctor with the client carer to get the referral, then I scan and send it. Some of those are pushing them to take an aged care package because they get better fees like four to $600 a month, and a high rate - hourly rate of payment to them as a provider. I see that as a big conflict of interest. So I'm often telling them to be strong, stay with the DVA service.

Availability of psychiatrists is very low. I think there's one or two in Wagga and many are travelling a long way, so they're disconnected. This is for the young ones from their family. And of course your very, very old veteran will not seek psychiatric assistance. It's hard to lobby and get through. But again I might go with them to the doctor. Complex diagnoses like encephalopathy, chronic pain, we're not good with in the Riverina. Sometimes, I've had to do research and find centres like the North Shore Pain clinic. We're not good with irritable bowel, which is a little bit – yeah, well, it's not a positive diagnosis and it's a lot – very difficult for DVA with encephalopathy issues outside of that. .

Emergency services. That's come up when we - we only knew about this, like, Thursday. So if a male is dislodged from his wife, a 30/ 40 year old, in an AVO or a – there's nowhere for them to go. They might get three days of paid accommodation in a motel. They land up at Edel Quinn which is a centre for drug and alcohol in Wagga, which is really to me a travesty. I know they're – I did a fair bit of research, they're proactive and – but they're really for ex-convicts, burnt out alcoholics and surely there's something better we can do for the young veteran who can't go home but he still wants to see his kids.

They did - I know they've lobbied the league. They've got real estate, as far as having accommodation available. Because it's just a, I mean, you wonder why there's suicide. Where do these poor young boys go? There's lots for women. It's a fact. Children, diabetics. But where do young injured males go who are psychologically injured?

And I did say GPs: they don't know the services. I know they think more on a biological: how are you cleaning? How are you shopping? Personal care. They don't think that way. So I do a lot of lobbying the client or I'll go with them to the doctor and then the doctors are very often no trouble. They have to initiate that referral. As well as initiating referrals to myself. Yes, I think that's - - -

COMMISSIONER FITZGERALD: Thank you very much. Can I just raise a couple of questions that you've raised? Just as an administrative issue, the reporting that you have to do for a Gold Card and the reporting you have to do for a White Card recipient is very different?

MS EMBERSON: Very. I can just order items for a Gold Card veteran. Well, let's say a simple back cushion. I feel, I have to write a next – well, it is – it has to be an extensive report on justifying a cushion or a back support.

COMMISSIONER FITZGERALD: Sure. You're aware – or are you aware that the so-called RAP program, which I think you're under, the Allied Health one, is under some review or change?

MS EMBERSON: No, but that'd be good to know.

COMMISSIONER FITZGERALD: Well, I won't go through that. One of the issues that you've raised, is you've – this issue of home care, veterans' community nursing and you've mentioned the issue of respite. Is there a better way for all of that to be organised? Somebody said that the home, care at home services, there's different entitlements under different acts and they all should be merged and what have you. But on the ground, is there a better way of dealing with home based services for veterans, however that is paid for?

MS EMBERSON: Well, I guess it's accessing. So I go - home care: I can do that direct or with the client. Usually, I fill a form and do a report. Veterans' community nursing needs a doctor referral. So that means we go to the doctor, get another referral and justify that. Then, yeah, it doesn't happen.

COMMISSIONER FITZGERALD: So is there a better - so my question is and you may not have thought about it, Judy, but is there a better way of organising all of that?

MS EMBERSON: Well, why can't I as a senior clinician, initiate some of the services. That's what I would suggest. You know, I've got a degree working for 40 years. If I see your grandmother, why can't we make it happen? Because by the time you need nursing, you really have to wait another week. Sometimes, they can't even get to the doctor. And time is slipping away. When they say, "Yes, I need help."

COMMISSIONER FITZGERALD: There is an issue that's been raised and that is over servicing by some Allied Health professionals. And the question is, what is the right mechanism by which you can deal with that? So, obviously, we know that there are areas where there's a shortage of services. And we know that many people are receiving, you know, the appropriate level and then there's this group over here largely provider driven, not claimant driven.

MS EMBERSON: Yes, yes.

COMMISSIONER FITZGERALD: What's the right level of oversight? Because we've been very critical of DVA and I might say Defence but particularly DVA about oversight. It's almost non-existent in some areas

and it's certainly not outcomes-focused at all. There's very little attention to individual outcomes or even the system's outcomes. It's all about processes.

So I'm just wondering whether you think there - you have any ideas for us in terms of the right level of oversight so that you get accessibility, you get the flexibility that you're talking about, but you also avoid the potential for over servicing in - - -

MS EMBERSON: Well, you just won't be paid, if you over service on the particular codes. They won't pay you. And may I say, they don't pay you for about six to eight weeks over Christmas/ New Year. So we used to go into Sydney for free workshops, whole days, and they've stopped that. Allied health could go in and then we would learn. And gain direct input from the OT and physio advisors. That has ceased, which is a shame because then new businesses can start up or people who think they can overuse these particular codes. And that's made us look - some of us look like we're doing the wrong thing.

It has a bad reflection on some of us. They haven't gained the message of volume of interaction. But a trained therapist usually goes – in my personal opinion, if I get you set up at 70, you will call me. If I get - because I personally don't have time to see - over service people, you'll call me if you do, because you'll remember me.

I do - can see where you can get - some new practitioners, let's say, get excited about over servicing. But I'm - I know demand will - stop that. But if we all were obliged to go into Sydney and to have the one-on-one workshop was a great - we got the culture, we got the message.

COMMISSIONER FITZGERALD: You deal with clients other than veterans?

MS EMBERSON: Yes. Not many.

COMMISSIONER FITZGERALD: And do you deal with other systems, other than DVA? Are there any lessons or learnings or differences between your dealings with DVA and your dealings with other organisations? WorkCover organisations and all that, generally, that we could be mindful of?

MS EMBERSON: Some of the young ones going through - this is just observational private WorkCover, or even specialised units, let's say ambulatory rehab Wagga based, they don't know a lot of what's on the ground that we can get from sensor lights to hoses, let's say. Be nice if

we spoke together more. I think a lot of the big centres probably aren't thorough enough.

They deal with that immediate diagnosis and not the implications. The going into someone's home is a great privilege and you learn all about function. I think they should have an environmental home assessment to anyone. You can't beat. You can't. You can see the dynamics, the relationship. That's invaluable and it's - there's a lot to be gained from knowing people in their home. That is incredible.

Other systems, a bit too quick, address that. See you later. Without an impact on their function. Intereach Commonwealth Care Resource Centre is an amazing centre for emergency respite. Again, we need an ACAT. We need to find vacancies. There's three or four forms to do before we - your grandmother's failing, she's got to go into emergency respite. That's not quick. When it's an emergency sometimes it means an ambulance to Wagga Base while that's sorted out. Yeah, there's a whole lot of things: discharge planners and, yeah.

COMMISSIONER FITZGERALD: Sure. But in relation to DVA itself, what are the one or two things that you think needs to change in the DVA system? You've only got two. So that's all I'm giving you. What would be the two that you would change to improve it?

MS EMBERSON: If I could, as a clinician, get the particular senior citizen or unwell person there veterans' community nursing. If we could get day - night and day or daily care without having to go through three or four steps, before they get too frail, or admitted to hospital. That's the big one, really. The nursing care.

COMMISSIONER SPENCER: Judy, just in relation to other systems do you do – are you engaged with the NDIS at all in (indistinct) services?

MS EMBERSON: No, I'm too old. I chose not to do that. But I know I see other people doing the NDIS and I am involved with - I see from afar. Yes.

COMMISSIONER SPENCER: Okay. No, no, thanks for that.

COMMISSIONER FITZGERALD: Judy, I get the impression you go well beyond, probably, frankly what you are paid to do in the sense of coordinating, connecting people up. One thing that strikes me, in a range of different issues that an individual will have, in a sense the individual gets divided into different areas of Allied Health, whereas the

overwhelming need, quite often, is the coordination of what's happening to them. And it seems to me you're doing some of that.

So I'm just wondering, in relation to - what flexibility could you be given, in addition to the one you've already mentioned? That is not having to go to a GP and get referrals and that sort of thing: what additional flexibility could you be given to try and do the things that you know make a difference on the ground?

MS EMBERSON: New, a new position at Wagga base just happened and she rang for someone who's had multiple admissions to the hospital, which is a great position. And I went straight away, liaise back. Because we can't have that person readmitting. It's a sign for prognosis. That's - the fact that we can loop and everyone talks, I think; sharing information is important.

COMMISSIONER SPENCER: And can I just ask, we've heard quite often around Australia that the fee schedule is an issue. And so your general experience - I know that you've mentioned already that, you know, apart from – which is significant - not being paid perhaps for a six or an eight week period - but generally speaking in terms of the fee schedule that you work with, is that adequate or do you think it's - - -

MS EMBERSON: Well, compared to our association, it's $70 an hour less.

COMMISSIONER SPENCER: Seventy dollars an hour less?

MS EMBERSON: Yes. And that's a full assessment and then it's half that for a follow-up.

COMMISSIONER SPENCER: So, do you see – and other providers saying, "Well, I'm not going to do that because it's not worth my time?"

MS EMBERSON: Yes. And that's – we were just saying even as psychiatrists. And some psychologists will – are anti-DVA because of a low fee compared to their professional - I mean, I travel. I, probably – that's of some benefit. But I go through a lot of cars. So, yeah. And I've probably got the personality to go with volume and distance; I don't mind travelling.

COMMISSIONER SPENCER: And, look, just a final question, Judy, and you may or may not have any comments on that. But one of the things I've already mentioned this morning is the role of ESOs. And there's a lot of hidden work that goes on which is extremely important and

valuable in supporting veterans. And it's often missed when you look at the, sort of, the big system. So when you think of the role of ESOs, what might there be additionally, might they be able to do to be supportive of some of the things you're talking about? And just to give a bit of context to that, we're very keen to think of ways in which the government may be able to fund some of these services or to leverage that resource in the community. But as you look at the ESOs and the potential for them to be doing even more than they're doing now, which they would want to do, what could that look like from your point of view, from your experience?

MS EMBERSON: Well, I have – I know a lot of them. I actually go and do a presentation. Here's the amazing resources. So, they all feel it's okay. A lot of them don't feel it's okay: "I don't need that yet." "I'm not old enough." But you know, once you've got some problems like falling, the big thing is falls (indistinct), wellness, fitness. And I like to network and I'm often liaised with the ESOs or the presidents of this particular veteran group. So they know or - I do presentations with them. I think that's important.

I think it'd be great if you employed trained, experienced social workers, psychologist, throw in an OT, who knows all about DVA. And this - it's complex, as are the ages, as are their limitations and carers, you know. There's serviceman and then you've got a service widow. There's a lifetime of work for a good trained - instead of - I'm having to drive to Canberra. If you had dedicated therapists around Australia who specialize in DVA, I think it's money well spent, as social workers, psychologist. I think you couldn't go wrong.

COMMISSIONER SPENCER: All right, good. Thanks, Judy. Yes, that's good.

COMMISSIONER FITZGERALD: Any final comment, Judy?

MS EMBERSON: Thank you. I think I jumped all around. But I think I got some of the things there.

COMMISSIONER FITZGERALD: Good. Thank you very much. If I could have Bob Bak, please? No, too quick. Grab a seat.

MS EMBERSON: Sorry.

MR BAK: No, you're right.

COMMISSIONER FITZGERALD: Thanks, Judy. Thank you. You're so quick. Putting us to shame. Bob, if you give us your full name and the organization that you represent.

MR BAK: Robert Bak, I'm the - - -

COMMISSIONER FITZGERALD: And the organisation you represent?

MR BAK: We represent the Integrated Service People's Association of Australia.

COMMISSIONER FITZGERALD: Thank you. If you can give us an opening statement and then we'll have a bit of a chat.

MR BAK: Just before we go on, have you got my latest submission, there?

COMMISSIONER FITZGERALD: This one here?

MR BAK: This one. The one I handed this morning?

COMMISSIONER FITZGERALD: No. I have with us, a two pager and then a very extensive one.

MR BAK: And then you've got one at the back? You've got an addendum on the back as well.

COMMISSIONER FITZGERALD: The final - that's the final page I have. It's information request 17.1, with - - -

MR BAK: Yes. So there should be an addendum. With my – with our letterhead on it.

COMMISSIONER FITZGERALD: Yes. So that's the one there.

MR BAK: I've got – yes.

COMMISSIONER FITZGERALD: That one there is it?

MR BAK: Yes.

COMMISSIONER FITZGERALD: Great. Okay. So you've got 10 minutes to tell us what you think and then we'll, as I said, have a chat.

MR BAK: Righto. Our response to the Productivity Commission's draft report dated December 28. This is done by ourselves and a group forum that we conducted last Wednesday. Okay.

Now, in essence, the Productivity Commission Report: A Better Way to Support Veterans, has been a long time coming. And it is about time the plight of our serving and ex-service ADF personnel were given a fair deal. The anomalies identified within all three legislations, and in particular the DRCA and the MRCA have yet to be fixed. A fairer and more beneficial legislation for service and ex-service personnel must and the sooner the better.

It is obvious, the draft report is the result of quite some investigation into the Department of Veterans Affairs and Defence. It is good that some poor practices have been identified and brought to the foray. Hopefully, these problems will be fixed in the not too distant future, especially the transitional management of our veterans and their rehabilitation. This report has some very good recommendations with regards to the combining of the legislations into only two by 2025.

Claims procedures, heads of liability brought into line, and as well as one standard of proof for all service and ex-service people, SOPs to be standard use in all three legislations. These are very excellent moves, and if this is acted upon and implemented, I'm sure this will lead to a better, simpler method of administration of veterans' claims.

If these recommendations are implemented, it would mean a fairer deal for veterans by being simpler to navigate and a bonus for DVA staff as well, providing better productivity outcomes in terms of saving on costs through duplicitous practices. There are some disappointing recommendations in relation to the Veterans' Review Board. If implemented, this would see an end to the Veterans' Review Board and leaving our veterans in the hands of the bureaucrats within DVA and the Department of Defence. It means the removal of another appeal path for our veterans. Or should I say, it would mean.

The VRB should remain sacrosanct and should never be removed. The VRB is the independent unbiased watchdog which gives our veterans a level playing field. The removal of the Gold Card is another disgusting effort to remove our entitlements from the Veterans' Support System. It is a conscious attempt to remove the wellbeing of our veterans and their families. It is a disgusting effort to remove this major entitlement from our veterans.

All the health recommendations within the report are only leading to a negative outcome for our veteran population. It is an attempt to bring the Veterans' Support System into line with Medicare. And I should say, in line with civilian insurance schemes, which we all, or a lot of us know has been very negative on those people involved. Overall, we think that these recommendations should be squashed - this is in relation to the Gold Card and health - without further talk on removing the benefits we have.

How is the removal of the Gold Card going to improve our veterans and their families' health? There are other ways to reduce health costs, we are sure. When conducting the forum on this draft report, all veterans present were very suspicious of the outcome of this report and what the government is really up to. They believe this is another attempt to remove the hard earned benefits they are receiving or have received in the past. Dollars is what this is all about, saving money at the expense of our very special people. Our veterans. Does the government really care about its very special people? We request the Productivity Commission have a good rethink of the health recommendations and the Veterans' Review Board.

COMMISSIONER FITZGERALD: Any other comments or that's fine for the moment?

MR BAK: That's all right for the moment.

COMMISSIONER FITZGERALD: No, that's terrific. Thanks very much. We appreciate your comments.

Can I just deal with a couple of issues? One of them is just in relation to the VRB.

MR BAK: Yes.

COMMISSIONER FITZGERALD: The only – the recommendation - what we're trying to do is to get DVA, or the Veteran Services Commission to better deal with the initial claim by the delegate. And so, as you would have heard from this morning, Bob, we're talking about better improved decision making by a delegate, a formal reconsideration process which uses outreach, the dispute resolution procedures in the VRB and then a decision making at the AAT. So that's our plan.

We know that the VRB is deeply loved by the veterans' community. We understand that. But do you think that, at the end of the day, the VRB would be necessary - we're not recommending its removal at this stage – it would be necessary, if you actually got DVA decision-making and its

reconsideration functions better? Or is it that you don't trust those - that that will happen? What's really behind the VRB? We understand how it works. We understand that it's popular. We understand many of the points you've raised, but at the end of the day, VRB only came into existence because veterans really didn't trust the department and there was good cause for that.

So do you think there's ever going to be likely to be a change? Or you just don't think so?

MR BAK: The only thing I can envisage happening is if they did improve their decision making, okay, there's still going to be errors made, regardless. As you mentioned in the report that the DVA has an error rate – an unacceptable error rate. Well, as you were reading my report, when you get a chance, in your responses to your submissions, these – hang on, lose my train of thought for a minute here. There's still going to be veterans who have had adverse decisions made.

COMMISSIONER FITZGERALD: Sure.

MR BAK: There was one step you missed there, there's the internal review within the department. That's (indistinct), it's a s.31 under the murderous 319 or whatever. So that - that's important. It gives DVA, virtually, a chance to redeem themselves, really. OK. Now, I've had many instances in the past couple of years. We started doing this in 2000, but the last few years has been abysmal. All right. Although, a lot of good decisions have come out as well. I've got to be fair about these things. All right? But if – like, for those people that are going to be left out, without having an internal review first up before it goes to the VRB, I think that's – we're moving one avenue of going through the whole appeal process.

Now, when we get to the Veterans' Review Board. Which, as you say, yeah, I'm not saying it's loved but it's independent but they're not adversary either. I recognize that they are independent. I recognize they have to consider the legislation and they are followed by it. They have to follow the law. That's fine.

So with the Veterans' Review Board, they've recently in New South Wales, I think Queensland as of the beginning this month, and Victoria, they have implemented the ultimate dispute resolution. Okay? Now, in the past – since that was conceived and they started using this ADR process, we have not lost one case for the veteran. And I think the Hume representative, firstly, is "Well, they said the same thing."

Well, I believe the ADR resolution should be kept. End of story. Now, the next thing after the ADR resolution, if they can't come to an agreement? Fine. It should be left to a full board hearing. That's a view where we're skipping. In other words the veteran is going to be denied that avenue.

So, no, I reckon keep the Veterans Review Board as it is, and if - and in relation to referring to the AAT – I'm not too sure what you mean about that. Are you talking about the VRB has a right to refer you straight to the AAT?
At the moment, it is up to the veteran whether he or she wants to go to the AAT for another hearing, and I think that's a better deal. Not bringing direct, straight to the AAT. They've got a million cases more.

COMMISSIONER FITZGERALD: Can I just go back one? I just need to clarify. We're actually strengthening the step before the VRB, which is this reconsideration process. So we hear you, we're strengthening that and we've had many recommendations around that. And you're right. There's already powers under the Acts that should be used.

But what we are discovering is the DVA traditionally has let matters go through the VRB which we think should have been reconsidered much earlier.

MR BAK: Yes, I have addressed that in the responses as well. They have been - in the last couple of years, if - the impression that we get is that if they are really busy, they're inundated with claims in the DVA and they've got to get so many through by a certain time, a lot of them make such stupid decisions, which I laugh at, you know, we all laugh at the decisions that they make. And when we go to the VRB you know, the ADT - ADR process, well, it proves the DVA were wrong.

Now, I don't know why this has happens in the past couple years. Is it because of extra claims being received by the DVA? Is it because there's not enough staffing within the DVA to deal with these matters. It's not very – if we're talking about looking after our veterans, let's get some people in there, or get extra staff in there who are very conversant with the legislation and with - and the bureaucracy within the Department. Let's get those people in there and see to these claims on a more efficient and fairer basis. All right?

COMMISSIONER FITZGERALD: Can I just ask this question? We support the ADR as you know, the Alternative Dispute Resolution procedures and as you know, as you've just indicated, it's being introduced

into Queensland and we would think that would be very positive. So we are at one in relation to that. We think the evidence is good. I suppose we have a difference that if at the end of the day, the ADR is in fact working really well, we would question whether you'd need that for more consideration. But I understand what you're saying about that. And time will tell.

The other issue, just which is not referred to in your paper, but I think it may be your full submission. Just to clarify, there's been some confusion about what we're doing with the Veterans' Services Commission. We have never put compensation under Defence, and we put - what we are recommending is putting policy under Defence. That's not very popular. Nobody seems to want that. But we had never, ever, ever thought of putting the actual administration of compensation health care and community services under Defence.

We see that as - within a commission, solely dedicated to veterans, run by a board of commissioners, and using very best practice. So, there is a misunderstanding in the veteran community.

MR BAK: That's the way I read – I read that.

COMMISSIONER FITZGERALD: I know, and it's our fault that's the case because we were never going to put the administration into Defence.

MR BAK: I just think it's like - - -

COMMISSIONER FITZGERALD: No, we would not be - - -

MR BAK: The bureaucracy in Defence is unbelievable. It's worse than DVA.

COMMISSIONER FITZGERALD: Well, can I ask this question? We did say that we thought putting policy in Defence might be a good idea. This happens in New Zealand; it happens in other parts of the world. But there's been great hostility to that. We hear that and we'll reflect on that. But why do you think that is? What is it about defence that makes it a poor place to deal with - not the administration, but just the policies relating to veterans? Given that you know you're there – you know, you were their personnel, you were their members.

MR BAK: Well, when we're talking about Defence, I have just - just before Christmas - I'm talking about transitional management now, okay?

COMMISSIONER FITZGERALD: Sure.

MR BAK: Now, this is Defence. I just completed looking after a veteran and this happened just before Christmas and we ended up talking. The thing is, she had a back condition. It had been reported in her file three times prior to her discharge. And on her final medical, they wouldn't give her an X-ray to find out what was wrong with her back. Okay?

So I got in touch with the director of medical services in Canberra. Army. Director of medical. Army. And he explained to me that, "Oh, look, if – if the on base physician doesn't think that the veteran requires an X-ray or another scan or something else, okay, that is their prerogative." Now, within Defence the director of health - medical services says, "Ah, all right, she says she's don't need a - she doesn't need an X-ray so I'll go along with that." Now, when I - when I spoke to this fellow, he's a brigadier. We're back and to and froing for a few days over the matter of giving her an X-ray because Defence's policy is - on people discharging that they must have their claims submitted to the DVA prior to discharge. All right?

So fair enough. How the hell is a veteran going to put in a claim for a back condition when she doesn't know what it is? Because if DVA don't give it to her, don't give the X-ray, so that we've got a proper diagnosis to put it in there with an X-ray report on the veteran's claim, right, well, it just seems ridiculous that they can't - that they won't give that X-ray. The money – it's again - it's money generated. $130 or whatever it is that Defence pays for an X-ray. Now, this person now has to wait an extra two months before - her claim has already gone in, so I'd envisage by the end of this month she'll have a letter to provide an X-ray or they will - they will arrange it for her.

So, that's an extra two months by the time they – by the time she's got her X-ray and gone back to - it's gone back to DVA, there's an extra two months that person has to wait for the outcome of her claim. Now, as far as I'm concerned, DVA and Defence there should be some sort of system in place where these things are standard and they're no different from each other.

COMMISSIONER FITZGERALD: So, just in relation to that, you'd be aware that we're recommending a Joint Transition Command which seeks to deal with those sorts of issues much - in a much better way. There are initiatives being undertaken by the ADF, particularly at Holsworthy Barracks in Sydney, and a couple of other places, but we are - we do think a wholesale change needs to happen within that space.

MR BAK: Well, there's a disconnect there.

COMMISSIONER FITZGERALD: Sure.

MR BAK: A clear disconnect between Defence and DVA, and I don't see what security breach there would be by providing things between the two departments because they (indistinct) well - they are connected.

COMMISSIONER FITZGERALD: Well, you'll be pleased with our recommendations in relation to that area because we are - we fully understand what you've just said about the disconnect, so that's it. Richard?

COMMISSIONER SPENCER: Yes, I just wanted to - Bob, go to the Veteran Advisory Council because there's a bit of commentary in your longer document here about - you were not – I don't think you were too impressed with our recommendation around that, or alternatively it was missing detail that you think is important. So, we thought it was an important piece of direct input to the Minister to be able to give advice about, you know, issues of key concern.

MR BAK: Which recommendation are we talking about?

COMMISSIONER SPENCER: So, let me just say - if I can get the reference to it. It's the Veterans' Advisory Council. Yes, it was a recommendation 11.3. So, it's on - - -

MR BAK: 11.3?

COMMISSIONER SPENCER: Yes. We had said the Australian government should establish a Veterans' Advisory Council to advise the Minister for Defence personnel and veterans on veterans' - on veteran issues.

MR BAK: Yes.

COMMISSIONER SPENCER: Including veterans' support system, and your response to that was - - -

MR BAK: No.

COMMISSIONER SPENCER: No. Another jobs for the boys' scheme.

MR BAK: That's right. White collar jobs only.

COMMISSIONER SPENCER: And it's my comment, I don't think you were too impressed with that. We – well, our intent there – so let's just talk a little bit about that. Why is that - it's important for the Minister, and as you know we want – we're suggesting that the Minister for Defence personnel and veterans be one minister, to get that integration at the highest level. That the VAC would be there to advise the Minister directly, and would have a combination of people or veterans - people with experience about workers compensation schemes.

How the Minister should think about policy at the highest level around veterans' needs into the future. So that was our intent, but clearly you're not convinced.

MR BAK: Certainly didn't come across that way to me – to us.

COMMISSIONER SPENCER: Okay.

MR BAK: Actually we had this forum last week and - - -

COMMISSIONER SPENCER: Yes, so what – so what are the concerns there? What – you know, what - - -

MR BAK: Well if you're going to have a VAC, veterans' – what was it called, Veterans' Advisory Council.

COMMISSIONER SPENCER: Yes.

MR BAK: You mentioned the Council should consist of part-time members.

COMMISSIONER SPENCER: Yes.

MR BAK: So, what does that mean? They're going to work two days a week or something, does it or what?

COMMISSIONER FITZGERALD: No, no. It's a - I should just say - just to clarify.

MR BAK: Yes.

COMMISSIONER FITZGERALD: The model is exactly the same as ministerial advisory councils where people meet four, five, six times a year, that's it.

MR BAK: Yes.

COMMISSIONER FITZGERALD: But they're - it's modelled on the very stock standard ministerial advisory councils that exist presently. Oddly, veterans, you have ESORT, which is the body made up of a select number of ESOs that sit within the DVA. But there's actually no body that actually refers to the Minister. So we wanted to elevate that, make it more important. Get advice directly to the Minister and not be put through the sieve of a department. So we actually thought it was a good thing.

MR BAK: Who is going to chair these things?

COMMISSIONER FITZGERALD: The Minister.

MR BAK: See, this is what I mean, there's got to be at least 50 per cent. I said 60 per cent in - - -

COMMISSIONER FITZGERALD: The Minister would chair. Yes.

MR BAK: Somebody that is also qualified in those fields.

COMMISSIONER FITZGERALD: Sure.

COMMISSIONER SPENCER: So further detail around that, obviously, and further explanation around that would be perhaps helpful.

MR BAK: (Indistinct words).

COMMISSIONER SPENCER: So, no, we'll take that on board. Look, I just want to come back to one of the earlier comments and a concern which we've heard several times, and that is this is just all about the money and the short answer is, "No, it isn't". And in fact we think that probably some of our recommendations would need additional investment by government. So just to explain that, as we said in our report we haven't done a lot of the costings at this stage about some of the changes. We're going to do more of that work for the final report, but our feeling at the moment is that there would be an ask in here for government to invest further funds around building better systems. So we'll see what that looks like through the final report.

MR BAK: Well, I've touched on that – I've touched on the – in my responses as well.

COMMISSIONER SPENCER: Yes.

MR BAK: Now I know nothing just falls out of the sky.

COMMISSIONER SPENCER: Yes.

MR BAK: But I think really if - in relation to the claims process, there would be heaps saved in relation to that - - -

COMMISSIONER FITZGERALD: (Indistinct words).

COMMISSIONER SPENCER: Yes.

MR BAK: - - - rather than the three interjecting legislations.

COMMISSIONER SPENCER: Yes.

MR BAK: There would be heaps of money saved.

COMMISSIONER SPENCER: Well, and experience in other schemes tells us there is tremendous potential for savings. Better, more effective, faster, quicker, more accurate decisions - - -

MR BAK: Yes.

COMMISSIONER SPENCER: - - - in the way we've been talking about.

MR BAK: Yes.

COMMISSIONER SPENCER: Which clearly is to the benefit of the veteran, and frankly is going to be more cost effective as well.

MR BAK: Yes.

COMMISSIONER SPENCER: So, that should be a win-win.

MR BAK: Well, it goes hand in hand.

COMMISSIONER SPENCER: Yes. So can I just ask you in relation to the Veteran Centric Reforms, so you've been seeing that roll out.

MR BAK: Yes.

COMMISSIONER SPENCER: Are you seeing changes within the department. Are you – do you see - - -

MR BAK: The only changes - really the only changes I've seen are for the worse in relation to rehab, rehabilitation. I've got clients up in Queensland, been to Afghanistan, two and three tours, and they're pretty messed up. Okay? Now, I've got one particular veteran that's – that she's been on - she does not have to provide a rehabilitation program, she doesn't have to attend one until the end of this month or this year, and it was two years ago, right. I fought very hard for this girl, this person, and - well we've come to the time now where they may be asking her to attend a rehab because of her age. She's only young. Right, and so - - -

COMMISSIONER SPENCER: Well, what's going wrong there? Is it - is it a failure to assess correctly or - - -

MR BAK: Well, the point – what's going wrong there - - -

COMMISSIONER SPENCER: Yes.

MR BAK: - - - is the DVA in rehab terms, nobody within the DVA talk to each other. It's like, "Oh, this is my job, that - that belongs to rehab". (Indistinct) sent it down there. Rehab then have their people and they phone the veterans while they're in a period of recovery, should I say, and they're demanding that these people attend these certain courses, they've made appointments for them, and all the rest, and the veteran is – is in no way or shape or form able to be part of a group for rehabilitation. So, you know, my own answer to people that come to me and, look, ask me for advice, I say see their doctors, whoever they may be, psychiatrists, GP, specialists or whatever. Okay.

See them and get a report from them, but ask the specialist, "Am I fit for rehabilitation?" and if they're not present it to DVA and let it go for another six months, 12 months or whatever, you know. But they are very intrusive into the veteran's life, especially those that are pretty squashed up – up in the head. You know, PTSD, depression, adjustment disorder, bipolar, all the rest of it.

COMMISSIONER SPENCER: Has the introduction of the White Card made any tangible difference, from your experience?

MR BAK: It's a good thing. I was pretty cynical of it at first when it came out, when they said person who have served – well, you say so in here, person who has served one day, definition of the veteran. I was cynical of that but during this forum last week, I know an ex-bus driver who was in Defence, he was working on recruit transport. He had a case where - he used to pick up the recruits and take them - take them down to Kapooka. Right. Now, this one person was crying all the way from

Sydney, where they jumped on the bus, to Goulburn and he didn't know why. Right.

So, because he was crying, the people on the bus started bullying him and calling him a sooky and a sissy and all that sort of thing. So then that changed my mind straight away. Yes.

COMMISSIONER SPENCER: Okay.

MR BAK: Things can happen.

COMMISSIONER SPENCER: Yes.

MR BAK: That you probably wouldn't think of on the day to day. That's why we held that forum. I wanted ideas from all these people.

COMMISSIONER SPENCER: And apart from the rehabilitation observations you've made, any other areas in terms of how the Department is changing its practice, engaging with veterans that you think gives hope for the future or are you - you're not seeing that at this (indistinct)?

MR BAK: I - I'm a cynical fellow. People – I'm aware of an online thing – myGov account and all that sort of stuff. I even got one myself – I hardly ever go there, but for the people getting out of the military they're treading a dangerous line by putting in a claim online. Because that's going to go to an assessor and my experience is over the last 12 months, people who have been discharged and they've already had their claim in, one out of the whole half a dozen of them, one person has been successful. Simply because the information was there on his medical record. Okay, and the rest of them were denied.

Now when a veteran gets his statement of principles and all of this jargon on that, it doesn't mean a thing to them. They should really go and see an advocate in their area, for that assistance. But for them - it just makes us suspicious that the DVA wants people to put in a claim, we'll deny these fellows and we'll get rid of these advocates. They're a pain in the backside, you know. But that's a fact, that's how some of them in their think. I've got a good - I've got a good rapport with people in there. With certain people, I just don't talk to them anymore. All right. Because they're - in my opinion they're – they're either too lazy to do the job, they're anti veteran – anti veteran centric. Okay, and they shouldn't even be in there as far as I'm concerned.

You know, if they're not in there to work hard and do the right thing by a veteran community, they shouldn't be there. End of story, and there's a lot of that going on.

COMMISSIONER SPENCER: Okay.

MR BAK: A lot.

COMMISSIONER SPENCER: Thanks Bob. Yes.

COMMISSIONER FITZGERALD: Just concluding, we note your comments in relation to health chapter.

MR BAK: Yes.

COMMISSIONER FITZGERALD: Can I make just a couple comments. I want to repeat what I said before, it's very important. No veteran that currently is entitled to a Gold Card would lose it. That's our recommendation.

MR BAK: No, I understand that.

COMMISSIONER FITZGERALD: And people under VEA that would continue on. What we're trying to do is - as I said this morning, is to look and see whether there's a better way. So since the Gold Card has come in, we've now got the White Card extended considerably, and there's a whole lot of different initiatives in the health space that have come into play. So we're just trying to take a stock of that and say, well what's changed in health space and what - is there a better way forward. You know, at the end of the day it may be the Gold Card stays as it is, but that's the context we're having a to look at.

We hear the - we hear the advocacy around the Gold Card. So what we're trying to do is really say is there a better way going forward? And that means mental health, physical health, you know, we've talked about rehabilitation and the card system. Now I just want to - nobody loses their card, that's not going to happen. No government would ever do that, and we're not recommending that. But we are having a good look at the health stuff and we'll appreciate your comments, and we've got those so thank you very much for that.

I should just say that the healthcare is going to continue to increase as a cost to government. It's currently over five point – nearly $5.3 billion a year. So it's, you know - it's a very important part of the veterans' compensation scheme. So getting it right has a dollar effect, but it won't

save any money. This is part of the budget that's just going grow and grow and grow and grow. So the government is not looking to save money.

What I think the government is trying to do is there a more efficient way of getting better outcomes for the dollars that are spent. But anyone who thinks this is a cost cutting exercise in the health area, it isn't. It's not possible. The health expenditure is just going to continue to grow and when it's already 5.3, I think it's right that we look at it. But I do - we will read all of your submission carefully in relation to the Gold Card. But you may have a final point you want to raise on that before we conclude.

MR BAK: I've got a couple of points. I - - -

COMMISSIONER FITZGERALD: Please.

MR BAK: If you don't mind, if I can just read out - - -

COMMISSIONER FITZGERALD: No, please.

MR BAK: - - - what I've (indistinct) - - -

COMMISSIONER FITZGERALD: Sure.

MR BAK: - - - in relation to 14.6. Draft recommendation health care.

COMMISSIONER FITZGERALD: Yes.

MR BAK: All right, I'm just – the draft – the Australian government should amend Veterans' Entitlement Act '86 vehicle assistance scheme – no, no, no.

COMMISSIONER FITZGERALD: We've got your comments, it's fine. I mean you – you - - -

MR BAK: Yes, here it is. In relation to the Gold Card. I said rubbish. All right. What you've proposed, what you've found.

COMMISSIONER FITZGERALD: What we're looking at.

MR BAK: Finding 15.1.

COMMISSIONER FITZGERALD: Yes - no, it's fine.

MR BAK: All right.

COMMISSIONER FITZGERALD: I've read that.

MR BAK: You've read that?

COMMISSIONER FITZGERALD: I've read your submissions. Yes, got it.

MR BAK: Okay.

COMMISSIONER FITZGERALD: And you're very clear.

MR BAK: Okay. Does anybody else want to hear it?

COMMISSIONER FITZGERALD: No, no, I don't want to hear any more. No, it's fine.

MR BAK: You don't want to hear any more? That – this is not just my thoughts.

COMMISSIONER FITZGERALD: No, no.

MR BAK: This is thoughts from a forum.

COMMISSIONER FITZGERALD: Look, these are common – look we've heard these before in the consultations we were going around before the draft. Some people have misunderstood what's in our report, that's perfectly fine. But I just want to go gain. We understand the sensitivity of this issue. We can't duck it. We can't have a simplistic solution. So we are going to give it one hell of a thorough examination. But that's what this is about, but we hear your concerns, and we hear concern from many, many, many veterans, and we heard it last year as well. So thank you for being so explicit about it.

MR BAK: I just have one more about the Gold Card. Okay?

COMMISSIONER FITZGERALD: Yes, and that's it.

MR BAK: This is something that hasn't come up. It only came up over the weekend, and I thought, right, yes, that's a good idea. Now, given the Gold Card runs counter to a number of key design principles. Right, at 15.1.

COMMISSIONER FITZGERALD: Yes.

MR BAK: You know, you haven't given any example of the key design principles. You haven't - there's been nothing written on there. That's what I'd like - I'd like to see.

COMMISSIONER FITZGERALD: Yes.

MR BAK: And this thing about pensioners getting a Gold Card with qualifying service at age 70. Service pensioners with qualifying service have 50 per cent disability pension at present. Under the VEA, when they turn 70. If they have 50 per cent disability. Veterans with any amount of service pension and 30 points from accepted conditions under the MRCA can also be issued with a gold card. Okay. Is the commission referring to all veterans under the VEA and MRCA or all the – under all three Acts? If that question you're put.

COMMISSIONER FITZGERALD: The question is really looking across the Acts. But what happened, as you know, the Howard government introduced an extension of the Gold Card to people over 70 that had met a particular criteria, which opened it up considerably and the second thing it did is it introduced it on the basis of no means testing. Whereas people that were receiving particular pensions in their 60s were means tested.

MR BAK: Yes.

COMMISSIONER FITZGERALD: When we've explored why that occurred, no one has an explanation for it and one or two of the ESO groups in the last week were totally opposed to it. They thought this was just policy on the run, and it is. But having now got the benefit in, in an unmeans tested way, you've extended it dramatically. Now, they're the sorts of things we've been looking at. There's been a whole lot of decisions made in the health area which we cannot find a rationale for. But once they're in, nobody is prepared to give them up. I understand that, absolutely fully.

But it doesn't mean necessarily we should continue those practices going forward. So we're looking at it.

MR BAK: Yes, well this is – well this is - - -

COMMISSIONER FITZGERALD: But the ESOs themselves are not able to say why the Gold Card was suddenly extended, it just was.

MR BAK: Yes, well I was – I wrote this response because this was an information request, it wasn't a recommendation.

COMMISSIONER FITZGERALD: Sure. Correct.

MR BAK: Okay? So now this other one, the Gold Card for dependents.

COMMISSIONER FITZGERALD: We've got your comments, and we'll look at that. So I don't need to go through that now.

MR BAK: All right.

COMMISSIONER FITZGERALD: And I haven't got time. But we'll hear it – and we've got a lot of comments in relation to that one. So - - -

MR BAK: Okay. So you don't want to hear any more?

COMMISSIONER FITZGERALD: No. That's it.

MR BAK: I mean I've got plenty more.

COMMISSIONER FITZGERALD: You've done very well, Bob, you know - - -

MR BAK: Plenty more here.

COMMISSIONER FITZGERALD: I'm sure. Thank you very much for that. And could we have Richard Salcole.

COMMISSIONER SPENCER: Thanks.

COMMISSIONER FITZGERALD: (Indistinct words). We'll read all that.

COMMISSIONER SPENCER: Thanks, Bob. (Indistinct words).

MR BAK: I hope so.

COMMISSIONER FITZGERALD: Richard, if you can give us. When you're seated, your name and any organisation that you represent.

MR SALCOLE: Good morning, Mr Commissioners, ladies and gentlemen and fellow veterans, I'm Richard Salcole. I am currently the Vice President of the Wagga RSL sub branch. However, I am here in the capacity as an individual veteran.

COMMISSIONER FITZGERALD: Could I just ask you a question, I've got you down as Contemporary Veterans?

MR SALCOLE: Yes. So - - -

COMMISSIONER FITZGERALD: Is that an organisation or is that just the views you're representing?

MR SALCOLE: The Contemporary Veterans group here in Wagga was formed as part of the RSL, as a sub entity, to try and get younger veterans into the community.

COMMISSIONER FITZGERALD: And your comments today represent their views or are these just your own views today?

MR SALCOLE: A cross-section of both.

COMMISSIONER FITZGERALD: All right. Lead on.

MR SALCOLE: Ladies and gents, I sit here before you as an individual having listened and heard many voices. I'm a veteran of over 30 years' service in the Australian Defence Force who only transitioned from permanent service in January 2016, and final service in the reserves in January 2018. As stated, I'm the current Vice President of our local sub branch, and as a contemporary veteran I am acutely aware of the issues facing our current generation of service members and veterans. I spent two years as a pension and welfare officer within the organisation, and managed claims for veterans from World War Two to current recruits that are going through initial training.

I'm trained in the administration of all current compensation Acts and of the welfare of veterans and their families. I've supported veterans through the death of loved ones and spent many hours sitting and listening to veterans before getting them to promise me that they would not commit self-harm and that they would talk to me in the morning in an attempt to prevent a suicide. So why am I here? The Commission is investigating what needs to be done to support veterans and their families. I'm here to assist them in understanding what a veteran is. A veteran is a label that has been placed upon a member who has made a commitment to the country that they are willing to, at any stage, day or night, regardless of the threat, the weather or the location, to defend Australia, its population and interests, both domestically and on foreign soil.

These select members of the Australian population have volunteered to put their life, their health and their future on hold for you and no guarantee that they will safe – there'll be safety in their exit from their service. Some members have been selected to serve overseas, while many have been employed within Australia to deploy instructing reinforcement, or providing essential support. They should not be forgotten just because they do not face the enemy. Their crucial role enabled others to do what they do to protect Australia and those interests. The forgotten are those who we leave behind, the families who we wave to - wave goodbye to everyday when we go to work, not knowing when or if they will see us again.

The children who move location every two years and struggle to assimilate into a new peer group at yet another school, and often being bullied for their family connection to the service. While the non-defence partner looks for yet another job and make connections in the community, while we get on with our daily duty, so do they. How long has this been going on? Since before 1901, and how long will it continue? Until governments stop sending men and women into harm's way. I've not had the opportunity to read the comments of the submission and the commission, and only recently received 704 page draft report.

But I do wish to address some key issues. I noted in the draft report, I – I went through the initial chapter and some of the statements that stood out. The preventing and minimising Defence injuries and illnesses. Defence services is unique in not only the way the deployed roles occur, but also the peacetime operations. Although Defence does provide training in the inherent activities conducted by Defence, those activities are dangerous. Risk assessments give a level of threat to an individual, however, missions change. Fatigue comes into play, mentally and physically. And simple human response can change a planned activity, but simple accidents can and will happen.

On from that, we did a lot of lead up training before we deployed to the Middle East. However, the conditions that we were training in were Australian conditions. The sand was Australian sand, the rocks that we were walking over were different. We get over there and the conditions that we were fighting in were totally different. There's nothing you can mirror the actual environment with, when you're training in Australia especially when we're not fighting on Australian soil. Simple things like just putting down rocks to prevent dust from flying all over the place when vehicles were travelling through then became a risk injury to ankles and Achilles injuries.

Restoring injured and ill veterans by providing timely and effective rehabilitation and healthcare, so they can participate in employment and life. On this point I noted that veterans injured in service of the country are provided the highest level of medical support and rehabilitation to return to a condition where they can return to a fighting state. While all efforts are made to support the veteran, it inevitably about the service and if the member falls behind in the schedule or does not respond to the treatment like everyone else, then they are pigeonholed and medically downgraded to match a set of policy rules based on outdated and over quoted resources.

Rehabilitation is outsourced to civilian organisations that do not understand nor take into account the full nature of service life. We have quite a few situations where organisations like Connect - and not singling them out specifically, just one that comes to mind – is employed by Defence to assist in the rehabilitation. But not understanding the full nature of service duties, they put on the civilian context and that doesn't necessarily engage all those other military aspects. A simple back injury could lead to a member not being able to complete a physical fitness test. That member is then downgraded and discharged because they can't pass their fitness test. In civilian employment, they'd still be able to continue to do their normal everyday job. It's just that deployed element that they can no longer do. That inherent activity in Defence means that that member is then put out the door.

Healthcare post Defence separation, while the required standard within the community again does not understand the vulnerabilities of Defence members. A member that has gone through their whole service career being assisted through – the ability of just being able to ring up the doctor and say, "Can I have an appointment?" I've had the issue myself and a number of others have as well that you get out of Defence, all of sudden you have to get a Medicare card. You have to know how to use that Medicare card. For some veterans, and I was one, I spent 30 years in Defence. I said to my wife, "How do I make a doctor's appointment?" Something that simple can throw a Defence's member's psyche out totally.

The current transition system is broken. The statement about providing effective transition support for veterans and their families; the way we transition a member depends on how they are discharged. A member who is medically discharged gets a lot of support because that injury has been identified by Defence and Defence are doing everything they can to be seen to be doing the best for the member. The member who had elected discharge at their own request, basically walks out the door and the door is closed behind them. I, myself, went through this and continue

to struggle with it every day. I've been diagnosed with anxiety, depression, separation anxiety and also agoraphobia. I'm only able to sit here, today, because I know people in the audience. If I didn't know anyone here, I wouldn't be here. What we have is an issue with members going through the medical separation are handed on to help providers on the outside. A member that has to seek their own support and their own medical services outside are quite often left in the dark. This thing adds to their anxiety and depression and causes them to go into a deeper mindset.

The service connection of the member runs much deeper than the uniform and an I.D. card. The connection of family before self; the indoctrination to a specific set of values and beliefs, and the lifestyle within the tight knit community of Defence cannot be replicated in everyday civilian life. Without specialist support, these members fall through the cracks. This goes not only for a member but their partner and dependents as well, who also become part of that larger Defence family. And when a member is isolated through separation, so are their immediate family.

What I mean by that is that the families move around with us; they become indoctrinated into that service tight knit group. When we leave Defence, so do they. All of a sudden they don't have that same peer group, the children are ostracized at school because their parents are no longer part of the Defence and the Defence kids don't want to know them and also they're trying to hang out with civvy kids and the civvy kids don't understand what their life's been like to that point.

Enabling opportunities for social integration. This is easier said than done. Again, depending on the unique service to the member as to how socially integrate they are and also how integrated their families are. Internal social enterprises such as Defence Community Organisation and the Defence National Welfare Coordination Centre and even unit welfare officers and support teams are only as effective of the personalities in that position. By personal example; over an almost 30 year career my spouse was contacted by DCO once; received no contact or support while I was deployed twice; and, no support while I was posted member unaccompanied on four separate occasions.

Our story has many parallels in modern Defence community where members do not come from tight knit core units or units that deploy as a formed body on a regular basis. Most families now live in isolation due to the demise of Defence communities and the requirement for members to live further and further away from their workplace. Most Defence members do not live - do not have a wide social basis outside of work. This insular connection, especially at the junior ranks, means that members separating literally feel the door slammed behind them and

thrust into the isolation of civilian world. The anxiety of separation and the grief emotion caused by the loss of driving factors are – sorry, by this loss, are driving factors into depression and, in some cases, the member committing suicide or self-harm. Connection with ex-service organisations before separation is crucial. It enables for the member and their family to not feel so isolated in its transition from Defence.

The providing adequate and appropriate compensation for veterans. DVA currently provide the compensation element for Defence and we've discussed this adnauseum today as well. A member is encouraged to submit a claim for liability and compensation prior to separation for any service related injuries or illnesses. However, there are many caveats. Time limits and policy constraints that either prevent a member from submitting a claim or through the bureaucracy, the member becomes so disheartened that they withdraw their application or do not follow through once liability's been accepted.

Since Federation, Defence members have been lumped under one or multiple compensation and rehabilitation acts. DVA has inherited a complicated and convoluted system. Over the past two years the introduction of the MyService application has simplified the process and displayed a side of DVA that was rarely seen in the past; that of human interaction. The complicated system of (indistinct) of compensation applied to varying conditions of employment over multiple generations of service personnel will take more than a quick fix to sort out.

What I mean by that is the conditions that members served in World War II, Korea, even Vietnam, are much different to what they are now. They weren't trained to the same level that current service members are with risk assessments, with occupational health and safety requirements. Even when I joined 30 years ago, or 30 plus years ago, hearing protection was something that was an optional item not something you must use. So most of us have got medical issues and concerns.

The retrospective application of a new act to previous cases could develop into a loss of entitlements or exclusion from previously accepted conditions that no longer apply. For example, mustard gas exposure; I've got a veteran from World War II that's going through that moment. The Veterans Entitlements Act, Service Related Compensation Act and Military Rehabilitation and Compensation Act and, now, lumped in with the DRCA, are individual acts that covered unique periods of service and, as such, member service may be covered by multiple acts which complicates their situation further and provides that not everyone cannot be tarred with the same brush.

In my view, the only way that the system could be simplified is if all members received a gold card or similar on separation from Defence to cover all medical expenses, whether service related or not. The same level as Medicare provided while the member was – sorry, of the medical care that was provided while the member was serving. A member serving in Defence has all their medical needs met on a daily basis. They step out the door and all of a sudden it's only those service related injuries and illnesses that are covered. I myself was on multiple medications prescribed by Defence doctors, I stepped out the door and trying to get those medications recognised through DVA has meant that I'm, now, not entitled to four different medications that I, now, have to pay for myself.

Compensation could then be looked at as an individual basis, as no two members have experienced the same exact service conditions throughout their entire period of service. Every individual within Defence is a separate individual. By tarring everyone with the same brush and expecting everyone to fit into nice little holes, doesn't work. The human element still needs to be looked at and, when considering what compensation, if any, is entitled to a member that is where it comes into with the individual service. As far as the medical concerns go, Defence members inherently end up with more injuries and illnesses than their civilian counterparts.

I was told at the age of 30 that my knees and my back were almost that of an 80 year old, due to the conditions of service; carrying packs; carrying equipment; and, lifting weights far exceeding those that are expected outside. What's expected as a two-person lift, a lot of Defence members must do on their own because of the lack of personnel. We went from a defence force of over 27000 people when I joined, just in the air force, to a population of 13000. That means that you have to do more with less. That was a mantra for a long time. Under the reforms, was "do more with less", so members were doing more with less by putting their bodies on the line. Therefore, there has been an increase in injuries due to a lack of personnel.

You also look at prior to the Defence Reform Programs in the 1990s when we had a lot of personnel. We were doing a lot more unit and team fitness and sport to actually maintain a fit and healthy body. Now, a lot of people are confined to a desk; a lot of people, their daily routine is, "This must be done in Mission Support," so, therefore, it has a mission critical outcome. You don't give up on your mates that are deployed because you want to go on DPT. So your fitness inevitably suffers through that and, therefore, injuries do occur in normal circumstances.

Commissioners I wish to tender that as my submission.

COMMISSIONER FITZGERALD: Thanks, Thank you very much. Can I just go back to a couple of things? Just on the transition if I might or social or integration as many people call it. You've said that it's pretty poor, in your own words. The elements that you think at the present time that are most egregious, most failing in that system, and we've made a whole range of recommendations around that, but what do you as a current or contemporary veteran - what were the things that you thought were missing in that process?

MR SALCOLE: As I stated, for those that are administered discharged they're the ones that at most risk. They elect to leave Defence within a certain timeframe and you don't know what you don't know. So there are a whole heap of entitlements and a whole heap of necessary factors that are missed out. In my own case, I was married, separated at the time of my discharge. I put down what was my discharge location because my family was here, yet, all my discharge paperwork went through Amberley in Brisbane. I was told by the transitions officer in that state that I had 12 months in which to enact my CTAS entitlement. I got down here and I was told, "No, you only had six months." So there was a difference in communication of entitlements there.

In noting that the job that I was in at the time, and this applies to a lot of younger members getting out, is work, work, work, right up until discharge. There is no transition period where you are taken out of your employment role and put into an area where you can actually effect your discharge in a timely manner and an effective mode of transition. So one of the things that I've looked at is if Defence were to look at a possibility and could be - although I don't like the term of Joint Transition Command - it could be in something similar to that where a member is posted to the transition command, rather than their unit to affect their transition once their discharge is approved.

COMMISSIONER FITZGERALD: In the army there are detachment units that are available for people - - -

MR SALCOLE: Correct. The Army Personnel Capability detachments work effectively within army.

COMMISSIONER FITZGERALD: Yes. Yet, it doesn't exist in, either, the navy or air force.

MR SALCOLE: No.

COMMISSIONER FITZGERALD: Well, why is that?

MR SALCOLE: I was employed as a member support co-ordinator in the air force once I transitioned to the reserves. The member support coordinator is there to assist members in the same process as the APCD for those (indistinct) in medically discharging to help those seriously injured, ill or wounded in that transition. However, the other two services don't have the transition capability.

COMMISSIONER FITZGERALD: Why do you think that is?

MR SALCOLE: The sheer nature of army; army is an intrinsic beast where it is all personnel orientated. Although the other two services say that people come first, in army it is about personnel on the ground and they are soldiers first. They are looked at as the capability within themselves. Within the other organizations it's a matter of you are part of the bigger capability and once you leave, you're just a number; you can be replaced.

Army have also had the advantage of having large numbers of personnel and they have larger groups of personnel transitioning around the same time.

COMMISSIONER FITZGERALD: Sure.

MR SALCOLE: Same as when you redeploy; army tend to deploy a unit air force and navy deploy personnel. So you'll, either, be posted to a ship or posted to a unit on deployment. Army tend to post a whole battalion or a whole company unit at the same time.

COMMISSIONER FITZGERALD: So that sort of potential to be moved aside for a period of time prior to transition, is not current in navy or air force.

MR SALCOLE: No.

COMMISSIONER FITZGERALD: You mentioned just before that a topic about the - once you become non-deployable you're really on a fast track out. Is there a view that that has become more so or less so over time? So we've heard that some people are saying that this has become much more the case recently. Others are not so clear about that.

MR SALCOLE: I think it's become more an individual basis. I recently saw on TV about an army major who was a chopper pilot, double amputee; has now returned to active flying duty, same as Douglas Barter in World War II. However, in other cases, if a member isn't as resilient or

isn't as determined to return to full active duty, their ushered out the door. Again, it's not - I think it's a lot better than it was 10 years ago. I, myself, saw a lot of people because they're obese, they were told, "The door's that way," in the end of the 80s as part of that reform program. "How do we get rid of people?" "Oh, you're obese, you can't pass a fitness test. See you later." Whereas, today, it's more focused on the rehabilitation and getting a member back to a fit state.

COMMISSIONER FITZGERALD: Right. Just in relation to that – and, Richard, you might have some questions - rehabilitation is about either a return to duty or a pathway to transition out and we've had lots of discussions with people, including last week about rehabilitation programs. Your experience of rehabilitation; is the balance between trying to get people back to duty or transitioning them out of the service? Do you think rehabilitation has got that right or not.

MR SALCOLE: I think, again, it's on an individual case. High profile cases get a lot of attention and some cases just fall through the cracks. I have a number of younger veterans that I deal with, now, that have mental health injuries and they basically said, "Here's the door," just because Defence didn't have the capability to actually spend the time and rehabilitate that member whilst in service or the transition out meant that they were, then, able to get a assistance dog; so something that would calm them down, something that would allay that anxiety a little bit to allow them to participate in normal life.

Again, it may be that a member transitions partially. Under Defence Regulations, now, we have the different SERCAT levels. So a member not always is going to transition fully out of Defence. The different reserve levels, now, mean that a member could go on part-time service, they may be a full-time member on part-time service. So there is a crossing over, now, and that is also going to have a large impact on the way we transition people in the future because it may be a partial transition or it may be a full transition out the door.

COMMISSIONER FITZGERALD: So can I specifically ask that we need to look a little bit more about the reserves in the final report and you're absolutely right. The nature of the workforce in the ADF is changing and part of that is transitioning into the reserves. But the issue for us is what does that mean in practice?

So, in a sense, if a person is moving from full-time permanent military service, they move into this so-called transition phase. But as you say, a whole lot go into reserves. But how should we approach that issue?

MR SALCOLE: The classic example with that is in my own case; I transitioned from the permanent air force to the reserves and started the next day, essentially. Because of that transition my CTAS entitlement almost stopped. So I missed out on my entitlement to do additional training support and training days before I left permanent service. If that entitlement was to continue it would mean that members transitioning from one to the other could use that time to actually set themselves up physically and emotionally, make sure that their transition methodologies are set; that they've got a CV in place, they have assistance to actually gain employment, their skills are recognized before they separate. We're not chasing the tail by trying to go through Freedom of Information to try and get members records to get things done post-service.

COMMISSIONER FITZGERALD: When a person decides to cease being a reservist, one of the questions that's been raised with us is whether or not there's anything that should take place at that point by way of transitional support; we get mixed messages. One is, well, they've had lots of times to think about transition. By the time they leave reserves they probably require little support. The other view would be, "Yes, they need support," but it's of a different nature.

MR SALCOLE: One of the big things I see with reserves at the moment; they're the forgotten service across all three arms of the Defence, in that the White Card that was brought in for non-liability health care does not cover reservists, unless they have done continuous full-time service.

COMMISSIONER FITZGERALD: Yes.

MR SALCOLE: Yet, a lot of reservists do actually participate in the maximum 100 days plus per year in training days and do see and do things that can cause mental distress.

COMMISSIONER FITZGERALD: So can you just clarify that for me?

MR SALCOLE: Yes.

COMMISSIONER FITZGERALD: If I move from permanent to the reserves I don't get access to the - - -

MR SALCOLE: Ah. If you've gone through from permanent to reserves, yes, you do. But if you've enlisted as a reservist and your only service has been in the reserves, you are not entitled to

COMMISSIONER FITZGERALD: Yes, so just to be clear; the White Card only applies where you had full-time permanent service.

MR SALCOLE: Yes.

COMMISSIONER FITZGERALD: Okay.

MR SALCOLE: So long as you've enlisted and done one day's full-time duty - - -

COMMISSIONER FITZGERALD: Yes.

MR SALCOLE: - - - either in the reserves or in permanent service, you'll get it, yeah.

COMMISSIONER FITZGERALD: That's what I thought. But if you start off and stay in reserves, then, you don't get it.

MR SALCOLE: You can do 30 years in the reserves and not have any entitlement. Another sort of that - just while I'm on reserves is the - it was mentioned before about medicals. One of the problems we have is you don't know what you don't know; there is actually an entitlement to have a full medical through a supreme practitioner on discharge. Most people don't know about that.

They do their separation health exam from either the permanent or the reserve forces and they go out and all of a sudden they're going, "Oh, that niggles gotten worse, " or, "My knees are not as good as they were." But in that 12 months after they discharge, they may have been able to get a full medical and have everything listed on their medical documents from that point on. And also the access to medical documents, now, that the new myGov access for doctors to be able all the stuff into your My Health's record, Defence need to be looking at that as well. When a member discharges, their health records need to be transitioned over to a doctor as well because our civilian doctors don't know what our Defence doctors know about us and there's a lot of stuff that you don't remember if you've had an extended period of service.

COMMISSIONER SPENCER: Richard you raised a very important issue and that is the impact of military life on families, both during service and when the member's transitioning. So well, what more should be done, both, during service and during the transition period do you think, to support the family as well as the member?

MR SALCOLE: I think during service it's more about educating the members to get their families involved in community. A lot of spouses – I do say spouses so it's gender neutral - because we have that issue now of who's the stay at home parent. It could be the husband, it could be the wife that's a stay-at-home. But to get them actively involved in some form of community activity so they're not isolated, so that when the member deploys, if they're from a unit where it's just the individual that deploys, that family is looked after because the units too busy; it gets on with its daily life. But the family itself is, then, isolated from service connection, so they feel on their own. That's a cause of a lot of the distress in families and separations while a member is deployed; they come home to a wife and kids that are no longer there which, then, adds to the member's own personal mental health.

There is a lot of consternation outside of how much help direct service organizations need to give the families as well, because as a member transitions out, they might go to their local RSL or Mate's Mate, Soldier On; 3,200 ex-service organizations out there to choose from, which is also an issue. There is - all these organizations have grown up because the major providers of assistance weren't there to support them.

There's a changing mentality at the moment that if a member needs support, they'll get everything thrown at them and, again, that sometimes complicates the matter; and the spouse doesn't know who to turn to. So if the schools are aware through the (indistinct) system, the education and housing officers are informed, "Okay, this family's transitioning out of Defence into the local area. The member's been posted in." One of things I advocate is that the member gets put in touch with an ex-service organisation in the area. It may not be the RSL because we don't have RSL sub-branches everywhere. But it could be that they're put in touch with them and said, "Okay, here is a point of contact for you." That organisation, then, assists that member in saying, "Have you got somewhere to live? Have you got somewhere to work. Have you got kids? Are they at school? Can we support them in making sure that they are accepted in the school that they're coming to?" Because of that transitional nature of Defence, the families are the isolated factor.

COMMISSIONER SPENCER: Well, Richard, we are conscious of that. So I mean that reinforces some of the recommendations. When you have a chance to look at our report, you'll see that engaging the family members earlier; being thoughtful about what they're going through and how best to support them. We're certainly under the banner of the Joint Transition Command - really concerned about that.

Coming to the ESOs because you raised an issue and we've commented on it several times this morning about the important work that ESOs do. It's a - it's a hidden asset; a terrifically valuable asset and to us, we often hear that veterans are most comfortable dealing with people who know what their experience is like.

MR SALCOLE: Correct.

COMMISSIONER SPENCER: So that is uniquely within the ESO space. So, and you been familiar with some of the initiatives that are underway to form hubs - - -

MR SALCOLE: Yep.

COMMISSIONER SPENCER: We have seen examples of that in Townsville, in Darwin and elsewhere. What ESOs do is essentially up to ESOs. That's not, you know, for anybody else to say. But we think it's important to look at the potential for government to leverage the services or the opportunities for veterans for ESOs to do the kind of support you're talking about.

MR SALCOLE: Yep.

COMMISSIONER SPENCER: So how would you - I mean from what you're saying, there seems to be great potential for that.

MR SALCOLE: There's one of those things - - -

COMMISSIONER SPENCER: Would that be helpful to do that?

MR SALCOLE: I'm a firm advocate of hubs. I saw effective operation of hubs in Canberra and the way the community is coming together to support veterans. It doesn't matter which organization you belong to, you can be part of that hub and the member has freedom of choice as to which organisation they want to go and talk to. They may have had a bad experience with one specific ESO or one person in a specific ESO, or one person in a specific ESO. So that they then taint that ESO, they can go and talk to someone else. Again we don't know what we don't know.

If there was an ability for - the classic example is here in Wagga. We had a DVA, an office established here. They then disestablished the office here and said, "Oh yeah, there is one at Wodonga, it's only an hour and a half away." That hour and a half is all right, if live here in Wagga. If you're out at Hay or Deniliquin, and you were coming to Wagga for treatment, because this is a major medical hub for the region, you could

have access that facility while you're here. But now you could go another hour and a half away.

It's all right in major capital cities, because a lot of infrastructure is built around human services. In the bush, it's not. The regional impact is that it is a large distance to travel. And for yourselves just come here today, you've seen, okay, there's some people in the room that came, an hour and a half, two hours, to actually come and listen the commission. We have that issue where, if you have a central hub, you know that, "Okay, I can go there, I can get my shopping done, I can go and do this, I can do that, and go and speak to whoever I need to speak to."

One of the initiatives, and Pete Robinson's in the room, one of the initiatives he's pushed for the last few years is that we have a central location where all veterans can come, regardless of their background. They have the ability to get in and do things, like similar to the defence shed in South Australia, give them tactically, give them something to do with their hands. A member who has mental health issues can be aided so much by having that tactile interaction. If it's just someone sitting there talking to them, or talking at them, it's not going to sink in.

But through Peter's interaction, he managed to get a welding course up and running through TAFE, as an interaction between the RSL and TAFE, we had members actually transitioning from Defence. We had members who'd been out of Defence for a number of years, and there were members that were still serving. All able to come together to complete a course of training, because they all speak the same language and that's the big thing about the ESOs.

COMMISSIONER SPENCER: No, thank you for that Richard. I just want to go back to this, we've mentioned this word "outsourcing" several times and with your 30 year career I'm just wondering if you've got any comments on something we've observed. And that is that, it seemed to us, there's a history going back several decades, of people who were - had medical issues and injuries, there were alternate roles for them within the military.

And we've heard stories about many people are quite happy to go to a role where, you know, meeting the physical requirements is no longer possible. But, it seems with the outsourcing and many different roles, security, catering, all kinds of other roles around the services, that those opportunities are not there anymore.

MR SALCOLE: Correct.

COMMISSIONER SPENCER: If you look at the modern - well, contemporary veteran, as you know, the length of service is typically now about seven or eight years. So maybe the times have changed, and people don't see a lifetime career. But do you think that issue of, you've got to be fit or you're out, you've got to meet the standards or you're out, do you think that's been exacerbated by this not having the opportunity to find other roles for people within the military? And as sort of a supplemental question, do you think that's changed the culture of it?

MR SALCOLE: Yes on both. The Defence family that we used to have, where members did 20 years plus, a lot of that was centred around superannuation schemes, DFRDB.

COMMISSIONER SPENCER: Yes.

MR SALCOLE: As well as, even in community now, the average length of a career is four to six years. So they've seen their friends transition around outside, and all of a sudden they've gone through school, they've gone and done a welding course, they're working up in the mines, they've come back, they're doing - so, the culture within Defence as well as just replicating that, it's still a slice of community.

What we do see more of now though, is that there is a lack of opportunity to stay in Defence, if that's what you choose to do, because of the downsizing, the reforms that we had back in the 90s, the lack of funding to Defence Force salaries has said that we, okay, we have essential services, then we have non-essential services. Essential services we need to be able to deploy, that's where the money goes. If he can't be deployed, then you can transition across and become a civilian, and work in the nonessential services, or even separate all together.

But, that culture then also changes, because that family that we had no longer exists, and it's just another workforce now. So that then exacerbates the seven year career, because people don't see it as a long term venture anymore.

COMMISSIONER SPENCER: Thanks Richard. Robert?

COMMISSIONER FITZGERALD: We're just going to run out of time, but I hear your comments about all medical expenses being funded when a when a member of the ADF leaves. And as you've heard from us, we're looking at all of these issues. The Gold Card at the moment covers a number of matters beyond just health.

MR SALCOLE: Correct.

COMMISSIONER FITZGERALD: Well, depends on how you define it. It picks up some aged care stuff, home care stuff, oral health, lots of other things as well. Is the issue that you're raising - you probably don't draw a distinction, but do you draw a distinction between meeting the medical needs of people in a very narrow sense, as distinct from the Gold Card which is much more expansive than that?

MR SALCOLE: Okay. The basic level of healthcare, I suppose that Medicare provides to people on the outside. Probably could be extended to the White Card to enable that transition to occur, without it affecting the Gold Card. But the Gold Card also picks up on those aspects of service that are unique to service life, the fact that your body is going to be broken and damaged a lot more than what has been counterpart is.

COMMISSIONER FITZGERALD: And just in relation to that, can I ask a question: have you got any views about the ability to access mental health services in this region.

MR SALCOLE: Mental health services in this region are pretty poor. And I've been fairly lucky. I was referred to a couple of mental health practitioners. That ranges from a tertiary trained counsellor, through a psychologist, to a psychiatrist. We have, as it was stated before, we had two psychiatrist in town that do see Defence members, and the rest are all - you have to get to Sydney, Canberra, Melbourne, which then again, if you have anxiety, the last thing I want to do is go and jump on a plane by myself. So then that means that then I've got to organise meetings and stuff around when my wife's available to go with me.

If I drive myself, if I have an anxiety attack halfway, I tend to turn around and come home, because home is my safe space. So again, that mindset of how far the veteran can actually travel on their own and the support available to the veteran forces other health issues onto that member as well. Because all of a sudden, they'll get a niggle in their back, and they'll go, "Ah, look, I can't travel two hours to go and see a doctor, I'm just going to not worry about it." Or, "I'll just go to me GP and I'll get more painkillers." So mental health is no different. If you can't get the access to the service regular and readily in the area, you're not going to worry about it.

COMMISSIONER FITZGERALD: Good. Thank you very much, Richard, for that.

MR SALCOLE: Thank you.

COMMISSIONER FITZGERALD: Is there anybody else who wishes to make a brief statement before we conclude. So, even if you're not prepared, we've got some - a few moments. Anybody? Sir. Just come across. So, if you can give us your full name and any organization that you represent, and if you'd like to make a brief statement.

MR HOGARTH: Peter Alexander Hogarth. I'm representing and assisting Mr Bob Back for the Integrated Service People's Association.

COMMISSIONER FITZGERALD: Sure.

MR HOGARTH: Just a brief history on myself. I have just recently separated the Air Force, after 39 years' service. And I've seen everything from the Deseal/Reseal program back in the late 70s, early 80s, up until current deployments in Iraq, Afghanistan, and locally with border protection, looking after asylum seekers. And it's good to see you again, Commissioners, of course we had dealings at RAF base Wagga last year, if you remember.

COMMISSIONER FITZGERALD: I do.

MR HOGARTH: I just want to talk about a couple of things that were raised by the previous presenters, and just to talk about what they said in in regards to some of the draft recommendations. If I may.

COMMISSIONER FITZGERALD: Just briefly, yes.

MR HOGARTH: Yes, very briefly. So, the first one is I want to talk about what Professor Pope brought to the table with draft recommendation 5.1, and that is to do with Sentinel. Sentinel has been in vogue with Defence for the last few years. The big thing we found with Sentinel, and it's still happening, it is not a complete tool for capturing events, as you're probably well aware. The latest ones, and I can only talk about Air Force specific, the latest ones they're looking at finalizing with Air Force is risk management, to do with risk management, and that is the implementation of risk registers, and they'll tie analysis into that.

So, the issue with Sentinel, and if the Commission is looking at providing Sentinel as a tool to assist DVA. The biggest thing we found in Defence was the lack of training, for the tool. So, currently there is only specific people at Air Force bases that are conversant with the tool. That is unit safety advisors, wing safety advisors, and RAF safe advisors, at particular establishments. So, the problem is that a person on the - on the hangar floor has a safety incident, which is called an "event" in Sentinel.

They are not trained up on the tool to input the data. So then, they go to a unit's safety adviser, to assist them in inputting the data. What is lost there, on occasion, is the context of which that data is inputted in relation to the incident. So, training has to be looked at. So, Professor Pope then talked about the Defence Injury Prevention program. Known as DIP, DIP data.

So about 10 years ago, and this is only locally, RAF Base Wagga, the DIP team, with the physical training instructors, was disbanded. So now the safety data is inputted by these specialist people, into Sentinel. That is rolled up, and that data is extracted, at the Defence Flight Safety Bureau to be inputted into the top board safety board, the Air Force Safety Board which, currently is held twice a year. The issue is the extraction of that data, allows Air Force Safety Board members to look at things they're going to target for audits, in the in the forthcoming year.

The only issue is, and I'm - I left on 13 January, this year - I was the secretariat for the Air Force Safety Board dealing directly with the Chief of Air Force. So the issue is that this data once discussed at Air Force Safety Board, is not disseminated down back to the force element group commanders, which then comes back to the unit. So, there may be cases where the units are dealing with an issue, right, it's fed up, but it's not brought back. So there's no, what do they call it, improvement. So that's the first thing.

So I'd like to now talk about what Richard Salcole brought to the table with regards, what's the difference. And I'll link what I said previously to now. The catch cry for Air Force, at the moment, is "Mission First, Safety Always." So let's now look back at the Deseal/Reseal program, where the catch cry back then was, "Platform First." The point I'm trying to make is where do people fit into that?

So it's often viewed, locally, as capability first, safety always. But what I've said to the commanders, up to and including the Chief of Air Force, never forget people are your capability. Because without people you will not be able to bring that capability to the frontline. You look at our values statement for Air Force. See if I can remember it, "Respect. Excellence. Agility. Dedication. Integrity. Teamwork." But you then overlay that on Defence values. The missing element, with Air Force values to Defence values, is loyalty. So people are pushed aside.

When I transitioned, sorry, when I started to transition, I started January last year, the transition, and it was only via word of mouth that I was told to start looking at getting my claims together for DVA. It certainly wasn't delivered at the transition seminar that I attended. So I started doing that.

The first thing was to get my medical documents, and then to go through them painstakingly, and over three Acts, it becomes very confusing. So I had to go, and with the assistance of Mr Bob Back, sit down and go through the claims. No other person was able to assist.

But before doing that, and I did that off my back by the way, before doing that, I went to the transition officer, at the time saying, "Where can I go for - to get assistance?" The transition officer is a civilian who had no idea of military aspects of service, and where to direct me. So they're just a few things.

The last thing I wish to say, and it wasn't brought up, we've talked about it, is accessing the DVA website. Now, Commissioners, I want you to put your hats on an early veteran trying to access local I.T. Whether it be a laptop, hasn't got a clue, would not know, and this is a generalised statement, would not know how to turn it on, let alone go to a site to access MyService, myGov, to assist. So they're just some of the things.

COMMISSIONER FITZGERALD: Thank you, Peter. I will be brief. But can I just go back a bit. This issue about people are your capability,

MR HOGARTH: Yes

COMMISSIONER FITZGERALD: As outsiders, complete outsiders, we would have thought that that is completely uncontested, that is that is what we would see it as. As we've been going through the inquiry, there is a view that within Defence, people are not necessarily seen as the most significant asset, and it does seem to vary between Army, Navy and Air Force, and I don't want to give a commentary on that.

MR HOGARTH: Yes.

COMMISSIONER FITZGERALD: But it does surprise us from the outside that people are not seen as the most important assets. You know, capability within the three defence services. So why do you think that is, if that is so? I mean, I don't want to overstate it, but it is very clear to us that there is a view within the three services, by serving personnel, that they are not seen as the as the - as the key asset to credibility. So why do you think that is?

MR HOGARTH: Because the focus is on obtaining platforms. For example, the F-35 that is coming into service. The two jets those that have landed in Australia, right? At 125 million apiece. We've obtained 72 of them, right? What thought was given into the maintaining of that platform? What thought was given into training the people? So the

platform becomes first, and I relate it back to the F-111 Deseal/Reseal, right? It was to get the jet in the air at all expense. And that's why we're still dealing, and I can say from the Air Force Safety Board perspective, the Deseal/Reseal Action Items are still current, to this day.

And the incident happened back in the late 70s. So, again, I say what have we learned? Our focus is on capability, the platforms we bring to the table. People are a distant.

COMMISSIONER SPENCER: No, no question. That is very helpful. Thank you Peter, and particularly those last comments, because that's something that has struck us, that - where are the individuals in all of this.

MR HOGARTH: Exactly.

COMMISSIONER SPENCER: And sometimes it's not clear, what the priorities are.

COMMISSIONER FITZGERALD: Thank you very much.

MR HOGARTH: Okay, thank you.

COMMISSIONER FITZGERALD: Is there anybody else that would want to make a comment before we conclude? Last chance.

UNIDENTIFIED SPEAKER: I just want to declare (indistinct).

COMMISSIONER FITZGERALD: Do you want to be on the record. We can do it after then, that's fine. Any other comments? Well, all it leaves is for us is to say thank you for your participation today. We very much appreciate it, and to adjourn the public hearing until we meet in Canberra tomorrow. And then as I indicated, later in the week we have Melbourne, Hobart, and then subsequently Brisbane and Townsville. So thank you very much.

MATTER ADJOURNED UNTIL
TUESDAY, 12 FEBRUARY 2019